BOARD MEETING

DATE: **WEDNESDAY 1 APRIL 2015**

TIME: **9:30 A.M. - 12:00 P.M.**

VENUE: **BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG**

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 Corporate Services Manager within one month of them changing.

AGENDA

Agenda Item		Lead Member	
	Welcome to Members of the Public and the Press		
	Apologies for Absence		
1.	**Items for Approval**		
1.1.	Minutes of the Board Meeting held on 4 February 2015	**BH**	*
1.2.	Minutes of the Special Board Meeting held on 4 March 2015	**BH**	*
1.3.	Running Action Note	**BH**	*
1.4.	Performance Management	**AMcM**	*
1.5.	Royal Bank of Scotland Bulk Cash Service	**SG**	*
1.6.	Strategic Planning Committee Revised Remit and Membership	**AMcM**	*
1.7.	Corporate Risk Register	**DF**	*
1.8.	Healthcare Associated Infection Update	**MJ**	*
1.9.	Unscheduled Care	**MJ**	*
1.10.	Edinburgh Partnership Community Plan 2015-18	**AMcM**	*
1.11.	Committee Chairs and Memberships	**BH**	*
1.12.	Audit & Risk Committee - Minutes of 19 February 2015	**JMcD**	*
1.13.	Healthcare Governance Committee - Minutes of 21 January 2015	**MB**	*
1.14.	Finance & Resources Committee - Minutes of 21 January 2015	**GW**	*
1.15.	Strategic Planning Committee - Minutes of 15 January & 12 February 2015	**BH**	*
1.16.	East Lothian Health & Social Care Partnership Shadow Board- Minutes of 22 January 2015	**MA**	*
1.17.	Edinburgh Community Health Partnership Sub-Committee - Minutes of 13 November 2014	**SA**	*

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

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1.18.	Midlothian Community Health Partnership Sub-Committee Minutes of 15 January 2015	**PJ**	*
1.19.	West Lothian Community Health & Care Partnership Board - Minutes of 3 February 2015	**FT**	*
1.20.	West Lothian Community Health & Care Partnership Sub-Committee - Minutes of 12 February 2015	**FT**	*

2. Items for Discussion (subject to review of the items for approval)
(9:35 a.m. - 12:00 p.m.)

2.1.	Waiting Times Performance, Progress and Elective Capacity Investment	**JC**	*
2.2.	Quality Report	**DF/MJ**	*
2.3.	Financial Position to February 2015	**SG**	*
2.4.	Financial Plan 2015/16 - 2019/20	**SG**	*
2.5.	Person-Centred Culture, Feedback and Complaints	**MJ/AB**	*
2.6.	Local Delivery Plan 2015-16	**AMcM**	*
2.7.	Corporate Objectives 2014-15	**AMcM**	*
2.8.	Corporate Objectives 2015-16	**AMcM**	*
2.9.	Improving Access to Psychological Therapies	**JF**	*
2.10.	Staff Survey Results - Presentation	**AB**	**p**
2.11.	Impact of Research in NHS Lothian	**JI**	*

3. **Next Development Session:** Wednesday 6 May 2015 at 9:30 a.m. in the Boardroom, Waverley Gate.

4. **Next Board Meeting:** Wednesday 24 June 2015 at 9:30 a.m. in the Boardroom, Waverley Gate.

5.	Resolution to take items in closed session		
6.	Minutes of the Private Meeting held on 4 February 2015	**BH**	®
7.	Matters Arising		
8.	Royal Hospital for Sick Children & Department of Clinical Neurosciences - Addendum to Full Business Case	**SG**	®
9.	Improving Older People's Care in Edinburgh - 2015-2016	**SG**	®
10.	Any Other Competent Business		

Board Meetings in 2015	**Development Sessions in 2015**
	6 May 2015
24 June 2015	15 July 2015
5 August 2015	2 September 2015
7 October 2015	3 November 2015*
2 December 2015	

* Tuesday

DRAFT **1.1**

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 4 February 2015, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mrs K Blair; Mr J Brettell; Councillor D Grant; Councillor R Henderson; Professor J Iredale; Mr P Johnston; Councillor C Johnstone; Mr A Joyce (Employee Director); Mrs A Meiklejohn; Mrs A Mitchell and Dr R Williams.

Executive and Corporate Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mr J Crombie (Director of Scheduled Care); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Ms M Johnson (Executive Director Nursing, AHPs and Unscheduled Care); Professor A K McCallum (Director of Public Health and Health Policy) and Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information).

In Attendance: Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications & Public Affairs).

Apologies for absence were received from Mr M Ash, Dr M Bryce, Mrs J McDowell, Councillor F Toner, Mr G Walker and Mr G Warner.

Declaration of Financial and Non-Financial Interest

The Chair 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.

79. Welcome and Introduction

79.1 The Chairman welcomed members of the public to the meeting. He also welcomed back Mrs Blair who he advised had resumed her duties as the Chair of the Acute Hospitals Committee.

80. Items for Approval

80.1 The Chairman reminded members that the agenda for the current meeting had been circulated previously to allow Board members to scrutinise the papers and advise whether any items should move from the approval to the discussion section of the agenda. No such requests had been made.

80.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated 'For Approval' papers without further discussion.

80.3 Minutes of the Board meeting held on 3 December 2014 – Approved.

80.4 Minutes of the Special Board meeting held on 14 January 2015 – Approved.

80.5 Running Action Note – Noted and approved.

80.6 Performance Management – The Board received the update on the existing performance against current 2014/15 HEAT targets and other relevant standards.

80.7 Corporate Risk Register – The Board agreed the recommendation to use the NHS Lothian corporate risk register, highlights of which had been contained in section 3.21 of the paper and summarised in appendix 1, to inform healthcare governance assurance requirements.

80.8 Committee Memberships - The Board agreed to appoint Mrs Julie McDowell as Chair of the Audit and Risk Committee. The Board also agreed to appoint Mr Iain Buchanan, Chair of the West Lothian Public Partnership Forum, to the West Lothian Community Health and Care Sub-Committee.

80.9 Audit and Risk Committee – Minutes of 8 December 2014 – Adopted.

80.10 Healthcare Governance Committee – Minutes of 25 November 2014 – Adopted.

80.11 Finance and Resources – Minutes of 12 November 2014 – Adopted.

80.12 Strategic Planning Committee – Minutes of 13 November and 11 December 2014 – Adopted.

80.13 East Lothian Health and Social Care Partnership Shadow Board – Minutes of 6 November 2014 – Adopted.

80.14 Edinburgh Health and Social Care Partnership Shadow Board – Minutes of 18 July 2014 – Adopted.

80.15 Midlothian Health and Social Care Partnership Shadow Board – Minutes of 23 October 2014 – Adopted.

80.16 West Lothian Health and Care Partnership Sub-Committee – Minutes of 18 December 2014 – Adopted.

80.17 West Lothian Health and Care Partnership Board – Minutes of 9 December 2014 – Adopted.

Items for Discussion

81. Healthcare Associated Infection Update

81.1 The Board noted that both the staphylococcus aureus bacteraemia and clostridium difficile HEAT targets had been breached at the year end.

81.2 The Board noted in terms of Ebola preparedness that a tabletop exercise had been arranged at the Western General Hospital on 13 January 2015 and the Royal Infirmary of Edinburgh on the 15 January 2015. It was noted that NHS Lothian was the host of the Scottish National Viral Haemorrhagic Fever Testing Service and this replaced the requirement to transport Scottish specimens to the rare and imported pathogens laboratory at Portendown, Wiltshire. It was noted that the turn around time for high possibility samples was 6 hours from time of receipt at the Royal Infirmary of Edinburgh.

81.3 The Board noted that NHS Lothian had recently dealt with 3 possible Ebola cases and although these had tested negative at the Scottish National Viral Haemorrhagic Fever Testing Service the incidents entailed activation of local and national action plans which had worked well through a structured national public health approach that involved key local and national agencies. It was noted that staff continued to be trained in the use of personal protective equipment.

81.4 The Board noted in terms of the Vale of Leven enquiry that the Scottish Government Health Department had provided a template to Boards to undertake a review against the recommendations and would be publishing their response to the recommendations in spring 2015. It was noted that NHS Lothian would be progressing actions to address the gaps in the remaining recommendations. Details of the submission to the Scottish Government Health Department had been shared with the Healthcare Governance Committee with the recommendations cross referenced to other work including the Scottish Patient Safety Programme. It was noted that feedback was awaited from the Scottish Government in relation to NHS Lothian's submission as well as other Health Board submissions. It was noted that work was in progress in any event to progress the recommendations.

81.5 The c-difficile position demonstrated that NHS Lothian was an outlier against other Health Boards. There had been a recent cluster of cases at the Royal Infirmary of Edinburgh and a specific action plan was being developed in order to address c-difficile issues. It was noted that very good surveillance methods were in place and that the 7 day service in terms of laboratory testing and reporting was unique within Scotland.

81.6 A c-difficile campaign had been run in November in the acute environment and from this learning modules had been developed. A presentation had been received from colleagues in Glasgow in respect of changes made to their antimicrobial prescribing policy and lessons had been learned in terms of the change in policy to be introduced in NHS Lothian which would become effective from 1 April 2015. In respect of the revised antimicrobial policy a measurement framework was in place to track any evidence of adverse impacts on patients.

81.7 The Board were reminded of the Healthcare Environment Inspectorate (HEI) inspection at the Western General Hospital that had been discussed in private session at the previous Board meeting. The formal report had published on 26 January 2015 and had been extremely disappointing. The Executive Director Nursing, AHPs and Unscheduled Care reiterated her previous apologies to patients and the Board for the poor performance. The main themes of concern from the inspectors were related to environmental cleaning standards and the apparent lack of cleanliness of near patient equipment including beds. Remedial action had been taken immediately following the initial inspection and this included additional cleaning to address the environmental issues and the focus on near patient

equipment cleaning. The inspectorate had noted significant improvements in the return visit on 27 November 2014. An ongoing detailed action plan was in place led by the site Chief Nurse.

81.8 The Board noted that NHS Lothian had requested specific support from Health Protection Scotland (HPS) and NHS Education Scotland (NES) to review healthcare environment inspectorate issues at the Western General Hospital and that their written report was awaited in terms of issues that might require to be followed up. It was noted work was underway with facilities and partnership colleagues in respect of changing the roles between facilities and nursing staff. This would mean that the distribution of food and drinks would revert back to nursing staff and domestic staff would take an enhanced role in the cleaning of patient areas. The creation of a whole ward team to include nurses and domestic staff was being worked on and would form part of a test of change exercise the outcomes of which would be reported back through the system and if successful rolled out across NHS Lothian.

81.9 The Board noted that the internal inspection regime was under review particularly in respect of more frequent ward inspections to include facilities staff with a particular focus on cleaning standards in order that issues could be addressed prior to any formal inspection regimes.

81.10 The Board noted in terms of the cancer ward that the inspectorate had commented on the small size of bed bays and a draft plan was in place to reduce the number of beds in some of these areas. It was noted in the medium term there would be extensive changes to the cancer centre.

81.11 It was reported in respect of the Vale of Leven report, HEI report and other reports that an overall action plan was being developed focused on patient and clinical aspects including environmental, estates and facilities processes. The draft action plan would be discussed at the Healthcare Governance Committee prior to coming forward to the Board. It was noted that the resources required to address the action plan were likely to be significant and that improvement would need to be prioritised.

81.12 The suggestion was made that the whole response to the HEI action plan was fundamental to everything that the Board done. The detailed work in progress was welcomed as was the awareness of the consequences and costs associated with future developments. The point was made however that there was an issue around staff on the ground having been acceptant of the conditions in place at the time of the inspection. The Board noted one of the issues was that right or wrongly people had become accustomed to particular standards and environments. The charge nurses in the wards involved had been upset at the outcome of the inspection and had since taken a lead role in making the necessary improvements and ensuring these were sustained. Moving forward it would be important that charge nurses were able to hold others to account for ensuring acceptable standards of cleanliness were in place and that appropriate escalation procedures were available if required. The relationship between the charge nurse and the domestic services supervisor would be key. An audit had started on infection control preventions which would provide a performance mechanism on a ward by ward basis and which would be used to address future issues.

81.13 A personal patient experience of ward 2 was provided by a Non Executive Board member who commented that the medical and nursing staff had been excellent. Other aspects of the patient experience had been less satisfactory and a report of

these had been prepared and would be the subject of discussion elsewhere. A key observation had been that between Friday afternoon and Monday afternoon the service appeared to closedown in terms of medical activity. It was recognised that some of the cleanliness issues were difficult to address because of the fabric of the building. The Board would need as part of the action plan process to receive assurance that lessons had been learned across the whole organisation.

81.14 The point was made that irrespective of the role of individual members of staff that anyone witnessing a blood spillage had a professional responsibility to either clean it up or ensure steps were put in place to have the spillage addressed as soon as possible. It was noted that the action plan would address issues like cleaning of spillages by addressing divisions of labour between nursing and domestic staff in conjunction with staff partnership colleagues as part of the previously referred to test of change initiative.

81.15 The Board noted that some issues picked up by inspectors would not always be superficially obvious to busy members of staff particularly if these related to the condition of the underside of equipment. However work continued with facilities staff to improve the cleaning regime.

81.16 The Healthcare Governance Committee had discussed the HEI report and other aspects of the agenda in detail and would continue to ensure changes were enacted. The previous Lothian antimicrobial policy had been in place for some time based on evidence around the use of an alternative toxic drug. There would be a need to be thoughtful of the other implications for healthcare and cost around the change in the antimicrobial policy. The Board were assured an assessment framework was in place and the results from this could be shared with both the Healthcare Governance Committee and the Area Drug and Therapeutic Committee.

81.17 The Board were reminded that the overall plan would be submitted to the Healthcare Governance Committee in April and thereafter to the Board and this would begin to cost the financial requirements, implications and timescales of future work as well as seeking to agree priorities on the basis that not all remedial action could be undertaken immediately.

81.18 The Board noted the recommendations contained in the circulated paper.

82. Unscheduled Care and Winter Planning

82.1 The Board noted that activity in December and January had been busy with the position continuing into the beginning of February across all services in the acute sector, community and social care. Lothian performance was inline with the rest of Scotland. Performance against the 4 hour target of 98% had been 92% in December and 87% in January. There had been an increase in 12 hour breaches, elective cancellations and boarders all of which suggested that the necessary patient flow was not happening.

82.2 It was reported that delayed discharges continued to be challenging and the position at the end of 2014 had been double that of the comparable period in the previous year. The position had however improved since the beginning of January with an increase in homecare and nursing home capacity including the Gylemuir facility.

82.3 The New Day Medicine and Medical Admissions Units had now opened. Work to create a new surgical assessment unit, expand ARAU beds and convert trolleys to day medicine had now been finished. A new day medicine 'hotline' pilot had begun on 14 January. This hotline had been developed in partnership with local GP representatives and should enable front door services to better plan daily medical workload.

82.4 The Board were advised there had been 2 fires, 1 at the Royal Victoria Hospital and the other at St Johns Hospital as well as a chemical spillage within the city all of which had impacted on patient flow. In all instances staff had acted swiftly and professionally.

82.5 The Board noted that looking ahead to the rest of winter that plans around long term issues for scheduled care relating to the strategic plan were being taken forward. The main focus of the plans for the year ahead would be on service redesign and the need to increase patient flow and reduce the length of patient stay as well as looking to increase day care opportunities. Some of these steps related to the financial position and the need to develop different models of care to assist in the meeting of LRP targets. The Board were advised for the current winter period a decision had been taken to avoid using bed capacity that was substandard in areas like the Astley Ainslie Hospital and Corstorphine Hospital which would previously have been used. This had put a pressure into the system although it was felt to be the correct decision going forward and had the support of clinicians in terms of the longer term impact on the patient experience.

82.6 A Non Executive Board member suggested that whilst he understood the need for the Board to meet targets set by the government that the fact that the Lothian system constantly achieved 90% performance against the 4 hour target was a positive achievement and benchmarked well against England, Wales and Northern Ireland. The Chief Executive commented the position was a fluctuating picture and in England they differentiated between all hospitals and core sites and the performance across all hospitals was better than the performance across core sites and this was the same in Lothian. It was pointed out for example that the Royal Hospital for Sick Children had consistently performed at 98 to 99% which pulled the average up and in fact St Johns Hospital performed generally in the mid 90% although if the focus was only on the Royal Infirmary of Edinburgh and the Western General Hospital then performance would be 3 or 4% lower than the average. Publicity the previous day suggested that the Scottish performance for the last quarter was in fact below the English average. The point was made that over the previous year Lothian had consistently performed above the Scottish average. The areas under most pressure were the larger Boards who had multiple A&E sites.

82.7 The Chief Executive commented however that the bottom line was that 90% performance meant that a lot of generally frail older people were lying on trolleys for long periods of time whilst awaiting a hospital bed. The vast majority of people not admitted were seen well within 4 hours. The part of the system that fell down was where people were waiting for admission and they unfortunately tended to be the most vulnerable patients. It would not be appropriate therefore to take any comfort from performance around the 90% position with there being a key need to get to 95% at the very least which would demonstrate a qualitive and quantative difference for frail older people waiting on trolleys for admission.

82.8 The Chief Executive commented the key issue was discharge and when the strategy paper was discussed later on the agenda it would be shown that a proposition was being made for a bold policy shift to stop opening beds in hospitals to compensate for the lack of social care. The current position meant that money was being spent that the system did not have in opening capacity in the wrong place with the result being patients got stuck in the system. The proposal moving forward was therefore to open capacity in the right place which was homecare, care home support and geriatric support in the community. The difficulty was that the NHS lever of control was less direct when facilitating a new model of care often provided by other agencies or the independent sector than would be the case if a new ward was opened at a hospital which was managed by NHS staff. This was part of the reason why the policy movement represented a bold radical shift in the way services were delivered.

82.9 The point was made that this was not only a bold and radical move but the correct step to make as there was clear evidence that patients deteriorated if they were treated in the wrong environment and subsequently ended up requiring more dependant care.

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

83. Consultant Vacancies

83.1 The Board were advised that the circulated paper was in response to a previous request about the position in respect of consultant vacancies. It was recognised that there was an Edinburgh effect which made Edinburgh an attractive place to live and work in. The point was made if Lothian had difficulties in recruitment there were generally national shortages in these specialties. NHS Lothian had found in emergency medicine where in the past recruitment difficulties had been experienced that through the local team redesigning jobs and creating a website and the appropriate use of induction talks that this had created a friendly environment in which people wanted to work. It was felt there could be lessons learned from this experience that could be applied in other difficult to recruit to specialties in order to make job descriptions as attractive as possible.

83.2 The Board noted in respect of previous discussions around advertising consultant posts on a 9.1 contract that confirmation had been received from the Scottish Government that Boards had flexibility around this in order to ensure they were able to compete in the market place. It was noted that job descriptions were reviewed annually by the Medical Director.

83.3 The Board noted that HAVAS a recruitment advertising agency had been commissioned to review NHS Lothian's International Recruitment Campaign for paediatrics (2012). This review had demonstrated that potential applicants were unsure where Lothian was situated geographically but when it was pointed out that Edinburgh was part of Lothian this had a positive impact on their perception. It was noted that the benefits of the Edinburgh location should be an issue for consideration in future marketing exercises. It was noted that through the South East and Tayside Regional Planning Group that the Director of Human Resources and Organisational Development and the Medical Director was looking at the benefits of moving to regional appointments with there having been recent success around the appointment of clinical development fellows.

83.4 The point was made that in future recruitment rounds that the close relationship between NHS Lothian and Edinburgh University needed to be capitalised on as this would make it more attractive for consultants considering joint NHS Lothian posts. There was a plan to extend the use of clinical development fellows as they were beneficial in assisting to sustain rotas. It was noted that there would be 21 clinical development fellows in the system in the current year and that this would rise to 30 in the following year. The additional engagement of clinical development fellows would have a by-product of reducing the spend on supplementary medical staffing. It was noted that the Board was a full participant in the work being progressed by the Scottish Government in partnership with NES and other Scottish Health Boards to pursue a range of measures including a strategy for medical recruitment advertising, Joint Board advertising and an international recruitment campaign.

83.5 The Board noted that the University of Edinburgh welcomed the introduction of the clinical development fellowship post and the move away from the traditional approach of employing retired people as locums. The new approach provided an opportunity to employ young people who would make step changes in service delivery. The point was made that the University of Edinburgh traded heavily on the Edinburgh cachet and would be willing to share data around the success of this approach.

83.6 The Chief Executive commented that whilst he would not be proposing changing the organisational brand that it should be possible to make recruitment advertisements more specifically focussed around Edinburgh with the precedent already having being set through the Edinburgh and Lothian's Health Foundation. The suggestion was made that such an approach could be piloted for the next 20 vacancies. It was agreed that this would be an appropriate action given the fact that it was incumbent upon the Board to explore opportunities to improve recruitment and retention.

83.7 The Vice Chair advised she had been involved in the team that had come up with the 'Inspiring Edinburgh' slogan and that lessons could be learned from this because Edinburgh was felt to portray a specific vision. She commented the circulated report was welcomed and where future gaps were evident like in medicine of the elderly as a consequence of demographic changes then thought would be needed on how to manage this. The areas that were currently difficult to recruit to were highlighted in the paper. It was noted however it was difficult to predict where national shortages would emerge and the position fluctuated across different specialties and areas. It was noted that work life balance was now a significant issue and that softer aspects like Edinburgh being a festival city, having good cycle tracks and being cheaper to live in than London were now becoming considerations when people were considering applying for jobs.

83.8 The point was made that in order to minimise the impact of consultant and primary care vacancies that there was a need to ensure the availability of successful sustainable careers as well as a successful and sustainable work and personal environment. It would be important that this featured in future recruitment rounds. In order to retain staff it would be important to consider the best ways of treating and valuing people. The Board were advised that once people had been recruited to NHS Lothian that retention was less of an issue as generally once people had been attracted to work in Lothian they tended to stay. The importance of considering different models of care and workforce plans to recognise that other staff specialties other than medical staff had a considerable contribution to make was stressed.

Assurance was provided that significant work was underway in this area to ensure that medical staff only undertook the duties they were uniquely qualified to perform and that this would provide opportunities for other staff groups like nurses, AHPs and chief scientist grades amongst others.

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

84. Waiting Times Performance, Progress, and Elective Capacity Investment

84.1 The Board were advised that the current report followed the format that had evolved over the last few months and followed on from the detailed Board discussion in December around performance.

84.2 The non TTG (treatment time guarantee) performance was discussed in the first instance. In terms of cancer 31 and 62 day the performance was on target. At the last Board meeting difficulties had been reported around scopes and in particular cystoscopy where the trend was now downwards with further improvement expected over the coming months. The system had been hit in December and early January by issues around cleaner washers which reduced colonoscopy capacity and moves were being made to resolve these issues although it would take a few months to reach a conclusion.

84.3 It was noted sections 11 and 12 of the paper characterised the position for CAMHS (Children and Adolescent Mental Health Services) and Psychological Therapies. There was evidence of improvement in the CAMHS service although there were ongoing issues in Psychological Therapies and these were being worked through at corporate director level.

84.4 The Board were reminded in respect of TTG performance of the briefing provided at the previous meeting in respect of the end of December position where a revised number of around 500 had been put in place. The actual outturn had been under that figure at 447 and that was partly due to individual choices and decisions made by patients around elective admissions during the festive period.

84.5 At the previous Board meeting there had been discussions about the availability of an additional £4m to sustain the provision in the last quarter of the current financial year. Following that Board meeting an additional £2m had been released to allow the system to start booking into additional sessions. Post the festive season agreement had been reached for the second tranche of £2m to be released to characterise an end of March position of around 550 patients. The system was then confounded by the number of elective cancellations. In December there had been a significant number of elective cases cancelled on the day of admission and in the last 2 weeks 32 orthopaedic elective cancellations had been experienced on the day of surgery. As the system moved into January attempts had been made to switch back on elective capacity after the holiday period but had encountered intensive pressures in respect of bed availability and the ability to bring the elective cases in to the system. The prediction was made that in January the system would be reporting around 130 on the day elective cancellations directly linked to the availability of beds.

84.6 The Board noted work had been underway with the Scottish Government on the above issue with an agreed plan that would see NHS Lothian move to a position of

500 at the end of March. Teams were now focussed on man marking each of these patients through the system to meet the 500 target. Given the number of cancellations in January the Scottish Government had agreed a further allocation of around £550k to try and deal with some of the cancellation issues. It was noted as recently as the current week that elective cancellations continued and this would be an issue as the system looked forward into 2015/16.

84.7 The financial plan committed to the spend that had been allocated to delivering for patients into 2015/16. This characterised as £9m spend in the independent sector on a non recurrent basis and £5m moving into recurrent.

84.8 Improvements were reported on performance around the head and neck specialty where there were now interviews set for March with candidates available. There was now evidence of some ability to deliver an increase in internal capacity to deal with the pressures in demand.

84.9 If delayed discharge levels remained at the position they were currently at then there was a real and present danger that ongoing elective cancellations would continue. The ability to isolate elective capacity in terms of beds was one that had been considered on a number of occasions and there was now a draft document that characterised the operational processes that could be put into play to ringfence elective beds. It was noted this approach would carry elements of risk and needed a focus on delivery around discharge and reducing the levels of delayed discharge. It was felt it was necessary to consider these options given the level of revenue spend in this area. The point was made that if cancellations continued then the burden of having to recover from these would be in the region of a further £4m.

84.10 In summary in respect of TTG it was reported that the system had performed better than had been anticipated at the end of December but there was a major challenge moving to the end of March number given the spend profile. Work was underway to look at what 2015/16 recovery would look like.

84.11 The question was raised about what the longest individual patient wait would be. It was anticipated that this would be around 22 weeks where the patient had not excluded themselves. This information would be included in the next Board paper. The question was raised when people excluded themselves on a multiple basis whether the system had a responsibility to ensure they were seen. In response it was noted in these cases the condition was likely to be elective and at the more minor end of the scale.

84.12 The point was made by a Board member that the end of March target of 500 patients represented a departure from the previously agreed position. The Board was advised that the Scottish Government had recognised the contributing factors to the Lothian position and accepted to revise the target to zero for the end of March would be unrealistic. This agreement was on record. A further point was made with reference to a previous paper that much appeared to depend on the position in respect of provision in the community and elective performance which was disappointing from a patient experience perspective. Reference was made to the strategic decision not to open beds and the question was raised about how in the short to medium term assurance could be provided that appropriate community and other alternative provision was in place.

84.13 The Board were advised there were a number of issues in the financial plan paper to be discussed later in the meeting that would start to address some of these concerns like the policy choices options and the primary care agenda. In addition discussions were being held with Joint Directors about the use of anticipated monies from the Scottish Government around the innovation fund; primary care and mental health funding all of which if received would provide additionality and would bridge primary care capacity increases as well as allowing relationships to continue to be developed within the primary and community setting.

84.14 The Board whilst welcoming the open and transparent report commented that it was disappointing to note that scoping figures particularly in respect of surveillance and review patients with overdue appointments was worse than the December 2013 position. Advice was sought on when it was anticipated the system would move back to an acceptable position. The Board were advised that plans were in place to move back to a more positive position although these had been hampered by extenuating circumstances. It was reported contingency plans were in place with a target recovery date of the end of March 2015. The endoscopy team were looking at possible ways of mitigating the position. There was a need to step back from the current position and look at options like nurse endoscopy and this needed to be embedded in practice better than was currently the case. It was noted that there would be a lead time for the training of nurse endoscopists although 2 posts had recently been recruited to within Lothian. It was noted there were some laboratory tests coming to the fore that would allow demand to be stemmed and this was being looked at in significant detail for rapid implementation as this would significantly improve performance. There was however a financial issue that needed to be taken into account. The Board noted the impact of external issues had been frustrating. It was felt however that there was now time available to work on redesign. The March position was anticipated to show an improving situation although the point was made that in the long term the key issue was about redesign and demand reduction.

84.15 The Board noted that were only a very small number of patients delayed in hospital for scheduled care reasons. The point was made in respect of the positive cancer performance that the key issue was the time between urgent referral and diagnosis and it would be interesting to see how this sat with the models of care being discussed in the strategic plan.

84.16 The Chief Executive commented in respect of the link between the structure paper and the finance paper that in the previous year an investment strategy called Delivering for Patients had been approved and had intended to move the position to zero. Since then NHS Lothian had spent £4.5m in year just to get to the current position. It was noted that when looking at elective cancellations which by definition meant that each operation was being paid for at least twice the big issue was about care in the community being able to deliver in conjunction with a significant reduction in delayed discharges.

84.17 The Board noted however that the Lothian delayed discharge position had increased substantially over the previous 12 months. This related back to reference around the need for policy shifts as it was known that booking patients, delayed discharges and cancelling procedures all of which were rising within Lothian was not good for patients. The Chief Executive commented there was therefore a need to break this cycle and for that reason he was proposing a bold policy choice. This policy choice would be to start to invest whatever resource could be brought to bear on the right things in the right places rather than the wrong things in the wrong places. It was

noted there were particular issues around social care capacity in the City of Edinburgh Council. The Board were advised when the financial plan came to the Finance and Resource Committee in March there would be a need to take a view on what the social care capacity provision in the City of Edinburgh would be because at the moment the system was enjoying a level of capacity that currently was not affordable.

84.18 The Board received the update report on waiting times performance, progress and elective capacity in vestment.

85. Quality Report

85.1 It was noted the quality report brought together a number of issues discussed elsewhere on the agenda.

85.2 In terms of HSMR data which was about to release it was reported that none of the 3 acute hospitals were statistical outliers and all had seen reductions from the October – December baseline. The Board were reminded that the 20% reduction by the end of 2015 was a national target and that Lothian's performance contributed to the overall position.

85.3 The position in respect of cardiac arrest calls had shown a reduction of 58% at St John's Hospital in the summer with the position currently reporting at 61%. Work was underway to achieve a sustained reduction over other Lothian sites. NHS Lothian was no longer an outlier in terms of surgical readmission rates although the position would continue to be closely monitored.

85.4 The Board noted that an external source had been commissioned to undertake the review of the complaints function. The report had been received to the previously agreed timescale. It was agreed that the Director of Human Resources and Organisational Development would circulate a copy of the report to Board members. Board members were thanked for their contribution to the process. Following the receipt of the report 4 workshop events had been arranged for staff which Board members were welcome to attend. The outputs from the 4 sessions would be collated and added as an appendix to the main report which would be submitted to the April Board meeting after discussion at the March meeting of the Healthcare Governance and Risk Committee. It was agreed any contributions Board members had to make on the report could be directed to either the Director of Human Resources and Organisational Development or fed in through the respective workforce sessions.

85.5 The Board noted the recommendations contained in the circulated paper.

86. Agenda Re-ordering

86.1 The Board agreed to consider the financial position to December 2014 before the paper on Our Health, Our Care, Our Future 2014 – 2014.

87. Financial Position to December 2014

87.1 The Board noted that work continued to manage the 2014/15 financial year end position. The financial position had improved in December and an additional allocation had been received by from the Scottish Government for hepatitis C drugs. There was now confidence that the system would achieve a breakeven position at the year end although a key issue was whether this would compromise flexibility for financial year 2015/16.

87.2 The Board received an update report on progress with the production of the financial plan following input from the previous Finance and Resources Committee and Board Development Sessions. The following 3 major workstreams had been undertaken since then:-

- Engagement had been undertaken with the Scottish Government to obtain clarity about allocations and the Barnett consequentials of the Chancellor of the Exchequers recent announcement. Progress had been made in closing the financial gap although issues around primary care and mental health allocations required further clarification.

- Intensive internal work had been undertaken around the delivery of LRP and an overall financial review. A small high level core team led by the Chief Executive had been established with a number of Executive Directors having freed up 2 days per week from their schedules to look at Local Reinvestment Plan pressures, other options and support requirements. Progress would be reported through the Finance and Resources Committee and also at the March Board Development Session.

- Non recurrent flexibility was being looked at in order to manage the position while some LRP schemes started to deliver their anticipated savings on a recurrent basis. The Board noted the production of the financial plan would be a challenge and would in all likelihood not be in recurrent balance.

87.3 The Board were advised of the process of submitting the Local Delivery Plan and the financial plan to the Scottish Government. It was noted in submitting the plan the assumptions under pinning it would be clearly articulated. The Scottish Government had been advised that a Board Development Session would be held on 4 March 2015 and that currently various discussions were ongoing. It was noted the Finance and Resources Committee meeting on 13 March would be the first opportunity the system would have to present a financial plan that was fully developed and able to come to the April Board meeting. The assessment of risk in the financial plan would set out areas that needed to be prioritised in the forthcoming year and would be robustly progressed at the Finance and Resources Committee.

87.4 It was confirmed that the LDP included definitions of factors on which the achievement of the plan was contingent upon. Specific reference had been made for example that delivery of TTG targets was dependant upon delayed discharges not increasing and not having inappropriate beds open within the system.

87.5 The point was made in respect of the appendix on the property and asset programme that a significant amount of expenditure appeared to be anticipated towards the year end. In respect of reserves it was questioned whether these could

be used to support the 2015/16 position. The Board were advised that historically spend on the programme tended to be backend loaded and this profile had not yet been changed. It was stressed however that capital was currently dealt with on an annual basis where as capital programmes tended to run for 3 – 4 years and in some instances because of periods of uncertainty spending was paused. The Board were advised good progress was in place around capital expenditure with discussions being held with the Scottish Government about either carrying forward any underspend or using it to purchase medical equipment.

87.6 The Board noted in the current year that increased resources had been put into the system to achieve financial breakeven and there would be a need to consider the extent to which this reduced flexibility in 2015/16. It was noted this would be addressed as part of the year end management process.

87.7 The Board noted the recommendations contained in the circulated paper and in particular that breakeven was still deliverable provided there was no further deterioration in financial performance and that the actions taken to reduce expenditure had the required impact.

88. Our Health, Our Care, Our Future 2014 – 2024

88.1 The Board noted that the circulated paper represented a progress report on the draft strategic plan agreed in April 2014. The plan had been subject to 4 months consultation the results of which had previously been fed back to the Board. The consultation exercise had highlighted a specific issue about capacity and access to primary care and it was hoped that the progress report would demonstrate these issues had been recognised and actions taken to address them. The Strategic Planning Committee had agreed rather than bring the full report to the Board that an update report on the key recommendations and strategic propositions to keep the organisation moving forward within the overall financial envelope should be brought forward. Proposals in the paper would also help to shift the balance of care and help to deliver some of the longer term ambitions the organisation had some of which included changes within scheduled care and unscheduled care as well as aspects of service within some of the sites that the system currently owned. The issues of policy choices were also addressed in respect of the financial sustainability agenda. It was proposed that through this process some fairly bold choices would be taken around policy choices that would be in the overall best interest of patients in respect of discharge to assess and eradicating boarding through the provision of community services. The paper also considered service redesign within the context of the longer term sustainability agenda.

88.2 The Board noted there were a number of key propositions in the paper relating to scheduled and unscheduled care including the future use of the Royal Victoria Hospital, Astley Ainslie Hospital and Corstorphine Hospital sites and this would be aligned to the future long term sustainability around the Midlothian, Royal Edinburgh Hospital and East Lothian Community Hospitals and other future developments around the Royal Victoria site and the establishment of an integrated care facility. The Board noted that the detailed GANTT chart set out the critical path and interdependencies associated with each proposition. It was noted for example that the propositions around the Liberton site had impacts around a wide range of other developments in Edinburgh, East Lothian, Midlothian and the Royal Infirmary of Edinburgh.

88.3 The Board noted in terms of financial sustainability and the weekly core group meetings that a number of propositions had emerged as part of these discussions. The paper set out a number of key workstreams around scheduled care to change the model of care to improve performance and drive efficiency for reinvesting. It was noted some of the proposals were only options whilst some were proposing moving from option to option appraisal status or indeed to business case. A number of these would require consultation or engagement.

88.4 It was confirmed that the Chief Officers of the Integration Joint Boards would be an integral part of the Clinical Change Cabinet process. The Chief Executive explained the background to the establishment of the Clinical Change Cabinet which had evolved from a flowopoly event involving all of the acute hospital sites in Lothian. At this event a desire had been evident for more high level engagement particularly with clinicians with the specific view of changing clinical practice. GPs had also been invited to attend although the timing of meetings might need to change to reflect pressures on GP diaries on a Friday afternoon. The initial focus of the Clinical Change Cabinet would be to look at discharging to assess at home; providing rehabilitation at home and not in hospital; risk management around discharge and the proper test of managing end of life care. The Clinical Change Cabinet would evolve over time.

88.5 The point was made in terms of managing end of life care that the key issue should be about self supported care with clinicians needing to be aware of patient expectations. The Board were advised the model proposed would be around clinically driven co-production and the involvement of patients and their families. This would include consideration on how information was provided to patients in future in order to protect patient safety and the quality of care provided. The Board were advised that proper assurance processes would be put in place with a view to supporting people to spend as much of the end of their life in their own homes or as near home as possible as there was long standing evidence that frail people were more prone to picking up infections if they were treated in hospital.

88.6 The Chairman commented the fact that the conundrum between resourcing the acute sector and impacts on the Integration Joint Boards existed increased the need to have as good a planning platform as possible. It was noted there were a raft of forums for discussions around financial plans and strategic plans. It would be important that NHS Lothian as a Board had a clear solid platform around what the strategic plan was in order that when barriers were encountered a point of reference was available in order to obtain reconciliation. The Chairman felt the Board was now better equipped and now had the type of masterplanning platform needed. He stressed however that there was a lot of day to day management required to implement the plan that would need to be resourced.

88.7 The Chief Executive commented that the notion of redirecting spend in the acute sector into the community was over simplistic. There were elements of acute care where the costs would continue to rise i.e. cancer care, acute drug expenditure and demand for elective procedures. There was therefore a need to work out how to resource this inextricable demand in the future. The Chief Executive commented what was being signalled was that the elements of acute care that could be influenced were around discharge either in a routine or delayed basis. It was noted this could be achieved through a home based model of rehabilitation and assessment for community care which was logical as it made sense to assess

patients needs in the community and at home whilst they were in that environment rather than in an acute hospital.

88.8 The Chief Executive commented what was being proposed represented radical shifts and reflected the policy choices set out in the paper. This highlighted that there were elements of hospital care where it was believed if a bold approach was taken that there could be a shift of activity and investment as well as the identification of specific beds and sites that could be closed to allow the position to move forward. In the past the response to delayed discharges had been to open poor facilities in hospital and the new proposition was to stop spending money in the wrong way. The proposition was therefore to have fewer rehabilitation beds and promote rehabilitation at home. In addition there would be fewer frail elderly beds in the system. These beds would be closed and the resource would be put into a variety of facilities.

88.9 The Chief Executive commented that the paper was the response to discussion previously held around the Board table. The proposal was to progress a small number of issues that could be done differently and required policy shifts and this would include closing beds, sites and the shifting of resource. It was noted there might be some initial concern in the system as the transitional moves were made. Currently NHS Lothian directly controlled its beds and the impact of decisions were immediate whilst in the new world of the 2020 Vision to support people at home or in a home setting this was very dependant upon a set of multiple providers including the NHS.

88.10 The Board were advised that the proposed way forward would lead to significant implications for primary care including information technology requirements and this represented a further conundrum around resource release. The point was made during the discussion about narrowing the financial gap that there was a need to be clear about what allocations NHS Lothian would receive from the Scottish Government. It was anticipated there might be one-off allocations around the primary care development fund and mental health all of which would have an impact on primary care and the community. The Board noted that there were propositions around primary care development in the LDP. The Chairman advised this debate reiterated the need to continue to develop the master-planning platform to address immediate barriers like those discussed. It was recognised in some instances either regional or national solutions might be required.

88.11 The point was made that the critical path analysis was useful as it demonstrated the extent of interdependencies and that the development of a sequential analysis would be the next area of focus in order to identify ‘show stoppers’. The Board received an update on the propositions around stroke rehabilitation beds and IPCC beds and how this impacted on the Royal Edinburgh Hospital, Royal Infirmary of Edinburgh, Liberton, Royal Victoria Hospital and East and Midlothian Services as well as community investment for community services. It was noted that the intention was to develop a future proof bed model. Concern was expressed that prime development sites might be sold off at a time when the population was aging and these might at a point in the future be required. The point was made however that building new facilities might not be the best solution in terms of the care and treatment of patients. Specific examples were provided around proposals for the Older People’s Model of Care including carehome, care at home and community developments to repatriate people out of hospital. The point was made that there needed to be full clarity about bed modelling in respect of community development.

88.12 The Chief Executive advised that elements of sites were being retained for redevelopment and that a logical approach was being taken to this although he did stress that there was a need to vacate some sites to generate savings and meet LRP requirements of £47m in the forthcoming year to allow investment in areas like waiting times and prescribing. It would not be possible to sit on a land bank of old hospitals. The feeling of the Executive and Corporate Directors was that they had estimated correctly the sites that needed to be retained for redevelopment whilst recognising that there were a number of sites that required to be vacated.

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

89. Any Other Competent Business

89.1 **Mr Jeremy Brettell**

89.2 The Chairman commented that this would be Mr Brettell's last formal Board meeting. He took the opportunity on behalf of the Board to convey appreciation for his service and contribution to both the Board and its governance processes. In particular attention was drawn to the significant work undertaken around the Audit and Risk Committee processes as well as input into other governance committees and the strategic planning process itself. The Board wished Mr Brettell well in ventures new.

90. Date and Time of Next Meeting

90.1 It had previously been agreed to hold a short Board meeting in advance of the March Development Session on 4 March 2015 to discuss and approve Integration of Health and Social Care: Integration Schemes. The next formal full scheduled Board meeting would be held at 9.30am on Wednesday 1 April 2015 in the Board Room, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

91. Invoking Standing Order 4.8

91.1 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.

DRAFT **1.2**

LOTHIAN NHS BOARD

Minutes of a Special Meeting of Lothian NHS Board held at 9.30am on Wednesday 4 March 2015, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mrs K Blair; Mr M Ash; Councillor D Grant; Councillor R Henderson; Professor J Iredale; Councillor C Johnstone; Mr A Joyce (Employee Director); Mrs A Meiklejohn; Mrs A Mitchell; Councillor F Toner; Mr G Walker and Dr R Williams.

Executive and Corporate Directors: Mr T Davison (Chief Executive); Dr D Farquharson, (Medical Director); Mrs S Goldsmith (Director of Finance); Ms M Johnson (Executive Director Nursing, AHPs and Unscheduled Care); Professor A K McCallum (Director of Public Health and Health Policy) and Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information).

In Attendance: Mr J Forrest (Joint Director, West Lothian, Health and Social Care Partnership); Mr P Gabbitas, (Joint Director, Edinburgh, Health and Social Care Partnership); Mrs E McHugh, (Joint Director, Edinburgh, Health and Social Care Partnership); Mr D A Small (Joint Director, East Lothian, Health and Social Care Partnership) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Dr M Bryce, Mr P Johnston, Mrs J McDowell, Mr G Warner, Mr A Boyter and Mr J Crombie.

Declaration of Financial and Non-Financial Interest

The Chair 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.

Cllr Toner sought advice on whether he as Chair of a Shadow Integration Joint Board needed to declare a conflict of interest around financial aspects of the arrangements. The Chairman commented whilst he understood the point being made he did not think there was an issue for the business being considered at the current meeting.

92. Welcome and Introduction

92.1 The Chairman welcomed the four Joint Directors to the meeting and also to Mr J McGaw, Programme Manager who had been instrumental in developing the integration schemes.

93. Integration of Health and Social Care ; Integration Schemes

93.1 The Board noted that the four integration schemes for each of the Partnerships required to be submitted to the Scottish Government by 31 March 2015. The timelines for each Council Meeting considering the content of the integration schemes was detailed. The integration schemes had been consulted upon during January and February 2015 and any comments and concerns had been reflected in the final version of the schemes presented to the Board. These issued had largely been around the need for future continued engagement with the 3rd Sector and the existing clinical network.

93.2 The Board noted an error in the West Lothian integration scheme in respect of the provision of Joint Health Protection Plans which were an area for participation/ cooperation and remained a parent body function. It was noted this anomaly would be rectified and was unique to the West Lothian integration scheme.

93.3 Assurance was provided to the Board that there had been full engagement with the Scottish Government and their comments had been fully reflected in the integration schemes before the Board. The Scottish Government were content with the proposal to delegate prison healthcare facilities to the Edinburgh Integration Joint Board.

93.4 The Board agreed the following integration schemes for submission to the Scottish Government:

- East Lothian Integration Scheme
- Edinburgh Integration Scheme;
- West Lothian Integration Scheme;
- Midlothian Integration Scheme

93.5 The Board further agreed:

to delegate school nursing and health visiting to East Lothian and Midlothian IJBs in the first phase rather than phase two as had been originally planned.

to delegate HMP Addiewell and HMP Edinburgh prison healthcare services to Edinburgh IJB.

that if amendments were required to be made to the Integration Schemes by Scottish Government after submission that these changes would be authorised by the Chief Executive and the Chairman on behalf of the Board.

94. Any Other Competent Business

94.1 <u>May Development Session/ Special Board Meeting</u> – A short Special Board Meeting would be held immediately before the 6 May Board Development Session to discuss the Joint Management arrangements for both Edinburgh and East Lothian Joint Integration Boards.

95. Date and Time of Next Meeting

95.1 The next meeting of the Board would be held between 09.30 am and 12.30 pm on Wednesday 1 April 2015 in the Board Room, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG.

95.2 A short Special Board meeting would also be held immediately prior to the Board Development session on 6 May 2015.

LOTHIAN NHS BOARD MEETING

RUNNING ACTION NOTE

1.3

Action Required	Lead	Due Date	Action Taken	Outcome
Renewing NHS Values (24/07/13)				
• Arrange engagement sessions for service teams.	**AB**	31/03/2015	*The Associate Director of Workforce is leading on this process. Meetings with management teams and partnership leads across NHS Lothian are being held to determine what they consider are the next priorities in embedding our values.*	**In progress**
• Development of the Implementation Plan to be included as a separate Board seminar.	**AB**	31/05/2015	*The Associate Director of Workforce is leading on this process. This will be developed after the above is completed.*	**In progress**
NHS Lothian Homeopathy Service				
• Cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014.	**AMcM**	1 April 2014	*NHS Lothian is represented by CLO at this stage.*	**In progress**
Workforce Risk Assessment				
• Further consideration is needed in a future paper around overall developments, staffing, culture & values and their impact on individual areas including service redesign.	**AB**	Autumn 2014	*This work will be undertaken in the HR&OD Strategy which will come to the Board following consideration by the Staff Governance Committee.*	**In progress**
• The Medical Director and Director of Human Resources & Organisational Development would take away the points raised and come back with proposals about how scope the job offer to candidates to make the posts as attractive as possible.	**AB/DF**	TBC	*A paper on recruitment will be discussed at the Staff Governance Committee and then taken to the Board*	**In Progress**
• The Director of Human Resources & Organisational Development to bring a paper to a future Board meeting detailing	**AB**	TBC	*A paper is being considered at the February Board meeting.*	**Completed**

Action Required	Lead	Due Date	Action Taken	Outcome
how long posts had been vacant and by vacancy group. The report would show comparable data comparisons with other large organisations and examples of work being done to make jobs more attractive to include consideration of the benefits or otherwise of making regional appointments. • The Medical Director would consider how best to bring a paper to the Board to address the fundamental capacity issue in primary care.	**DF**		*The Board Development Day on 14/1/15 highlighted the challenges on recruitment and retention in General Practice and the need to look at alternative models of care.*	**In Progress**
Financial Position to 31 December 2013 (05/02/2014)				
• Finances / LRP to be discussed at a future development session.	**SG**	November 2014	*Further detailed review and discussion at F & R Committee in January and planned for March Committee Meeting.*	**In progress**
Integration Process & Milestones (05/02/2014)				
• The four draft integration plans would be submitted to the Board in December.	**AMcM**	December 2014	*A paper on the work plan and process for 2014/15 was taken to the April Board. Session on 17 April for Chairs of Shadow Boards and Joint Directors and others on delegation of functions.*	**December Board**
Strategic Plan (02/04/14)				
• An updated strategic plan to be brought to the Board in February 2015 to allow work to be concluded and to align with the timescale for the financial planning for the Board and establishment of new integration bodies for 2015 /16. The Board to also receive an implementation plan to deliver the health and inequalities strategy as part of the overall strategic plan in 2014 as well as a similar implementation plan to delivery the cancer strategy to the same timeframe..	**AMcM**	February 2015 Board	*An update will be provided at the Private Board session in December 2014*	**An update report to be brought to the February 2015 Board meeting**
Integrating Children Services in Lothian (02/04/14)				
• Formal consultation on the proposals to be undertaken	**AMcM**	July 2014	*Paused whilst the review of the model*	**Paper to**

Action Required	Lead	Due Date	Action Taken	Outcome
between May & July 2014.			*of integration in Edinburgh is complete, but work has been done and we can go to consult quickly post decision re adult services.*	**March Special Board Session**
Local Access Policy (02/04/04)				
• A 6 month post implementation audit would be undertaken.	**JC**	October 2014	*Report will be available for Board post October 2014*	**In progress**
Staff Survey Results (02/04/14)				
• The Board would receive a further presentation once the Staff Governance Committee had considered the survey outcomes in detail.	**AB**		*A presentation will be provided at the April 2015 Board meeting.*	**In progress**
CAHMS and Psychological Therapies (06/08/14)				
• An update paper to be brought to the Board early in 2015.	**AMcM**	February 2015	*Work in progress*	
Integration Update (25/06/14)				
• Update report to future Board meetings.	**AMcM**	December 2014	*Paper on the agenda.*	**Update to December Board**
Unscheduled Care Update (25/06/14)				
• Paper to December Board meeting.	**MJ**	4 December	*Paper on December Board agenda*	
Financial Position (25/06/14)				
• A benchmarking approach to be adopted to understand the reasons for the 10% increase in acute drug costs.	**SG**	4 December	*Full Finance Report on agenda.*	**To December Board**
Revised Corporate Communications Strategy (25/06/14)				
• Arrange further discussion either at a development session or at a future Board meeting.	**AB**	Ongoing	*Paper to future Board meeting.*	

Action Required	Lead	Due Date	Action Taken	Outcome
Waiting Times, Performance, Progress & Elective capacity Investment (01/10/14)				
• Discuss investments and outcomes at the November Board Seminar.	**JC**	December 2014	*Full update report on Board agenda. Investments and outcomes that were discussed at the November Board Seminar.*	**Update to December Board**
Complaints Function (3/12/2014)				
• A review of the complaints functions was being undertaken to a tight timescale with the intention being to bring a paper to a future Board meeting to cover all of the complaints issues and to agree with the Board the level of granularity and frequency of future dedicated complaints papers to the full Board. • It was agreed that the Director of Human Resources and Organisational Development would circulate a copy of the report to Board members. The main report would be submitted to the April Board meeting after discussion at the March meeting of the Healthcare Governance and Risk Committee.	**AB** **AB**		*The complaints review is on the April agenda* *Circulated*	**In Progress** **Circulated**
Vale of Leven Report (03/12/2014)				
• An update report would be provided to the Healthcare Governance Committee in January and thereafter to the Board in February.	**MJ**			**An update will be provided at the next meeting.**
Consultant Vacancies				
• It should be possible to make recruitment advertisements more specifically focused around Edinburgh with the precedent already having being set through the Edinburgh and Lothian's Health Foundation. The suggestion was made	**AB/DF**			

Action Required	Lead	Due Date	Action Taken	Outcome
that such an approach could be piloted for the next 20 vacancies.				

1.4

NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - PERFORMANCE MANAGEMENT

This paper aims to summarise the key points.

The relevant paragraph in the full paper is referenced against each point.

Updates are provided on the following HEAT targets and standards. None changed their previous red-green status.	
Smoking Cessation remained red	4.1
Early Access to Antenatal Care remained green	4.2
Carbon Emissions remained red	4.3
Energy Efficiency remained green	4.3
Delayed Discharge remained red	4.4
Reduction in Emergency Bed Days remained red	4.5
Stroke Bundles remained red	4.6

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NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

PERFORMANCE MANAGEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board on the most recently available information on NHS Lothian performance against HEAT targets and standards not featured elsewhere on the agenda. The data as reported is through both local and national systems.

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

2 Recommendations

2.1 Receive this update on the existing performance against current 2014/15 HEAT targets and other relevant standards.

3 Discussion of Key Issues

3.1 The HEAT system sets out targets and measures which the NHS Boards are monitored and evaluated against, along with the 2014 –15 Heat National Standards. For those referenced in this paper the table below sets out NHS Lothian's current achievements against selected targets, with a more detailed description of these being provided under item 4 of the paper, key risks and areas to highlight.

Heat ID	Description	Current Status	Lead Director
H6.1	Smoking Cessation.	Red	AKM
H11.1	Early Access to Antenatal Care	Green	AMcM
E8.1	Carbon Emissions	Red	AB
E 8.2	Energy Efficiency	Green	AB
T15.1	Delayed Discharge	Red	MJ
T12.1	Reduction in Emergency Bed Days	Red	MJ
2014 –15 HEAT NATIONAL STANDARD			
Stroke Bundles		Red	MJ

3.2 Appropriate performance against delivery of targets is maintained through lead directors, committees and local management groups; the performance management paper provides an overview of that achievement.

4 Key risks and areas to highlight:

HEALTH IMPROVEMENT

4.1 **Heat id H6.1; Smoking Cessation. Last updated March 2015**
(Responsible Director: Director of Public Health and Health Policy)

The latest data published by ISD on Smoking Cessation covers up to 30/09/2014 and shows that the Board's performance was 237 successful quits against a target of 830. This was 71.4% below target, placing NHS Lothian 5th out of the 14 Boards .monitored.

4.2 **Heat id H11.1; Early Access to Antenatal Care Last updated March 2015**
(Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

The latest data published by ISD covers up to 30/09/2013 and shows that the Board's performance was 84.9% against a target of 75%. This was 9.9% above target. More recent performance in January 2015 was 88.17% overall. Our focus remains on the 10% not being booked within 12 weeks. Actions being taken to mitigate risks are:

- Meetings with ISD to ensure consistency of reporting and comparing of data.
- Regularly reviewing real time data on Maternity TRAK re: Quintiles linked to booking and births.
- Using data collected to inform work with Community Planning Partners and using the Early Years Collaborative methodology to engage women.

EFFICIENCY AND GOVERNANCE IMPROVEMENT

4.3 **Heat id E8.1&8.2; Carbon Emissions and Energy Efficiency Last updated March 2015**
(Responsible Director: Director of Human Resources and Organisational Development)

Over the period from April to December 2014, reduction of CO_2 is 1.94% worse than target at 17,620 tonnes of reported emissions against a target of 17,284.

Reduction of energy was 4.27% better than the target of 596,290 GJ at 570,857.

The Board has previously received a summary of the energy improvements that have been put in place following a £1.5M investment programme over 2 years.

TREATMENT APPROPRIATE TO INDIVIDUALS

4.4 **Heat id T15.1; Delayed Discharge Last updated March 2015**
(Responsible Director: Director of Nursing, AHPs and Unscheduled Care)

In February the overall number of patients held on the DD data base was 453, which includes internal healthcare delays as well as those waiting on social care

Reported to ISD following monthly census return

- 161 delays after the complex coded delays (X codes) removed
- 215 overall including X codes
- 55 patients delayed >4 wks .
- 36 days is the average length as a delayed discharge
- 3 Non-Lothian delays
- 54 X codes

February has seen a slight improvement over January, with the number of delays breaching the HEAT target (Zero delays over 4 weeks) coming down from 75 to 55.

The turnover in the downstream units at Liberton and Royal Victoria is very slow, and evident at the Western General and Royal Infirmary, both carrying a high number of delays. The Royal Edinburgh has seen some of its more complex (X coded) delays discharge to supported accommodation across January, but delays here are still very high.

The table below shows the ISD census return (215) with additional detail of "operational" delays by hospital, providing a comparison. The 225 reported to ISD when published will have the complex codes removed and read 161.

15th February 2015 Hospital Delayed Discharge Census	Reportable delays that fall within the ISD Monthly census rules	Operational "delays" on day of census
Astley Ainslie Hospital	8	9
Belhaven Hospital	7	12
Edington Cottage Hospital	3	5
Ellen's Glen House	4	7
Ferryfield House	2	2
Findlay House	2	5
Learning Disabilities Service Healthc	3	4
Liberton Hospital	9	26
Midlothian Community Hospital	8	12
Roodlands General Hospital	7	10
Royal Edinburgh Hospital	42	78
Royal Infirmary of Edinburgh at Little	7	88
Royal Victoria Hospital	49	73
St John's Hospital	12	20
St Michael's Hospital	6	12
The Greenbank Centre	6	1
The Islay Centre		5
Tippethill Hospital	3	4
Western General Hospital	32	73
William Fraser Centre	5	7
Totals	215	453

The high number of patients with a delayed discharge in Lothian is a serious and sustained issue for NHS Lothian and for the outcomes of patients affected by the delay.

The four health and social care systems across Lothian are affected differently, with the situation most serious in Edinburgh and East Lothian. The main reasons for

delay remain the same: a lack of care home capacity, specifically for people with dementia or challenging behaviour, and access to home care packages.

4.5 **Heat id T12.1;Reduction in Emergency Bed Days Last updated March 2015**
(Responsible Director: Director of Nursing)

The HEAT target seeks a reduction in the occupied bed days per 1,000 population over those aged over 75 month-on-month by 0.3% with the aim of reducing by 8.7% to 4,709 between April'11 and March'15. The most recent figures compiled nationally are for the year to September 2014 which has a target of 4,791. Provisionally ISD place performance at 5004. This suggests an overall decrease on the previous rolling year (Oct.'13-Sept.'14) of 9.8%.

These are set out by local authority area below. Board members should be aware that ISD are emphasising the provisional nature of these figures, which may therefore it understating the position.

	NHSL	EL	ML	CEC	WL
Oct'13	**5549**	**5939**	**5459**	**5853**	**4251**
Sept'14	**5004**	**5063**	**5305**	**5139**	**4313**
	-9.8%	**-14.7%**	**-2.8%**	**-12.2%**	**1.5%**

2014-15 HEAT NATIONAL STANDARDS

4.6 **Stroke**
(Responsible Director: Director of Nursing, AHPs and Unscheduled Care)

Lothian's performance against the bundle: October 36%, November 58.7% and December 55.7%. Local Delivery Plan stroke bundle target to be met by April 2015: 65%.

During financial year 2014/15, stroke performance is being monitored against a composite stroke bundle, which will measure the proportion of patients with an initial diagnosis of stroke receiving four key elements of care. By 31st March 2015 NHS Boards will be expected to demonstrate an increase in the number of patients receiving the bundle. This will give a more rounded picture of stroke care, but it will, in the first instance, mean that performance will appear to be lower than under the HEAT standard.

Trajectories have been submitted to SGHD and agreed for each of the four elements and the overall bundle performance. Our local targets are noted below. From October to December 2014, performance in each of the four elements changed as follows;

a) Access to a stroke unit by the day after admission – increased from 63.2% to 68.5% [October – 63.2%, November – 72.9%, December 68.5%] (local target = 85%)
b) Imaging undertaken within 24 hours – remains stable and above the national target [October 97.3%, November 98.1%, December 98.1%] (national target = 90%)

c) Swallow screen – increased from 64.9% to 77.4% [October – 64.9%, November – 82.7%, December 77.4%] (local target = 90%)
d) Aspirin – decreased from 93.2% to 84.2% [October – 93.2%, November – 86.5%, December 84.2%] (local target = 90%)

Our agreed local target for bundle performance is 65%, and overall performance against the bundle has increased over the last few months - from 36% in October to 55.7% in December 2014. Winter bed pressures have contributed to the lack of access to the stroke unit across all sites, and this continues to challenge any performance improvement for the bundle across all sites.

The outreach nurse service has been instrumental in improving performance in these standards over the last year, but it has proved difficult to sustain this. Training for the new staff nurses in the stroke units is underway and together with front door nurses, they have been identified to attend STAT (stroke and TIA assessment training) sessions. RIE and WGH are working towards a more sustainable outreach model where the outreach function is available and consistent 24/7.

Performance of swallow remains erratic and new performance management models are being implemented to improve this. One such model has been seen at the WGH front-door whereby as soon as swallow fails are identified, they are fed back to the front-door and stroke unit clinical teams for immediate investigation and training. Key learning points from weekly exception reports are also now included in the WGH stroke unit ward safety briefing to ensure learning is shared with all nurses performing stroke outreach.

Analysis of exception reports against each of the standards continues to be used across all three acute sites to identify improvements and direct training of stroke unit staff.

Niall Downie
Strategic Planning
19 March 2015
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Andrew Jackson
Information Services
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NHS LOTHIAN

1.5

Board Meeting
1 April 2015

Director of Finance

SUMMARY PAPER - ROYAL BANK OF SCOTLAND BULK CASH SERVICE

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• There is a requirement for the Cash Offices on the main hospital sites to order a delivery of coinage on a daily / weekly basis to cover the needs of the service.	3.1
• In compliance with new Scottish Government banking contract previous informal arrangements that were in place with local branches for the provision of change will be withdrawn. As a result an application for Bulk Cash and / or Consolidated Cash service should be completed.	3.2 – 3.4
• The Audit and Risk Committee agreed at its December meeting to recommend that the Board approve the use of the Royal Bank of Scotland bulk cash service subject to the certain matters being clarified and presented to the Board	3.5 – 3.9

Doreen Howard
Head of financial Control
12 March 2015
doreen.howard@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
1 April 2015

Director of Finance

ROYAL BANK OF SCOTLAND BULK CASH SERVICE

1 Purpose of the Report

1.1 The purpose of this report is to secure the Board's approval for the use of the Royal Bank of Scotland Bulk Cash Service in association with the operation of the Board's bank accounts.

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

2 Recommendations

2.1 Approve the resolution for the Royal Bank of Scotland to provide a "Bulk Cash and/or Consolidated Cash" service.

2.2 That the Head of Financial Control and one other bank signatory, as detailed in the Board's Scheme of Delegation, Section 37, have authority to sign the application for the provision of "Bulk Cash and/or Consolidated Cash" service.

2.3 That the Chairman signs the "Resolution of Lothian Health Board" on the Board's behalf.

3 Summary of Issues

3.1 There is a requirement for the Cash Offices on the main hospital sites to order a delivery of coinage on a daily / weekly basis to cover the needs of the service.

3.2 In compliance with new Scottish Government banking contract previous informal arrangements that were in place with local branches for the provision of change will be withdrawn.

3.3 The existence of these informal arrangements has come to light when alternative arrangements were being implemented due to the closure of the sub branch located on the Royal Infirmary of Edinburgh site.

3.4 After discussions with our RBS Relationship Manager, the Board were informed that all cash orders were required to be handled directly with the RBS Cash Centre. As a result an application for Bulk Cash and / or Consolidated Cash service should be completed.

3.5 The Audit & Risk Committee agreed at it's meeting on 8 December 2015, to recommend that the Board approve the use of the Royal Bank of Scotland bulk cash service subject to the certain matters being clarified and presented to the Board.

3.6 There any no individual limits of the authority but rather a maximum weekly provision which will not exceed £25,000 of notes and £25,000 of coins for the Board with a site limit of £2,000 of notes and £4,000 of coins.

3.7 The Board is not exposed to any additional liability. Due to the internal control environment that is in place any discrepancy occurring is identified and reported to the Royal Bank of Scotland immediately and well within the Bank's 3 month period.

3.8 The terms and conditions, which are included on page 6 and 7 of the application form (Appendix 1), set out the agreement between the Royal Bank of Scotland and Lothian Health Board and are governed by the Scottish Government Banking Contract.

3.9 These arrangements are associated with the operation of only the Board's bank accounts.

4 Key Risks

4.1 The Cash Offices do not have the coinage to reimburse patients with any travel costs they are entitled to.

4.2 The Cash Offices will be unable to provide a change service to the various income generation outlets that are in operation.

4.3 Staff will be put at risk in travelling to branches to collect change.

5 Risk Register

5.1 There is no additional risk to the Board.

6 Impact on Inequality, Including Health Inequalities

6.1 There is no impact on Inequalities, including Health Inequalities.

7 Involving People

7.1 There is no change to current strategies.

8 Resource Implications

8.1 The resource implications are a minor saving to the Board as the Cash Carriers will not be required to undertake a double run as the cash will be pre ordered and dropped off when the Cash Carrier uplifts the daily / weekly lodgements.

Doreen Howard
Head of financial Control
12 March 2015
doreen.howard@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Bulk Cash and/or Consolidated Cash Customer Application Form
Appendix 2: Resolution of the Board

RBS
The Royal Bank of Scotland

Bulk Cash and/or Consolidated Cash Customer Application Form

Use this Application form to apply for the Bulk Cash and/or Consolidated Cash service(s).

If applicable, provide a completed Board Resolution or Declaration of Partnership and return with this completed application form. This can be obtained from your Relationship Manager.

Please note - when filling out this form please use the tab and arrow keys to move between the relevant fields. Ensure you do **not** use the return or enter keys. Please use BLOCK CAPITALS.

1. Customer details

Business name

Address line 1

Address line 2

Address line 3

Address line 4

Postcode

Contact name

Position held

Preferred daytime contact number (including extension if applicable)

Fax number

I/We confirm that my/our business is a Protected Customer ☐

A Protected Customer is a consumer, a Micro-enterprise, which means a business whose annual turnover and/or balance sheet total does not exceed €2million, or a Charity, whose annual income is less than £1 million.

2. Carrier details

Carrier name

Address line 1

Address line 2

Address line 3

Address line 4

Postcode

Contact name

Preferred daytime contact number (including extension if applicable)

Fax number

Carrier contract/reference number (to be supplied by your carrier)

3. Bulk Cash – Request for a Drawing Limit

Summary of all cash deliveries which will be processed by the Carrier – enter here the combined total amount to include any Additional Customer Outlet Details Form(s) submitted with this application form.

Note Drawing Limit	£	
Frequency	Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐	
Coin Drawing Limit	£	
Frequency	Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐	
Total number of outlets covered		
Number of Additional Customer Outlet Details Forms attached		

4. Consolidated Cash – Request for cash processing

Summary of all cash collections which will be processed by the Carrier - enter here the combined total amounts to include any Additional Customer Outlet Details Form(s) submitted with this application form.

Total value of notes	(Per annum) £	
Total value of coin	(Per annum) £	
Total number of cheques	(Per annum)	
Total value of cheques	(Per annum) £	
Total value of notes, coin and cheques	(Per annum) £	
Total number of outlets covered		
Number of Additional Customer Outlet Details Forms attached		

5. Customer Outlet Details - Bulk Cash

5.1 Account details – enter here the account number to be debited in respect of the Bulk Cash service.

Account number | Sort code

Statement narrative (this reference will appear on your statement*)

*Please refer to the Terms & Conditions specified in clause 2.8.

5.2 Customer outlet details* (if different from section 1)

Business/outlet name

Address line 1

Address line 2

Address line 3

Address line 4

Postcode

Contact name

Preferred daytime contact number (including extension if applicable)

Fax number

*If the service is to be provided at more than one outlet, complete an Additional Customer Outlet Details Form for each.

5.3 Bulk Cash – enter here the Drawing Limit you require for this outlet.

Note Drawing Limit £

Frequency Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐

Coin Drawing Limit £

Frequency Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐

5.4 Seasonal peaks – please give details of any seasonal peaks.

5.5 Carrier details - please provide details below of the carrier depot to be used*

Contact name

Telephone number

Please provide the Carrier depot for each of the following:

Notes | Coin

*Complete with the assistance of the carrier.

6. Customer outlet details - Consolidated Cash

6.1 Account details – enter here the account number to be credited in respect of the Consolidated Cash service.

Account number | Sort code

Statement narrative (this reference will appear on your statement*)

*Please refer to the Terms & Conditions specified in clause 2.8.

6.2 Customer outlet details*

Business/outlet name

Address line 1

Address line 2

Address line 3

Address line 4

Postcode

Contact name

Preferred daytime contact number (including extension if applicable)

Fax number

*If the service is to be provided at more than one outlet, complete an Additional Customer Outlet Details Form for each.

6.3 Consolidated Cash - enter here the average cash/cheque collections for this outlet.

Total value of notes	(Per annum) £	
Total value of coin	(Per annum) £	
Total number of cheques	(Per annum)	
Total value of cheques	(Per annum) £	
Total value of notes, coin and cheques	(Per annum) £	

6.4 Seasonal peaks – please give details of any seasonal peaks.

6.5 Carrier details - please provide details below of the carrier depot to be used*

Contact name

Telephone number

Please provide the Carrier depot for each of the following:

Notes | Coin

*Complete with the assistance of the carrier.

7. Customer Agreement

Giving your consent

By signing this application you are agreeing that we may use your information in the way described in this form and in the 'Use of Personal Information and Regulatory Details' information document which is provided with the Business Current Account Terms.

I/We have read and understood the Terms and Conditions relating to the service(s) and agree to abide by them.
I/We confirm that the details on this form are full and correct and agree to notify the Bank of any changes.
I/We confirm that the application has been signed in accordance with the Bank Account Mandate.
I/We authorise the Bank to respond to any enquiries that the Carrier may initiate in connection with the operation of the service(s).
I/We authorise the Bank to debit/credit my/our account(s) for value received upon and subject to the terms set out in clause 6 of the Terms & Conditions.

Customer signature

Name _____

Position held _____

Date (DD/MM/YYYY) _____

Customer signature

Name _____

Position held _____

Date (DD/MM/YYYY) _____

For Relationship Manager use only

A. I confirm the application has been completed in accordance with the current Bank Account Mandate and recommend its acceptance by the Bank. ☐

B. I confirm the Board Resolution/Declaration is approved and retained at this office. ☐

C. I approve the Bulk Cash Drawing Limit(s) detailed in Section 3 as consistent with my knowledge of the business and meeting credit policy guidelines. ☐

D. I can confirm that the customer has been made aware of all appropriate and suitable cash solutions available to them. ☐

RM signature

Retail/Corporate unit _____

Location _____

Contact number _____

RM name (print) _____

ISV number ☐

Date (DD/MM/YYYY) _____

Portfolio number ☐

Please forward the completed application form by Inter Branch Mail to:
The Manager, Carrier Management Team, Contract Management, 2nd Floor, Zone 4 Aldgate Union,
10 Whitechapel High Street, London Depot E1 8DX, Depot code 190.

Bulk Cash and/or Consolidated Cash Terms and Conditions

These Terms and Conditions **(Terms)** and the related application form set out the Agreement between the Bank and the Customer. The Agreement also includes the "Use of Personal Information and the Regulatory Details" information document and the tariff. The Bank will provide a copy of these Terms at any time on request.

The Agreement is supplemental to, and must be read in conjunction with the Business Current Account agreement **(Account Agreement)** Words and expressions defined in the Account Agreement have the same meaning in these Terms, unless the context indicates otherwise.

The Agreement will remain in force until it is terminated in accordance with the termination provisions in these Terms.

Some of the provisions in these Terms apply only if the Customer is a **Protected Customer**. A Protected Customer is a consumer, a **Micro-enterprise**, which means a business whose annual turnover and/or balance sheet total does not exceed €2 million, or a **Charity**, whose annual income is less than £1 million.

Definitions

In these Terms and Conditions the following terms and expressions shall have the following meanings:

'Agreement' means the agreement between the Bank and the Customer.

'Application Form' means this form which the Customer will sign which embodies these Terms and Conditions and which form part of the Agreement with the Bank.

'Banking' in the case of Bulk Cash means the note and/or coin collected from the Bank and delivered to the Customer, and for Consolidated Cash, means the Keying Documents and banking in bulk of note and/or coin and cheques delivered to the Bank by the Carrier.

'Business Day' a day on which the banks in the United Kingdom generally open for business other than weekends and local bank holidays.

'Carrier' means the external secure Carrier company, approved by the Bank, which provides collection and delivery services between the Customer and the Bank.

'Code Line Data' means the complete line of pre-printed numbers at the bottom of each cheque i.e. the cheque serial number, Bank sort code and Bank account number.

'Drawing Limits' means the maximum amount authorised by the Bank which the Customer is permitted to draw in cash within a stipulated period of time as set out in the Application Form.

'Keying Document' means in the case of Consolidated Cash, a document prepared by the Carrier to enable the Bank to apply value to the Customer's account.

'Service' means for the supply of Bulk Cash, the collection by a Carrier appointed by the Customer, to obtain Banking from the Bank on behalf of and for delivery to the Customer, as set out in the Customer Outlet Details section in the Application Form and Additional Customer Outlet Details Form. And for Consolidated Cash, means the receipt of Keying Documents and Banking in bulk from a Carrier appointed by the Customer for deposit to the Customer's bank account as set out in the Customer Outlet Details section of the Application Form and Additional Customer Outlet Details Form.

'the Bank' means The Royal Bank of Scotland plc.

'the Customer' means the limited company, partnership, limited liability partnership, sole trader, society, association or other unincorporated body who has signed the Application Form and to whom the Service(s) is/are provided.

1. The Bank's responsibilities

The Bank will:

1.1 Use reasonable endeavours to ensure that procedures and sufficient operations, expertise and resource are available to provide the Service(s). The Bank may, without giving a reason, refuse use of the Service.

1.2 In the case of Bulk Cash, ensure instructions for Bulk Cash notes and/or coin requirements are acted upon providing such instructions are received from duly authorised representatives of the Carrier, in accordance with agreed timescales as set out in the Application Form. The time of receipt of Banking will be the time the Bank receives Banking rather than the time the Customer sends Banking. Banking received on a non-Business Day, or after the notified cut-off time for receiving an instruction, will be treated as received on the next Business Day.

1.3 In the case of Bulk Cash, debit the Customer's designated bank account when delivery of the Bulk Cash order of Banking is effected as advised by the Carrier. Title and risk in the Banking shall pass from the Bank to the Customer on delivery by the Carrier, following which the Customer's account will be debited.

1.4 In the case of Consolidated Cash, accept delivery of Banking from the Carrier on the basis that such Banking shall not be inspected or verified until it is processed in accordance with conditions 1.5 and 1.6.

1.5 In the case of Consolidated Cash, process UK Sterling cheques as follows:

1.5.1 Cheques received at the Bank's Cash Centre by 1.00pm on a Business Day will be added to the Customer's balance on the same Business Day, or if the Bank receives it after 1.00pm (or on a non- Business Day) on the next Business Day.

1.5.2 The money will be credited to the Customer's account for interest purposes two Business Days after it is added to the Customer's balance.

1.5.3 The money will be available for the Customer to use no later than four Business Days after it is added to the Customer's balance.

1.5.4 If the bank, building society or other organisation that the cheque was drawn on decides not to honour it, they will normally explain the reason for non-payment. The Bank will deduct the amount of the cheque from the Customer's balance no later than the end of the sixth Business Day after it was added to the Customer's balance. After that, the Bank will not deduct the amount of the Customer's cheque from its balance unless the Customer gives its consent to the Bank's doing so or the Customer is knowingly involved in a fraud concerning the cheque.

Where legal reasons require, or in certain limited circumstances beyond the Bank's control, the payment of a cheque into the Customer's account may be prevented or may take longer than the time periods set out above.

1.6 In the case of Consolidated Cash, process notes and coin as follows:

1.6.1 Notes and coin received at the Bank's Cash Centre by 1.00pm on a Business Day will be processed and credited to the Customer's account for interest purposes on the same Business Day and will be available for the Customer to use on the next Business Day. Notes and coin received at the Bank's Cash Centre after 1.00pm on a Business Day, or on a non-Business Day, will be processed and credited to the Customer's account for interest purposes on the next Business Day and will be available for the Customer to use on the second Business Day following receipt.

1.6.2 Where the Customer is a Protected Customer, notes and coin received at the Bank's Cash Centre by 1.00pm on a Business Day will be processed on the same Business Day. Notes and coin received at the Bank's Cash Centre after 1.00pm, or on a non-Business Day will be processed on the next Business Day. The money will be credited to the Customer's account for interest purposes and will be available for the Customer to use immediately after processing.

1.7 The next Business Day after such processing, amend and separately notify the Customer in writing (by first class post) of any difference in credits in excess of £1 in value in relation to cheques.

1.8 Return unpaid cheques from the Bank's unit dealing with unpaid cheques to the Customer's address (as provided by the Customer in section 1 of the Application Form) unless alternative arrangements have been agreed between the parties.

1.9 Not be responsible for providing any stationery items to the Customer in respect of the Service.

2. Customer responsibilities

The Customer will:

2.1 In the case of Bulk Cash, ensure that all Banking requirements are forwarded to the Carrier in sufficient time to allow for the Carrier to place an order with the relevant Cash and/or Coin Centre so as to meet the requested delivery date to the Customer.

2.2 Notify Cash & Coin Operations of any new or closed outlets by giving not less than 21 days' prior written notice.

2.3 Advise Cash & Coin Operations as soon as is reasonably practical if the required contact name/details change.

2.4 Notify Cash & Coin Operations, giving 30 days' prior written notice of any change to its chosen Carrier.

2.5 Notify its Relationship Manager as soon as reasonably practical of changes required in relation to its Drawing Limits.

2.6 In the case of Consolidated Cash, ensure that all Banking is presented in accordance with the Bank and Carrier instructions.

2.7 Ensure they record and retain Code Line Data and the name of the cheque drawer, and if required, contact the cheque issuer to assist the resolution of any differences subsequently identified.

2.8 Notify the Carrier of the debit/credit keying narrative(s) required to reconcile their account(s) as it is the Carrier's responsibility to advise the Bank of this information.

2.9 In consideration of the Bank providing to the Customer the Service the Customer hereby confirms and warrants that all cheques delivered to the Bank's processing centres by the Carrier in Banking, or otherwise, for the credit of the Customer, will only be payable to the Customer and not to third parties.

2.10 In the event of a claim being brought against the Bank for inadvertently accepting to the credit of the Customer's account(s) a cheque payable to a third party and whether endorsed or not and even if crossed Account Payee or Account Payee Only, the Bank may in its sole discretion pay the claimant the amount of the claim forthwith without obtaining the Customer's consent or concurrence.

2.11 The Customer hereby authorises the Bank to accept delivery of Banking from the Carrier without the contents of the Banking being checked by the Carrier.

2.12 The Customer agrees to reimburse the Bank on demand for any loss, damage or expense which it may sustain by virtue of its agreeing to these arrangements and undertakes to reimburse the Bank on demand with any amounts which it may claim from the Customer arising from this clause 2 which it is hereby irrevocably authorised to debit any such sums to the Customer account(s) with the Bank even if this results in account(s) becoming overdrawn.

2.13 For the purpose of this clause 2 the Bank shall extend to and include any branch of The Royal Bank of Scotland plc and/or any banking agent used by The Royal Bank of Scotland plc.

2.14 This Clause 2 shall be subject to the liability provisions in the Account Agreement and shall not exclude liability for any matter which may not be excluded by law.

3. Liability

3.1 The liability of the Bank and the Customer under this Agreement is set out in the Account Agreement. A copy of the Account Agreement will be provided by the Bank at any time on request.

3.2 Unless the Customer raises any query within 3 months after the relevant occurrence, the Bank shall have no liability to the Customer or any person claiming through the Customer in respect of or arising out of any such occurrence.

3.3 Where an enquiry concerning a particular Banking has been made within the timescale defined in 3.2, the Bank will provide responses to specific accounting queries from the Customer by whatever means within five Bank Working Days of receipt unless extended timescales have been agreed by both parties.

3.4 Where an enquiry is made later than 3 months after the date when the transaction took place, the Bank will use its reasonable endeavours to investigate the enquiry but can give no guarantees in respect of the outcome of such investigations.

4. Termination

4.1 The Agreement will come into force after the completed Application Form, Additional Customer Outlet Details Form and all other documents executed by the Customer in connection with the Service(s) have been accepted by the Bank and such acceptance has been communicated in the agreed manner to the Customer via its relationship manager. Subject to 4.2 below, and unless the Bank considers that there are exceptional circumstances, the Bank will give the Customer not less than 60 days written notice to terminate this Agreement.

4.2 The Bank may by written notice forthwith terminate this Agreement:

4.2.1 if the Customer enters into liquidation whether compulsory or voluntary (other than for the purpose of amalgamations or reconstruction) or permits a Receiver to be appointed in respect of all or any of its assets or has an administration order passed over it:

4.2.2 if the Customer commits a breach of any provision of this Agreement and having been given written notice of the breach, has not corrected such breach within 30 days of receiving notice:

4.2.3 if the Bank becomes entitled to terminate or close any other agreement or account with the Customer by reason of any breach by the Customer or, in the case of any account or agreement terminable without such breach, has notified the Customer in writing of concerns regarding the Customer's conduct of the account or agreement or the Customer's financial position and the Customer has failed to satisfy the Bank's concerns within 30 days of receiving such notice.

4.3 The Customer may terminate this Agreement by giving the Bank 30 days' written notice.

4.4 Upon termination of this Agreement, the Bank will cease provision of the Service(s).

4.5 Termination of the Agreement shall be without prejudice to any ongoing obligation of either party which still then remains to be fully performed or any outstanding liability of either party to the other.

4.6 For the avoidance of doubt, the rights and obligations of the parties under this clause 4 shall not be prejudiced or affected in any way by the terms of any agreement between the Customer and the Carrier, including the Carrier Contract (as defined in clause 5 below). Termination of this Agreement does not operate to terminate the Carrier Contract.

4.7 Termination, amendment or variation of the Agreement will not impact or affect the Account Agreement which shall be terminated, varied or amended in accordance with its own terms.

4.8 This Agreement relates solely to the provision of the Service and does not otherwise affect the Account Agreement which shall continue to apply. In the event of any conflict between this Agreement and the Account Agreement, this Agreement shall prevail in so far as the conflict relates to the subject matter of this Agreement, in any other case, the Account Agreement shall prevail.

5. Carrier Contract

5.1 The Agreement between the Customer and the Bank shall not include the transportation, security and insurance of banking between Customer outlets and the Bank's premises. This shall be the subject of separate contracts between the Customer and its chosen Carrier ("the Carrier Contract").

5.2 It is the Customer's obligation to ensure that the Carrier Contract requires collection and delivery between the Customer outlet(s) and the Bank's Cash Centre(s) at the times appropriate to ensure delivery to the Bank's Cash Centre(s) to enable processing for value as set out in clause 1.

6. Authority to Debit and/or Credit Account

6.1 The Bank is irrevocably authorised to accept instructions from the Carrier to debit and/or credit the Customer's account with the Bank as if the Customer had authorised the debit and/or credit. The Customer agrees that all such debits and/or credits shall be valid and effective in all respects and fully binding on the Customer.

6.2 The Bank is only required to make funds available within the Customer's Drawing Limits. The Customer agrees not to requisition sums in excess of its Drawing Limits from either the Bank or the Carrier, without obtaining the Bank's prior consent to do so.

6.3 The Bank reserves the right to seek further internal sanction before making any requested cash available, or in the event that the Customer makes a request which exceeds its Drawing Limits, as the Bank deems appropriate. Notwithstanding any provision to the contrary in this Agreement, the Bank will not be liable for any delays in supplying the Carrier with cash for delivery to the Customer in the event that such a sanction is deemed necessary by the Bank.

6.4 The Customer agrees that should the Bank require further internal sanction before making any requested cash available to the Carrier for collection the Bank may make such a requirement known to the Carrier.

7. Changes to the Terms

7.1 The Bank reserves the right at all times to supplement, to delete from or otherwise vary any or all of these Terms. If the change is to the Customer's advantage, the Bank may make the change immediately and will notify the Customer either before the change comes into effect or at the earliest opportunity afterwards. In other cases, the Bank will give not less than 60 days' written advance notice of the changes made. The Customer may within 60 days of the date of an advance notice, end this Agreement. If the Customer is unhappy with any changes made to these Terms, the Customer may give notice to the Bank to terminate the agreement at any time prior to those changes coming into effect.

7.2 Revised Terms and Conditions will be available online and from the Bank.

8. Applicable Law

If the Account is at a branch in Scotland, Scots law applies to the Agreement and Scottish Courts have exclusive jurisdiction. If the Account is elsewhere, English law applies to the Agreement and English Courts have exclusive jurisdiction.

9. Complaints/Issues

At The Royal Bank of Scotland we do everything we can to make sure our customers get the best possible service. If required, general guidance regarding how and where customers should complain can be found in the contractual RBS Terms and Conditions.

If you are not happy with the service you are receiving you can contact the following areas directly who will be able to assist you:-

- For carrier related issues contact your chosen carrier
- For transaction/processing related issues or instances when you are unsure where the responsibility lies, speak to one of the following areas using the contact number you have been given :-

  – Corporate Service Team

  – Cash and Coin Helpdesk

  – Direct Banking for Business

Lothian NHS Board

Resolution by Lothian Health Board

The Royal Bank of Scotland Bulk Cash service

Resolution of the Board

At a meeting of the Lothian Health Board held on the 4th February 2015, it was resolved that the Royal Bank of Scotland be asked to provide a bulk cash service and that Doreen Howard, Head of Financial Control and one other signatory as per the bank mandate shall be authorised to sign the Royal Bank of Scotland Bulk Cash Application Form for and on behalf of Lothian Health Board.

Lothian Health Board noted that the Application Form includes the terms and conditions of the service which acts as an indemnity in favour of the Bank and protects the interests of Lothian Health Board.

Certified a true copy, of the minutes of the Lothian Health Board meeting held on the 4th of February 2015 and approved by the Board at the meeting held on 1st of April 2015.

Chairman _____Date _____

Headquarters
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Chair Brian G. Houston
Chief Executive Tim Davison

Lothian NHS Board is the common name of Lothian Health Board

NHS LOTHIAN

1.6

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

STRATEGIC PLANNING COMMITTEE - REVISED REMIT AND MEMBERSHIP

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• The Board is recommended to agree revised Terms of Reference (ToR) for the above Committee	2.1
• ToR require to be reviewed in light of the development of the strategic plan and the strategic plans to be developed by Integrated Joint Boards	3.2,3.3
• It is proposed that IJBs at represented by their Chair or Vice-chair, and the Chief Officer/ Joint Director	3.3
• The revised ToR, including remit, membership and meeting frequency are set out in the appendix	Appendix 1
• The revised ToR will require to be reviewed once the IJBs are formally in existence	3.4

Libby Tait
Associate Director, Strategic Planning
17 March 2015
Libby.tait@nshlothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

STRATEGIC PLANNING COMMITTEE - REVISED REMIT AND MEMBERSHIP

1 Purpose of the Report

The purpose of this report is to recommend that the Board approves the revised Terms of Reference of the Strategic Planning Committee, to take account of the development of the NHS Lothian Strategic Plan, and the move of strategic planning responsibilities for delegated services to four Integrated Joint Boards(IJBs) across Lothian during 2015/16.

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

2 Recommendations

2.1 Agree the revised terms of reference, including changed membership to reflect changes to responsibilities and structure;

2.2 Recognise that the terms of reference of the committee will be subject to further review and confirmation once the IJBs are formally in existence;

2.3 Agree that future meetings in 2015 will take place bi-monthly, in April, June, August, October and December.

3 Discussion of Key Issues

3.1 The NHS Lothian Strategic Plan 2014-2024 which sets out the priorities, direction of travel and high level actions and timelines to deliver our strategic objectives in line with the 2020 Vision has been developed and consulted on during 2014. A progress report on the key propositions was approved by NHS Lothian Board in February 2015.

3.2 There is now a need to review the terms of reference including the membership of the Strategic Planning Committee, which was established initially to oversee the development of the strategic plan and the recommended strategic direction on behalf of the Board.

3.3 The Committee is envisaged to have a significant role both in relation to overseeing progress with the implementation of the NHS Lothian Strategic Plan, and ensuring that strategies and service change plans reflect the requirements of the four IJBs' strategic plans as these develop. IJB representation on the Strategic Planning Committee is essential to ensure effective coherence and synergy and it is proposed that either the Chair or Vice-chair of each IJB, and the Joint Director

(Chief Officer) should be represented on the Committee, subject to consultation and agreement with each IJB.

3.4 The integration schemes of the four IJBs which were approved by the Board on 4 March 2015 indicate that the terms of reference, membership and reporting arrangements of the relevant committees of the integration parties will be reviewed, and the IJBs will be consulted as part of this process. It is therefore recognised that the revised terms of reference now proposed for adoption are subject to further review and confirmation once the IJBs are formally in existence later in 2015.

3.5 The proposed revised terms of reference are attached as an appendix to this report.

4 Key Risks

4.1 There are no new risks arising from this report.

5 Risk Register

5.1 There are no new risks arising from this report for NHS Lothian's risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This report does not propose any new policy or service change.

7 Involving People

7.1 The revised terms of reference have been consulted on informally with Shadow IJBs representatives, however formal review and confirmation with IJBs is anticipated in due course, as set out in the Integration Schemes submitted for Scottish Government approval.

8 Resource Implications

8.1 There are no new resource implications arising from this update.

Libby Tait
Associate Director Strategic Planning
17 March 2015
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List of Appendices

Appendix 1: Strategic Planning Committee Terms of Reference

Strategic Planning Committee –Terms of Reference

1 Remit

1.1 To be assured that all NHS Lothian strategies and service change plans reflect the national directions for relevant services, along with the priorities identified within the NHS Lothian Strategic Plan, reflect the requirements of the four Integrated Joint Boards' (IJB's) strategic plans, and are aligned to the delivery of the outcomes set out therein.

1.2 To oversee the management of progress with the implementation of the NHS Lothian Strategic Plan and all NHS Board approved strategies, and ensure reports and briefings are provided which allow the Board and the IJBs to monitor implementation of their Strategic Plans.

1.3 To receive and respond to IJB Strategic Plan consultations on behalf of the Board.

1.4 To receive information about the content of the Integrated Joint Boards' strategic plans, and ensure that reports are made available to IJBs on matters which are pertinent to their strategic planning functions.

1.5 To oversee strategic planning for the full range of acute services provided by NHS Lothian for local, regional and national population groups which are not delegated by to the IJBs.

1.6 To consider the interface between NHS Lothian services and regional and national planning agendas. To receive information about the plans and outcomes of the four Lothian Community Planning Partnerships and assure synergy with NHS Lothian's strategic direction.

1.7 To receive information about the content of Children's Partnership plans and assure synergy with NHS Lothian's strategic plans for Children and Young People.

1.8 To consider and approve on behalf of the Board plans to change service models which will deliver the redesign, modernisation and integration of services required to implement approved Board strategies and IJB Strategic Plans.

1.9 To specifically seek assurance on the strategic fit (with Lothian and IJB strategic plans) of service changes which are essential components of the delivery of efficient and affordable capital and infrastructure investments prior to formal approval by Finance and Resources Committee.

1.10 To monitor the implementation of key Lothian strategies and associated actions such as cancer, palliative care and the strategy for children and young people.

2 Membership of the Committee

2.1 NHS Lothian Board wishes to enable its governance to fully and effectively engage with and reflect the requirements of the IJB strategic plans. To achieve this it is normally expected that the NHS Lothian non-executive Directors who perform the function of chair or vice-chair of each IJB will be members of the Strategic Planning

Committee. Representation of the Acute Committee through its Chair is equally important to promote strategic coherence and consistency across the whole system.

2.2 The Committee will consist of 8 Non-Executive Board Members as follows:

Committee Chair: Board Chairman
Non-Executive Chair or Vice Chair- East Lothian IJB
Non-Executive Chair or Vice Chair- Edinburgh IJB
Non-Executive Chair or Vice Chair– Midlothian IJB
Non-Executive Chair or Vice Chair- West Lothian IJB
Chair – Acute Service Committee
Employee Director (or named deputy)
Non-Executive - University of Edinburgh Stakeholder member

Corporate Directors:
Chief Executive
Director of Strategic Planning, Performance Reporting and Information
Medical Director
Finance Director
Director of Nursing and Allied Health Professionals
Director, Public Health and Health Policy
Chief Officer – Acute Services
H R Director
Joint Directors (Chief Officers) of Health and Social Care Partnerships

All Board members shall have the right of attendance and have access to papers.

Officers of the Board will be in attendance as appropriate to the agenda.

3 Frequency of Meetings

3.1 Meetings of the Committee shall normally be every two months

4 Quorum

4.1 No business shall be transacted at a meeting of the Committee unless at least three non-executive members are present.

5 Reporting Arrangements

5.1 The Committee will report to the Board by means of submission of minutes and a summary from the chair of the Committee to the next available Board meeting.

5.2 Papers and progress reports will be tabled at the Board as required as will the draft strategic commissioning plans developed through the IJB's.

NHS LOTHIAN

1.7

Board Meeting
1 April 2015

Medical Director

SUMMARY PAPER - CORPORATE RISK REGISTER

This paper summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

	Para
• The purpose of this report is to set out changes to the NHS Lothian Corporate Risk Register, approved by the February 2015 Audit & Risk Committee.	1.1
• The Risk Management Steering Group (RMSG) undertook a review of risks on the Corporate Risk Register. The results were summarised and areas of consensus and variation were set out in a paper to inform discussion, along with NHS Lothian's Corporate Objectives and current performance. The RMSG were asked as a group to agree a consensus and rationale for changes to the NHS Lothian Corporate Risk Register for consideration by the Audit and Risk Committee in February 2015.	3.2
• The Audit & Risk Committee agreed all the proposed changes with the exception of Medical Workforce Sustainability which is to remain on the Corporate Risk Register. Table 3 sets out the proposed revised Corporate Risk Register.	3.5
• Table 4, compliance with Risk Appetite would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4). The Board is also outwith appetite with respect to ensuring a sustainable Financial Framework. There are a number of papers on the Board agenda which set out actions to improve the current position with respect to healthcare acquired infections, unscheduled care and finance.	3.3 & Table 2

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10 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Medical Director

REVIEW OF NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to set out changes to the NHS Lothian Corporate Risk Register, approved by the February 2015 Audit & Risk Committee.

2 Recommendations

2.1 Approve the recommendations set out in Table 1, which were supported by the Audit & Risk Committee

2.2 Approve the recommendations for removal of risks from NHS Lothian corporate risk register as set out in Table 2, which were supported by the Audit & Risk Committee, with the exception of Medical Workforce Sustainability which was recommended to remain on the Corporate Risk Register

2.3 Approve the agreed amended Corporate Risk Register (Table 3)

2.4 Note that NHS Lothian is outwith its risk appetite on corporate objectives where low risk appetite has been set. Papers on the Board agenda set out actions to improve results, e.g. HAI, Unscheduled Care.

3 Discussion of Key Issues

3.1 The Risk Management Steering Group (RMSG) in January 2015 undertook a review of the risks on the Corporate Risk Register to ensure they were fit for purpose and reflected NHS Lothian's risk profile. Individual members were asked to review the risk and grading using a 5 x 5 matrix within the context of the two following principles:-

- The Corporate Risk Register needs to be focused on specific unmanaged risks that executive management cannot themselves address by their actions
- What decisions does the Board need to take to mitigate the unmanaged risks.

3.2 The results were summarised and areas of consensus and variation were set out in a paper to inform discussion, along with NHS Lothian's Corporate Objectives and current performance. The RMSG were asked as a group to agree a consensus and rationale for changes to the NHS Lothian Corporate Risk Register for consideration by the Audit and Risk Committee in February 2015.

3.3 Table 1 sets out recommendations that were considered and approved by the Audit & Risk Committee (February 2015) and rationale for Risk Register changes.

Table 1 – Changes to Corporate Risks and Rationale

Risk ID	Title & Description of Risk	Current Grading	Recommendation	Rationale
1076	Healthcare Associated Infection Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment.	High 16	⇧ Very High 20	Range of evidence to support increase: • Not achieving HEAT target for SABs & C.Diff • Benchmarking C.Diff illustrates not seem reduction in comparison to other Boards • Impacts on experience and outcome - LoS • Risk appetite in the Red • Date risk Opened 11/06/2007
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target. On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years. If the Board and management fail to systematically and robustly respond to this challenge now, it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.	High 12	⇧ Very High 20	Range of evidence to support increase:- • Risk appetite in the Red • Reliance on non-recurring strategy • Date risk opened 23/04/2014
3203	Unscheduled Care NHS Boards in Scotland are required to achieve a 4 hour Emergency Care standard of 95% by September 2014 after which this will rise to 98%. Performance against this standard is a measure of the effectiveness of performance against the whole healthcare system. It reflects the effectiveness of patient flow through the system. There is a risk that sub-standard performance could be triggered by a number of factors causing pressures and bottle necks across the unscheduled care patient pathway. In turn, poor performance metrics place additional pressure within the system leading to the potential for significant disruption and a downward spiral in performance and service delivery overall. While the system remains susceptible to slight	High 10	Risk to be made into two separate risks:- • Achieving the 4-Hour Emergency Care standard of 98% ⇧ 20 • Achieving the Delayed Discharge targets at 2 and 4 weeks ⇧20	• It was considered that the Unscheduled Care risk included both A&E and Delayed Discharge issues, which required separate plans/controls to address this risk. • Given the current performance, it was also proposed that each of these risks be High 20, as the likelihood and consequence of this risk materially has increased. • Risk appetite in Red • Date risk opened 26/03/2012

Risk ID	Title & Description of Risk	Current Grading	Recommendation	Rationale
	variations in hospital flow, the increase in national performance standards from 95% to 98% (from September 2014) will be a significant challenge. As a result there remains a risk that NHS Lothian's ability to meet and surpass the national 4 hour Emergency care Standard will remain challenging It is understood that poor performance against these measures will have a direct and adverse impact on patient care. Whole system working involves GP's, SAS, Local Authorities, NHS24, LUCS, primary care and secondary care.			
3480	Patient Safety There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm.	High 16	• Remain High 16 ⇔ • Rename to link to Delivery of SPSP Work Programme to reflect the risk description.	• There is a range of evidence from process and outcome indicators that shows improvements are still required around reliability of safety essentials and outcomes related to priority workstreams, e.g. pressure ulcers. • Harm impacts on experience, outcome, LoS, etc • Date risk opened 07/05/2013
3211	Achievement of National Waiting Times Targets There is a risk of: Lack of management of national waiting times targets for a number of reasons due to lack of core capacity or appropriate use of what is available. Overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money. Lack of robust management process and staff capability to deliver consistent management of waiting lists. Risk of adverse publicity relating to failure to meet waiting times targets.	High 12	• ⇧ High 16	• Data available shows non-compliance with targets and the Board has been asked to make a decision about resource to address the current situation. • Impacts on Experience, Safety and Efficiency. • Date risk opened 02/04/2012
3454	Patient Experience There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.	High 12	• ⇧High 16 • Replace this risk with Management of Complaints and Feedback	• The aspect of this current risk that is not being managed and requires Board action is the management of complaints and feedback which has been highlighted by the Board. • Review taking place. Once plan in place, this risk will be reviewed. • Acknowledgment that patient experience runs through the vast majority of the corporate risks. • Date risk opened 13/02/2013
3455	Health & Safety 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	High 15	• ⇔High 15 Replace risk to Management of Violence & Aggression	• This is a very generic risk • The H&S risk which is not being managed at executive level is that of management of violence and aggression.

Risk ID	Title & Description of Risk	Current Grading	Recommendation	Rationale
	relevant H&S regulations. 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.			Support by both data and HSE involvement. • Date risk opened 13/02/2013
3567	Health & Social Care Integration There is a risk that the Board and its Partners fail to submit agreed integration plans that satisfy the Scottish Government requirements to agreed timescales resulting in a failure to meet its legal responsibilities (Public Bodies Joint Working Act).	High 16	• ⇩ Medium 9	• Clear understanding of actions to be taken. • Integration schemes progressing within set Scottish Government timelines and guidance. • Date risk opened 16/01/2014

3.4 Table 2 sets out risks recommended for removal and rationale. The Audit & Risk Committee supported all the removal recommendations with the exception of Medical Workforce Sustainability which will remain on the Corporate Risk Register.

Table 2 – Risks to be removed

Risk ID	Title & Description of Risk	Current Grading	Recommendation	Rationale
1085	Public Protection (Child, Adult, MAPPA) There is a risk of harm to individuals and to the Organisation's reputation because of increasing complexity of cases, reduced capacity of medical and nursing specialist services including the vacancy for the Designated Doctor for Child Protection and the limitations of the existing IM &T infrastructure. This has the potential to be a contributing factor in the occurrence of harm to a patient, public or member of staff. This may lead to adverse outcome for the organisation.	High 15	• Remove from Corporate Risk Register	• The aspects of this risk which are under the control of NHS Lothian are well managed. • Date risk opened 11/06/2007
2812	Data Protection Act 1998 Compliance There is a risk that NHS Lothian breaches the Data Protection Act 1998 by accidental or unauthorised disclosure to third parties, of identifiable sensitive data relating to patients or staff. Disclosure of manual or electronic identifiable data could occur by accidental loss such as theft, or by failure to implement policy or appropriate control and security of, use and disclosure of personal data. Consequences of inappropriate disclosure are; distress to individuals, reputational damage to organisation, legal action or financial penalty up to £500,000.	Med 9	• Remove from Corporate Risk Register and replace on Public Health Risk Register.	• Risk well managed by existing lead. No risks unmanaged and/or require Board decisions. • Date risk opened 23/11/2010
1966	Preparedness in Emergency Planning NHS Lothian is a Category 1 responder under the Civil Contingencies Act 2004 (CCA) and associated Scottish regulations. There is a risk that insufficient preparedness for some emergencies would mean that people	Med 8	• Remove from Corporate Risk Register and replace on Public Health Risk Register.	• Risk well managed by existing lead. No risks unmanaged and/or require Board decisions. • Date risk opened 26/07/2010

Risk ID	Title & Description of Risk	Current Grading	Recommendation	Rationale
	might suffer avoidable harm and that our statutory duties under CCA would not be met. These duties often require joint working with other agencies, e.g. Police and local authorities. The main multi-agency forums for this are the East Scotland Regional and Local Resilience Partnership (RRP & LRP). Guidance on emergency preparedness is given in Scottish Government Preparing Scotland and in Preparing for Emergencies – Guidance for Health Boards in Scotland.			
3486	Data Quality There is a risk that poor data quality impacts upon patient safety. Poorly entered data could lead to the incorrect information being extracted for patient management or performance reporting.	High 12	Remove from Corporate Risk Register and review once data/information diagnostics complete.	• It is acknowledged that data quality is an issue within a larger risk of timely robust information across cost, quality and activity. • Date risk opened 24/05/2013
3527	Medical Workforce Sustainability There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.	High 16	Remove from Corporate Risk Register – not approved by Audit & Risk Committee.	• This risk is currently being managed when specific service issues arise, they will be escalated through the RMSG. • Date risk opened 26/07/2013 • Audit & Risk Committee asked for this risk to remain on the Corporate Risk Register.
3189	Maintenance Backlog Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk.	High 16	Remove and undertake an operational review of facilities and report back to RMSG on risks that cannot be currently managed at a divisional level for recommendation.	• This risk was discussed in terms if facilities are fit for purpose. There are a number of plans such as RHSC and REAS that address some of the issues. • Operational divisions asked to review facilities not fit for purpose in conjunction with facilities management and report back to RMSG in April. • Date risk opened 16/02/22012
3328	Road Traffic Management There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites.	High	Remove from Corporate Risk Register.	• Operational Teams asked to review and report back to RMSG in April. • Date risk opened 25/07/2012
3531	Lack of Managers Capacity There is a risk that management capacity, particularly in the acute sector and at executive level, will impact on developing and implementing robust plans to deliver key strategic objectives, or that operational management will be stretched to the extent that	Medium 9	Remove from Corporate Risk Register.	• This risk is a contributory factor and manifests itself in a number of the above risks and as such should be removed. • Date risk opened 23/08/2013

Risk ID	Title & Description of Risk	Current Grading	Recommendation	Rationale
	objectives are not met.			

3.5 In Summary the Audit and Risk Committee approved the amended Corporate Risk Register as summarised below (Table 3). There are 10 risks in total, the top 4 risks at 20 High are:

- Healthcare Associated Infection
- Achieving the emergency 4 hour standard
- Achieving the Delayed Discharges targets at two and four weeks
- The scale for quality of the Board's service is reduced due to the failure to respond to the scale of the financial challenge

3.5.1 The Audit & Risk Committee approved the removal of seven risks (see Table 2 above) of which three are being reviewed:

- Two at a divisional level with respect to Facilities being for purpose and Road Traffic Management, with the agreement to discuss in April at the RMSG any risk that cannot be managed at divisional level.

- One risk concerning information management across cost, quality and activity, which will be reviewed following a diagnostic piece of work led by Strategic Planning.

Table 3 - Corporate Risk Register (see Appendix 1)

	Risk ID	Title & Description of Risk	Grading	Executive Lead
1.	1076	Healthcare Associated Infection	20	**Director of Nursing and Unscheduled Care Services**
2.	3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	20	Director of Finance and Resources
3.	TBC	Achieving the 4 hour Emergency Target .	20	**Director of Nursing and Unscheduled Care Services**
4.	TBC	Achieving the Delayed Discharge targets at 2 and 4 weeks	20	**Director of Nursing and Unscheduled Care Services**
5.	3480	Delivery of the SPSP Work Programme	16	Medical Director
6.	3211	Achievement of National Waiting Times Targets	16	Director of Scheduled Care
7.	3454	Management of Complaints and Feedback	16	Director of Human Resources
8.	3527	Medical Workforce Suitability	16	Medical Director
9.	3455	Management of Violence and Aggression	15	Director of Human Resources and Organisational Development
10	3567	Health and Social Care Integration	9	Director of Strategic Planning and

	Risk ID	Title & Description of Risk	Grading	Executive Lead
				Ehealth

3.6 The Audit & Risk Committee have asked for the top four risks to be reviewed by the RMSG as it was the committee's view that not all those risks graded at 20 are the same. This review by the RMSG will take place in March 2015.

3.7 Risk Appetite

The Board agreed in August 2014 to report Lothian's Risk Appetite at each meeting using the table below.

Table 4

	Current Status	**Current Position**	**Data Report**
Corporate Objective 1 – Improving Patient & Staff Safety. **Low Risk Appetite**			
• Scotland target to reduce acute hospital mortality by 20% (Scotland-14.4%) with a tolerance of 15-20% by Dec 2015 [1]	Green	12.7%	Quality Report (Graphs 7-9)
• Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015	Green	99.7%	Patient Safety Programme Annual Report (July)
• Achieve 184 or fewer SAB by March 2015 with a tolerance of 95% against target. n=193 to 184	Red	227 (as at Jan 2015)	Quality Report (Graph 12) HAI report on Board Agenda
• Achieve 262 or fewer C.Diff by March 2015 with a tolerance of 95% against target. n=275-262	Red	341 (as at Jan 2015)	Quality Report (Graph 11) HAI report on Board Agenda
• Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015	Green	20%	Quality Report (Graph 15)
• Reduce staff harm – to be agreed with executive lead	Tbc		
Corporate Objective 2 – Improving Patient & Staff Experience. **Low Risk Appetite**			
• 95% of patients would rate their care experience as good/very good, with a tolerance of 93-95%	Green	98%	In-depth patient surveys, Person Centred Culture paper
• 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%	Tbc	Tbc	To be collected
• Staff absence below 4% with a 5% tolerance (4-4.2%)	Red	5.5%	Quality Report (Graph 6)
Corporate Objective 3 – Improving the way we deliver Scheduled Care. **Low Risk Appetite**			
• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Green	86.3%	Scheduled Care Report
• 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%	Green	94%	Quality Report (Graph 18)
Corporate Objective 4 – Improving the way we deliver Unscheduled Care. **Low Risk Appetite**			
• 98% of patients are waiting less than 4 hours from	Red	92%	Quality Report

[1] This is a Scotland-wide target which NHS Lothian will contribute to.

	Current Status	Current Position	Data Report
arrival to admission by Sept 2014 with tolerance of 93-98%			(Graph 17) Unscheduled Care report on Board Agenda
• No of patients will wait no more than 14 days to be discharged by April 2015 with a tolerance of 13 to 14 days	Red	94	Quality Report (Graph 5)
• No of patients will wait no more than 28 days to be discharged from hospital by April 2015 with a tolerance of 26-28 days	Red	55	Quality Report (Graph 5)
• 90% of all stroke patients to be admitted to stroke unit on day of admission following a stroke with a tolerance of 85-90%	Red	62.6%	Quality Report (Graphs 19-21)
Corporate Objective 6 – Protect and Improve Health in Lothian for all. **Medium Risk Appetite**			
• To deliver 7,001 quits successful quits at 12 weeks post-quit in the 40% most deprived within board SIMD areas, i.e. the bottom two local SIMD quintiles over the 1 year ending March 2015, with a tolerance of 40-43%	Green	43%	Performance Report on Board Agenda
• 80% of pregnant women have access to antenatal care by 12th week by March 2015, with a tolerance of 70-80%	Green	84%	Performance Report
Corporate Objective 7 – Ensure the delivery of a sustainable financial framework. **Medium Risk Appetite**			
• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Green	£1,148k underspend at period 10 (inc. unachieved LRP), equating to 1.3%	Period 10 Finance Report Finance report on Board Agenda
• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%	Red	£4,075k overspend for the year-to-date (inc. unachieved LRP) equating to 0.4%	Period 10 Finance Report

3.7.1 The above reporting would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4). The Board is also outwith appetite with respect to ensuring a sustainable Financial Framework. There are separate papers on the Board agenda that set out actions to address areas outwith appetite, i.e. HAI, Finance and Unscheduled 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 Focus of paper

6 Impact on Inequality, Including Health Inequalities

6.1 No service change/policy/strategy.

7 Involving People

7.1 No proposed changes to strategy/policy or service change.

8 Resource Implications

8.1 The resources implications are related to the risks set out in the Corporate Risk Register.

Jo Bennett
Clinical Governance & Risk Manager
10 March 2015
Jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Corporate Risk Register, February 2015

APPENDIX 1

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
1076	1:Improving Patient Safety	Healthcare Associated Infection	Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment.	•NHS Lothian has an Infection Prevention & Control Service to provide access to specialist knowledge. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established to cover both acute and community settings. •The UHS and CHP Infection Prevention and Control Committees are in place and report to the board through LICAC. •IT based system in place to facilitate the IPCN to monitor incidences of HAI within their clinical remits and to monitor for trends and patterns. SPSP have provided a collection of tools to support good practice to minimise potential for HAI risk to patients. IPCNs work collaboratively with clinical teams and bed management to provide advice and guidance on isolation and restriction of patient movements to balance the risk of transmission and impact on patient flow. •IPCNs communicate directly with clinical services, escalating as appropriate. SAB and CDI rates are reported weekly and monthly through IPCT reports which are sent by email and available on intranet. At senior management level there is CMG, Healthcare Governance and board papers. All incidences of SAB & CDI are investigated, clusters of 2 or more have further investigations for links and SBARs are provided to report findings and advise of any recommendations. Systems are in place to escalate investigations. HAI Matrix utilised to identify reporting level HAI-ORT. Communications provide support to manage public release of information as required. •Packages of audits are in place to monitor standards and are currently being updated and linked to the National Standard Infection Control Precautions Chapter. •HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro and the Education Strategy is available on line. •There is a Decontamination Operational Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment.	Reviewed by A&R Committee 17/02/15 Recommended Risk Grade/Rating increased to High/20 Range of evidence to support increase: • Not achieving HEAT target for SABs & C.Diff • Benchmarking C.Diff illustrates not seem reduction in comparison to other Boards • Impacts on experience and outcome – LoS • Risk appetite in the Red • Date risk Opened 11/06/2007 December 2014: Risk has been reviewed and remains as High Risk. Based on current trends NHS Lothian is unlikely to achieve either of the HEAT Targets for HAI inspections. Action plan has been updated	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 6	Sarah Ballard-Smith	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3600	7:Ensure the Delivery of a Sustainable Financial Framework	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target. On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years. The December 2014 Finance Board paper update the Board on the current financial challenge. If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.	The Board has already established a financial governance framework and systems of financial control. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested. NHS Lothian is currently reliant on non-recurring efficiency savings. A detailed Action Plan, attached to this risk, is in place and is regularly reviewed by the Senior Finance Team.	Reviewed by A&R Committee 17/02/2015 Risk grade/rating increased to High/20 Range of evidence to support increase:- • Risk appetite in the Red • Reliance on non-recurring strategy • Date risk opened 23/04/2014 January 2015 - Risk Reviewed. Description and Controls updated. Adequacy of control - Action plan is in place and regularly reviewed to mitigate against this risk.	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3203	4:Improve the way we deliver Unscheduled Care	Unscheduled Care / To be made into two Risks (both Very High/20)	NHS Boards in Scotland are required to achieve a 4 hour Emergency Care standard of 95% by September 2014 after which this will rise to 98%. Performance against this standard is a measure of the effectiveness of performance against the whole healthcare system. It reflects the effectiveness of patient flow through the system. There is a risk that sub-standard performance could be triggered by a number of factors causing pressures and bottle necks across the unscheduled care patient pathway. In turn, poor performance metrics place additional pressure within the system leading to the potential for significant disruption and a downward spiral in performance and service delivery overall. While the system remains susceptible to slight variations in hospital flow, the increase in national performance standards from 95% to 98% (from September 2014) remains a significant challenge. As a result there remains a risk that NHS Lothian's ability to meet and surpass the national 4 hour Emergency care Standard will remain challenging It is understood that poor performance against these measures will have a direct and adverse impact on patient care. Whole system working involves GP's, SAS, Local Authorities, NHS24, LUCS, primary care and secondary care.	A range of governance arrangements are in place for Unscheduled Care notably: • Bi monthly Unscheduled Care Board meeting jointly chaired by the Director of Health & Social Care (City of Edinburgh Council) and NHS Lothian's Director for Unscheduled Care – Oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. • This is supplemented by further governance arrangements including quarterly Formal SMT meetings and fortnightly Informal SMT meetings. Both are chaired by the Director for Unscheduled Care. • The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis. • Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, StJ). • Upward reporting to Acute Services Committee A number of performance metrics are considered and reviewed, including: • 4 hour Emergency Care Standard and performance against trajectory • 8 and 12 hour breaches • Attendance and admissions • Adherence to national guidance/ recommendations • Delayed Discharge • Boarding of Patients • Winter Planning • Length of Stay (LOS) • Cancellation of Elective Procedures • Finance • Adherence to national guidance/ recommendations NHS Lothian's strategic approach to improving unscheduled care performance is outlined within the Local Unscheduled Care Action Plan (LUCAP). NHS Lothian's LUCAP will reflect a 'whole systems' approach to planning and delivery of unscheduled care operating across acute, primary care and health and social care settings.	Reviewed by A&R Committee 17/02/2015 Risk to be made into two separate risks:- • Achieving the 4-Hour Emergency Care standard of 98% Risk grade/rating Very High 20 • Achieving the Delayed Discharge targets at 2 and 4 weeks Risk grade/rating Very High/20 • It was considered that the Unscheduled Care risk included both A&E and Delayed Discharge issues, which required separate plans/controls to address this risk. • Given the current performance, it was also proposed that each of these risks be High 20, as the likelihood and consequence of this risk materially has increased. • Risk appetite in Red • Date risk opened 26/03/2012 December 2014: Risk Reviewed. Controls updated. Increasing pressures on patient flow due to number of delayed discharges continues to hamper performance. Additional winter capacity to be made available (Jan-Mar) to deal with anticipated heightened demand. This includes the opening of beds at Gylemuir House, a joint venture with City of Edinburgh Council LUCAP 2 approved by Scottish Govt with Quarterly update undertaken as at September. Next update due by 23rd January 2015. Significant work has been undertaken during 2014 in supporting a range of service redesign initiatives within unscheduled care services. These outputs will inform proposals to be submitted to NHS Lothian Board in February 2015.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Melanie Johnson	Finance & Resources Comittee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3480	1:Improving Patient Safety	Delivery of SPSP Work Programme	There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm	• The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety. • 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 incident reporting and response. • The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring. • Incident Management Policy and Procedure (2011). • Quality Improvement Strategy (2011-14) sets out a range of improvement programmes to improve safety and outcomes of care. • Quality of care which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. • Quality Assurance Mechanism proposed to validate self reporting of patient safety data • Quarterly visit by HIS to discuss progress actions • Adverse Event Improvement Plan in place monitored via HCG • Quality Management Group at the Board initiated to strengthen governance, monitor and inform improvement of a range of improvement programmes including Patient Safety Programme. • Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly. •Single System medicines reconciliation group.	Reviewed at A&R Committee 17/02/2015 Risk grade/rating to remain High/16 Risk to be renamed to link to Delivery of SPSP Work Programme to reflect description. • There is a range of evidence from process and outcome indicators that shows improvements are still required around reliability of safety essentials and outcomes related to priority workstreams, e.g. pressure ulcers. • Harm impacts on experience, outcome, LoS, etc • Date risk opened 07/05/2013	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Dr David Farquharson	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3211	3:Improve the way we deliver Scheduled Care	Achievement of National Waiting Times Targets	There is a risk of: Lack of management of national waiting times targets for a number of reasons due to lack of core capacity or appropriate use of what is available Overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money. Lack of robust management process and staff capability to deliver consistent management of waiting lists. Risk of adverse publicity relating to failure to meet waiting times targets.	Monthly Access Performance and Government Group meeting chaired by Director of Scheduled Care oversees this area. These are supplemented by weekly scheduled reviews between this Director and Directors of Operations. It considers: • Performance against trajectory across a range of measures (including waiting time standards) • Finance • Governance position, in terms of adherence to national guidance and local access policy/SOPs This meeting reports to the Acute Services Committee with a comprehensive overview provided in September 2014. The approach to recovering the waiting time position is outlined in Delivering for Patients, due to be considered at the Board in February 2014. Papers on CAMHS and psychological therapies presented to the Board in June outlining difficulties in delivering standards of 18 weeks coming into force in December. Further investments were approved. The December 2014 Board meeting heard that the DFP trajectories would not be delivered as specified and additional financial support was required to maintain waits at their current level. A decision on additional support is to be considered in light of updates on the financial forecast for 2014/5.	Reviewed by A&R Committee 17/02/2015 Risk Grade/Rating increased to High/16 Rationale: • Data available shows non-compliance with targets and the Board has been asked to make a decision about resource to address the current situation. • Impacts on Experience, Safety and Efficiency. • Date risk opened 02/04/2012 December 2014: Risk Reviewed – Controls and Action Progress updated	Satisfactory; controls adequately designed to manage risk and working as intended	High 16	Low 1	Jim Crombie	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3454	2:Improve Patient and Staff Experience	Management of Complaints and Feedback	There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.	The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care. • The 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 incident reporting and response. • The Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care. • Delivering Better Care commitments have been agreed and plans are now in place to deliver on the required actions from the HIS Older People's review and the updated vulnerable Patient's Quality Improvement Framework. This activity is reported to the Board through the Executive lead. These plans are informed by inspection reports produced by Healthcare Improvement Scotland, local audit and regular checks i.e. PQI, mock OPAH ,frailty bundle audit and via the Clinical manager ward assurance checklists. The tools in use have been adapted and updated to reflect the person centred agenda. • Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit & Risk Committee and Healthcare Governance Committee • The Delivering Better Care established on 2012 as a resource for staff (primarily nursing) but where appropriate, other disciplines continue to deliver support to clinical areas on the key ambitions of harm reduction work is now on going to streamline programmes of work for 2015/16 working more closely with Clinical Goverance and using improvement methodology. • As part of the improving care to vulnerable patient's support manual with detailed information inclusive of a rapid patient essential care check sheet was implemented within acute and community In patient facilities during 2013 and has recently been reviewed and the e-version on all PC's has been updated. • The National Person Centred & Care Collaborative is a key priority for NHS Lothian with the aim of capturing and responding to patient, carer and staff experience and the Quality Improvement Plan was approved by NHS Lothian Board in October 2014. The aim of the collaborative is to ensure all patients receive a positive experience and get the outcome they expect (by Dec 2015). This will be demonstrated in a number of ways which will include a specific measure of 905% achieved. A local collaborative will take place in February 2015 and will link patient and staff experience to develop a 'person centred culture' across our organisation. Following a visit to Northumbria, NHS L are testing their questionnaire in a number of different in-patient areas. • A review and update of "Tell us Ten Things" TTT questionnaire was undertaken during November 2014 to ensure the questions map to the '5 must do with me' elements of the PCHC Collaborative. • Enhanced reporting arrangements will be put in place via the Healthcare Governance Committee and NHS Lothian Board - the first of which will be for the January 2015 HCG Committee. • Funding to support this for 2015/16 has been confirmed by Scot Gov, NB does not cover all costs. Rationale for Adequacy of Controls is through the newly developed quality management group discussions are ongoing.	Reviewed by A&R Committee 17/02/2015 Risk Grade/Rating increased to High/16 Replace title of risk with 'Management of Complaints and Feedback' Rationale: • The aspect of this current risk that is not being managed and requires Board action is the management of complaints and feedback which has been highlighted by the Board. • Review taking place. Once plan in place, this risk will be reviewed. • Acknowledgment that patient experience runs through the vast majority of the corporate risks. • Date risk opened 13/02/2013 December 2014: Risk Reviewed and controls updated. Funding for 2015/16 has been identified to continue elements of improvement work and in conjunction with the DBC hub and Clinical Governance discussions are on going as to how the work of the DBC Hub and the emerging Quality Improvement hub will progress this will include discussions on how funding will be allocated. The vulnerable Patients Quality Improvement Framework has been revisited in light of the OPAC September 14 self assessment, the document has been made more user friendly with a supporting Driver diagram .NHS Lothian are anticipating a HIS Visit in April 2015 with HIS using new scrutiny process ,a workshop to prepare CMT's is to be held in January 2015 and all CMT's have identified a virtual group to progress this work. Feedback from previous patient experience surveys have been fed back to the local teams. NHS Lothian Board have approved the Person Centred Culture QI Plan and a local collaborative will take place in February 2015. The patient Quality Indicator tool (PQI) has been reviewed and now also incorporates Person centred questions. The Jan HCG paper will include reporting of TTT and the in-depth patient experience surveys Adequacy of controls changed to Inadequate following discussion at Risk Management Steering Group.	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Melanie Johnson	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3527	8:Ensure the Delivery of a Sustainable Workforce Framework	Medical Workforce Sustainability	There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.	•In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. •For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG. •A report is taken to each Board meeting updating the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. The main challenges have been in Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Radiology and Medicine for the Elderly. •For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. •A Medical Workforce Group has being established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model.	Reviewed at A&R Committee 17/02/2015 It was agreed to keep this risk on the Corporate Risk Register. January 2015: Risk Reviewed and action updates. Risk Grade/Rating remains as High/16.	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Dr David Farquharson	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3455	1:Improving Patient Safety	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. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being.	•Closed loop Health & safety management system in place. •Robust H&S Committee structure. •H&S policies and procedures in place (attached document). •Competent specialist H&S advice in place. Robust Occupational Health Services. Learning lessons through incident investigation. •Director of Occupational Health & Safety/Occupational Physician delivers an annual report to the NHSL H&S Committee with specific actions within these reports. ROSPA QSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed.	Reviewed by A&R Committee 17/02/2015 Risk Grade/Rating remains at High/15 Risk title changed to 'Management of Violence & Aggression' Rationale: • This is a very generic risk • The H&S risk which is not being managed at executive level is that of management of violence and aggression. Support by both data and HSE involvement. • Date risk opened 13/02/2013 December 2014: Risk Reviewed and updated. "Risk - Health & Safety ID 3455, has remained at orange as the RMSG previously agreed to include the "threat of prosecution" as a significant risk factor and we were subsequently prosecuted and fined on 2 counts of breach of H&S legislation last year and will most probably be prosecuted in the future following the 2009 WGH fatal traffic accident. We were lucky not to be prosecuted following the SJH Labs ruptured copper pipe incident. In addition, over the previous few years we have received a number of HSE Enforcement Notices due to the NHS Lothian failure to implement closed loop H&S management systems (ie controls are adequately designed but not effectively implemented) as Policies are not implemented or compliance checked, risks are not adequately assessed and controlled at local level by trained / competent local managers, control implementation is not checked and assured by appropriate site inspections, incidents are not investigated to identify immediate and underlying causes then action planned to prevent recurrence etc etc. Until there is robust evidence that interventions are resulting in a reduction of measurable negative outcomes (such as reduced harm incidents reported and lost time due to injury and illness) then this risk must remain at the current rating".	Adequate but partially effective; control is properly designed but not being implemented properly	High 15	Medium 6	Alan Boyter	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3567	11:Improve Integration - Integrated Joint Boards	Health & Social Care Integration	There is a risk that the Board and its Partners fail to submit agreed integration plans that satisfy the Scottish Government requirements to agreed timescales resulting in a failure to meet its legal responsibilities (Public Bodies Joint Working Act)	•A leadership group with the NHS Lothian CEO and Chair has been in Edinburgh to oversee the development of that particular integration scheme •Integration of Health and Social Care Plan Lothian Leadership Group •Named leads for the writing of the Integration Schemes in each area •Nominated leads for the development of each key section •Common text produced for development in each Local Authority area •Structured engagement with senior staff in the Health Board and Local Authority in East, Mid and Edinburgh •First set of Regulations published in October. Integration Schemes developed in response. •Plans will be open to consideration by the three governance committees during the consultation. •The Board will adopt the "body corporate" integration model (Section 1(4)(a) of the Act) in all four integration schemes •The Board has agreed the functions that must be delegated as defined in the current version of the draft Regulations •Edinburgh Leadership Group established to oversee the Integration Scheme and establishment of the Integration Joint Board •Executives and officers from West Lothian Council and NHS Lothian working to produce an Integration Scheme agreeable to both organisations •The Board has approved the East and Midlothian Schemes for consultation •The Board will consider the Edinburgh and West Lothian Integration Schemes on January 14th. Rationale for Adequacy of Controls: The Scottish Government have issue the final regulations, guidance and orders in relation to health and social care integration. Integration Schemes drafted and all now expected to be out for consultation by January 15th.	Reviewed by A&R Committee 17/02/2015 Risk grade/rating reduced to Medium/9 Rationale: • Clear understanding of actions to be taken. • Integration schemes progressing within set Scottish Government timelines and guidance. • Date risk opened 16/01/2014 January 2015: Risk Reviewed and Controls Updated. Adequacy of controls is now more adequate than previously reported but there is still potentially a risk that the West Lothian Scheme will not be approved by the Health Board or that the changes required by the Health Board in the Scheme will not be approved by the West Lothian Council. This risk is lower in the other three areas.	Adequate but partially effective; control is properly designed but not being implemented properly	Medium 9	Low 3	Alex McMahon	NHS Lothian Baord

NHS LOTHIAN

1.8

Board Meeting
1 April 2015

Executive Nurse Director

SUMMARY PAPER – HEALTHCARE ASSOCIATED INFECTION UPDATE

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• Progress against Health Efficiency Access Treatment Targets	3.1
• *Staphylococcus aureus* Bacteraemia (SAB): NHS Lothian's target by March 2015 is to achieve a rate of 0.24 per 1000 acute occupied bed days (≤184 incidences). The current rate is 0.34 (254 incidences) this breaches NHS Lothian Target.	3.2
• *Clostridium difficile* Infection (CDI): NHS Lothian's target by March 2015 is to achieve a rate of 0.32 per 1000 total occupied bed days (≤262 incidences). The current rate is 0.48 (362 incidences) this breaches NHS Lothian Target. Antibiotic Policy Short Life Working Group has completed what was set out to achieve and this brings to an end the need for further meetings of this group.	3.3
• Norovirus outbreaks: since August 2014 there have been 49 incidents of gastro-enteritis investigated in NHS Lothian, with 243 patients and 54 staff affected.	3.4
• Meticillin Resistant Staphylococcus aureus (MRSA) Screening Programme: latest quarterly report for NHS Lothian indicated further improvement in compliance with MRSA screening; Clinical Risk Assessment has improved from 62% to 71%, with swabbing remaining at 78%.	3.5
• Mandatory Surgical Site Infection Surveillance: for the period 1 October 2014 to 31 December 2014, there were 1040 procedures performed and 10 Surgical Site Infections were detected at a rate of 1.0%.	3.6
• Ebola Preparedness: Training Session for NHS Scotland Board has been organised for 22 April 2015 by the Army Medical Services Training Centre with the aim to learn from their experience.	3.7
• Antibiotic Prescribing Guidelines: revised UHS Antibiotic Prescribing Guidelines were implemented on 2 February 2015.	3.8
• Healthcare Environmental Inspectorate: carried out an Announced Inspection at Ellen's Glen Hospital on 11 March 2015.	3.9
• Vale of Leven: Work is ongoing against the 50 recommendations noted within the Vale of Leven Enquiry that has been identified as mostly implemented or partially implemented within NHS Lothian.	3.10

Fiona Cameron
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17 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Executive Nurse Director

HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Executive Nurse Director in advance of the meeting.

1.2 The document is in the new format (Appendix 1) as agreed with Clinical Management Group and Clinical Governance combining infection control and antimicrobial. This is in the monthly report format and there will also be a quarterly format with the first quarterly report due in April which will also include patient safety data.

2 Recommendations

2.1 The Board is recommended to:

- acknowledge receipt of the new format for Healthcare Associated Infection Reporting Template for February 2015. (Appendix 1)
- acknowledge receipt of the Healthcare Associated Infection Reporting Template for March 2015. (Appendix 2)
- note NHS Lothian's *Staphylococcus aureus* Bacteraemia March 2015 target is a rate of 0.24 per 1000 bed days (≤184 incidences). The current rate is 0.34 (254 incidences) meaning that the target has been breached.
- note NHS Lothian's *Clostridium difficile* Infection target by March 2015 is to achieve a rate of 0.32 per 1000 bed days (≤262 incidences). The current rate is 0.48 (362 incidences) meaning the target has been breached.
- support the Antimicrobial Team activities in relation to Antimicrobial Prescribing Review and reduction of antimicrobials associated with *Clostridium difficile*.
- acknowledge and support ongoing actions to address gaps identified within the response to Vale of Leven Inquiry recommendations.

3 Discussion of Key Issues

3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2015

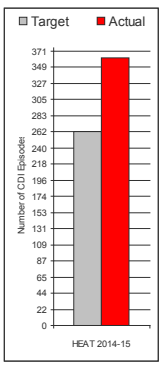

Figure 1: No. of CDI Episodes 2014-15

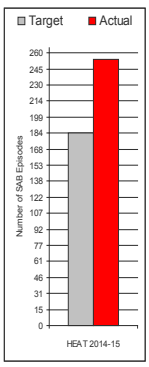

Figure 2: No. of SAB Episodes 2014-15

3.2 *Staphylococcus aureus* Bacteraemia: NHS Lothian's Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days (≤184 incidences) by March 2015 with a current rate of 0.34. There were 27 episodes of *Staphylococcus aureus* Bacteraemia in February 2015 (1 Meticillin Resistant *Staphylococcus aureus*, 26 Meticillin Sensitive *Staphylococcus aureus*), compared to 29 in January 2015 (3 Meticillin Resistant *Staphylococcus aureus*, 26 Meticillin Sensitive *Staphylococcus aureus*).

Target Date	Target	Actual
Year Ending 31/3/2013	213	255
Year Ending 31/3/2014	219	243
Year Ending 31/3/2015	184	254

* Cumulative to date

3.2.1 Key Messages:

- NHS Lothian remains vulnerable to *Staphylococcus aureus* Bacteraemia mainly through the use of Invasive Device Use (vascular access and urinary catheters). Optimising care of these devices and avoiding use wherever possible remains the key priority.
- Actions are focussed on audit and education to improve this, focusing on preventable bacteraemia
- Recent increase in IVDU related SAB, local and national investigations ongoing

3.3 *Clostridium difficile* Infection: NHS Lothian's Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days (≤262 incidences) by March 2015 in patients aged 15 and over, with a current rate of 0.48. There were 21 episodes of *Clostridium difficile* Infection in patients aged 15 or over in February 2015, compared to 30 in January 2015.

Target Date	Target	Actual
Year Ending 31/3/2013	418	364
Year Ending 31/3/2014	313	425
Year Ending 31/3/2015	262	362

* Cumulative to date

3.3.1 Since the publication of the new antimicrobial guidance the Antibiotic Policy Short Life Working Group have noted:

- Gentamicin use increased all 3 acute sites in February 2015 as surrogate measure of effective change
- No increase adverse drug events related to Gentamicin had been reported at time of report.
- Antimicrobial Management Team continue to work on step down advice, update of learnpro module and consideration is still being given to the development of an app.

3.3.2 *Clostridium difficile* Infection Action Plan, work continues to progress and the updated plan is attached for information (Appendix 2)

3.4 Norovirus: since August 2014 there have been 49 incidents of gastro-enteritis investigated in NHS Lothian, with 243 patients and 54 staff affected. In comparison for the same period for season 2013/14 there have been 81 incidents of gastro-enteritis investigated in NHS Lothian, with 510 patients and 116 staff affected. There have been 186 bed days lost so far for season 2014/15, in comparison for

the same period for season 2013/14 there have been 633 NHS Lothian bed days lost.

3.5 Meticillin Resistant Staphylococcus aureus (MRSA) Screening Programme: the latest quarterly report for NHS Lothian provided by Health Protection Scotland in January 2015 indicated further improvement in compliance with MRSA screening; Clinical Risk Assessment has improved from 62% to 71%, with swabbing remaining at 78%.

3.6 Mandatory Surgical Site Infection Surveillance: for the period 1 October 2014 to 31 December 2014, there were 1040 procedures performed and 10 Surgical Site Infections were detected at a rate of 1.0%. Surgical Site Infection rates for caesarean section (inpatient and Post discharge surveillance to day 10) for NHS Lothian are marginally up this quarter from 0.9 to 1.0%. The seven infections were post-discharge infections and were classified as superficial infections.

The Surgical Site Infection wound criteria are now available electronically in Maternity Trak for the Community Midwives to complete at day 10 post discharge. NHS Lothian is now reporting day ten post discharge completion rates to Health Protection Scotland. These range from at the Royal Infirmary 95 to 96% and at St Johns 94 to 98%. There was one deep Surgical Site Infection for Hip arthroplasty this month quarter which was a re-admission. There were two deep Surgical Site Infections for Repair of Neck of Femur this quarter. These were both noted to be in-patient infections.

3.7 Ebola Preparedness: in response to the ongoing outbreak of Ebola Virus Disease in Sierra Leone, Guinea and Liberia, an Ebola Training Session for NHS Scotland Board has been organised to be held on 22 April 2015 by the Army Medical Services Training Centre near York to discuss the preparations and training that the Military Healthcare Workers receive prior to deployment to Sierra Leone with the aim to learn from their experience. From NHS Lothian there will be representatives sent that include senior managers, front line staff and infection prevention and control.

3.8 Antibiotic Prescribing indicators: in clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines was just below the target level for all three acute sites and ranged from 70 to 100%. Documentation of indication for antibiotic treatment was at the target level of 100% for all three acute sites but documentation of antibiotic duration was below target level at 40 to 63%.

A new prescribing indicator for oral antibiotic prescribing in downstream medical wards was introduced in May 2014 by the Scottish Antimicrobial Prescribing Group. In January compliance with documentation of indication for an oral antibiotic averaged 100% compliance but compliance with the UHS Antibiotic Prescribing Guidelines varied from 80 to 95% for all three acute sites. Documentation of intended duration of an oral antibiotic ranged from 55 to 80% for the sites. Compliance with the guidelines for duration of oral antibiotics varied from 25 to 100%.

Antibiotic Prescribing Guidelines: revised UHS Antibiotic Prescribing Guidelines were implemented on 2nd February 2015 to facilitate use of more narrow spectrum and less broad spectrum antibiotics for empiric treatment of infection. Over-use of broad spectrum antibiotics is associated with *Clostridium difficile* infection and

development of antibiotic resistance. It is hoped that implementation of the revised guidelines will result in a reduction of *Clostridium difficile* infection and improvement in the NHS Lothian HEAT target for *Clostridium difficile* infection.

3.9 Healthcare Environmental Inspectorate: the Healthcare Environment Inspectorate advised NHS Lothian of their intention to carry out an Announced Inspection at Ellen's Glen Hospital on 11 March 2015.

The Healthcare Environment Inspectorate have requested a 16 week update on the action plan developed following the Unannounced Inspection at Western General Hospital on 18–19 November and 27 November 2014 with a deadline to return to the Inspectorate by 24 March 2015.

3.10 Vale of Leven Enquiry: Work is ongoing against the 50 recommendations noted within the Vale of Leven Enquiry that has been identified as mostly implemented or partially implemented within NHS Lothian.

4 Key Risks

4.1 The key risks associated with the recommendations are:

- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Based on current trend for *Clostridium difficile* Infection NHS Lothian is not on target to achieve the set Health Efficiency Access Treatment Target.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register 1076 is currently graded high due to reported incidences of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection impacting on negative trend to achieving Health Efficiency Access Treatment Target. The risk register covers Norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Inequality, Including Health Inequalities

6.1 Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. Accordingly, changes made are reducing the burden of Healthcare Associated Infection.

7 Involving People

7.1 Patient public representatives are actively involved during the Healthcare Environment Inspectorate inspections, with one member sitting on the Healthcare Environment Inspectorate Steering Group. Other patient public representatives sit on the Infection Control Committees for Acute and Community and Lothian Infection Control Advisory Committee.

8 Resource Implications

8.1 Infection Prevention and Control is an invest to save service. The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection is variable, depending on increased length of stay and additional treatment requirements.

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17 March 2015
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List of Appendices

Appendix 1: Clinical Management Group Infection Report March 2015
Appendix 2: Healthcare Associated Infection Reporting Template for March 2015
Appendix 3: Corporate *Clostridium difficile* Infection Action Plan

APPENDIX 1

NHS Lothian Monthly Infection Report - March 2015

Date produced: 2nd March 2015

This report is in development. The intial focus for development has been the acute sites.
A more comprehensive report is available quarterly. Brief commentary is provided alongside each figure.

Note that for data on infections, infections are attributed to the clinical area from which the sample was sent.

Contacts

Infections data janathan.daniel@nhslothian.scot.nhs.uk

Antimicrobial data eilidh.fletcher@nhslothian.scot.nhs.uk

Primary Data sources

Prescribing data: Ascribe (to June 2014); JAC (from June 2014)

Activity data: TRAK oracle

Infections data: Apex labs system

Please see individual sheets for other data sources

Abbreviations

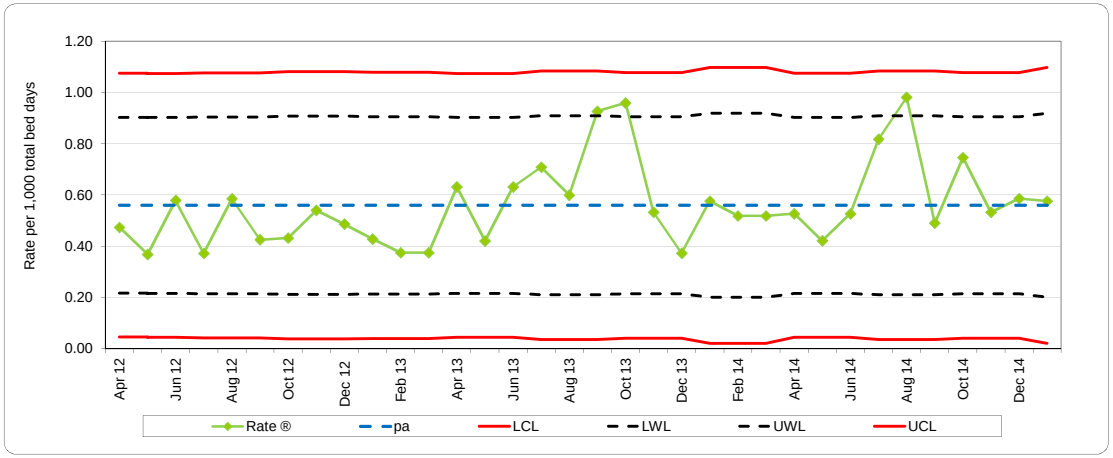
DDD - Defined Daily Dose
The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults.

OBD - Midnight Occupied Bed Days

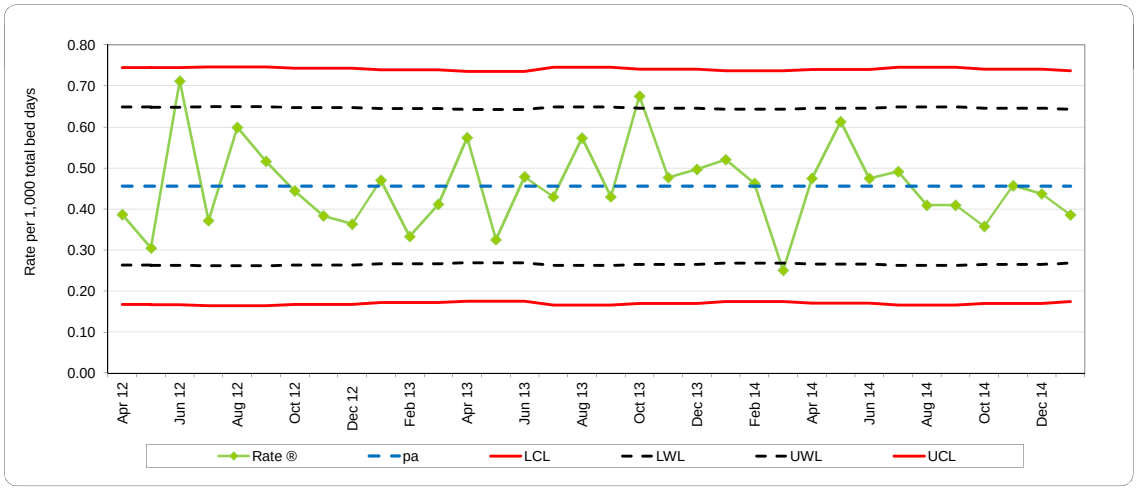
CDI - Clostridium difficile infection

For SPC charts: pa - process average, **LCL** - lower control limit, **LWL** - lower warning limit

1.1 u-chart - NHS Lothian CDI rate per 1,000 bed days for15-64 year age group (Apr 2012-Jan 2015)

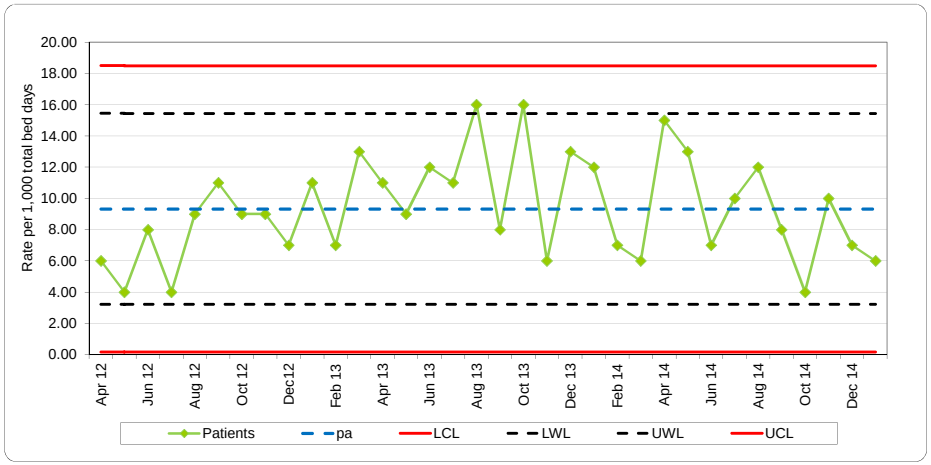


1.2 u-chart - NHS Lothian CDI rate per 1000 OBDs for 65 year and over age group (Apr 2012-Jan 2015)

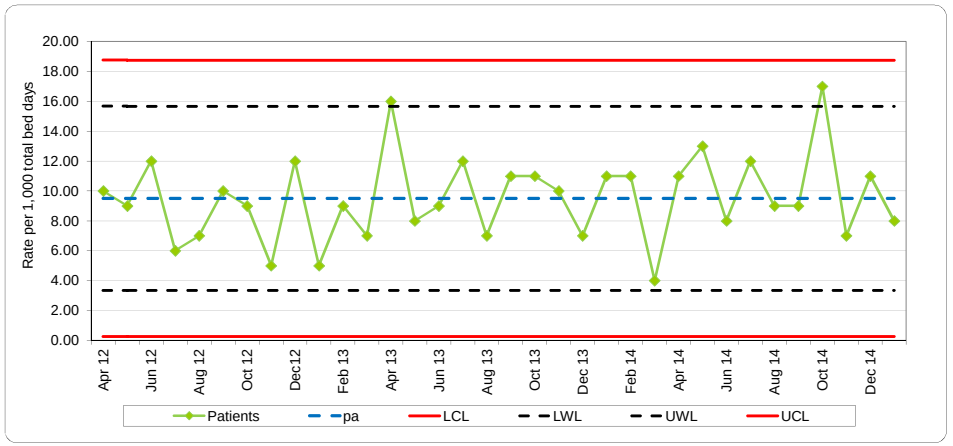


Source: IPCT
All data
No change in rate for either age group.

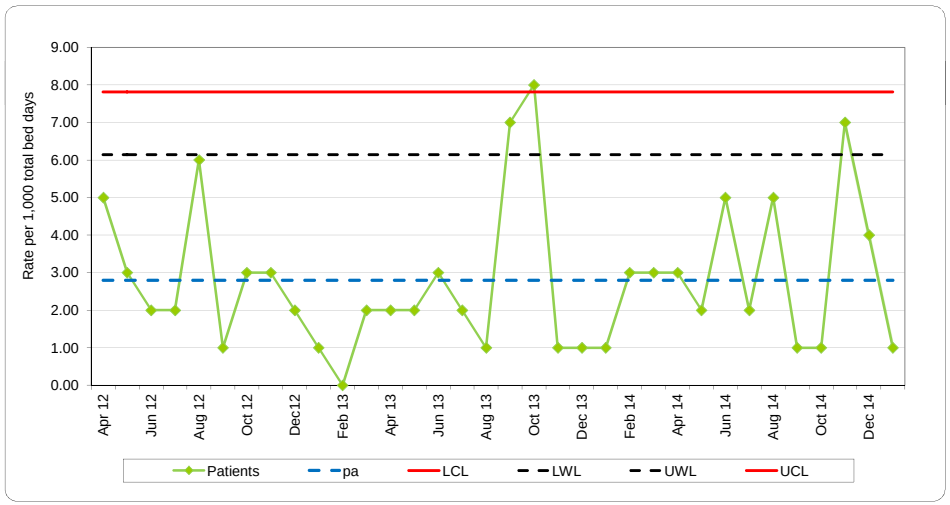
1.3 c-chart of number of episodes of CDI per month in RIE in pts aged 15+ (Apr 2012-Jan 2015)



1.4 c-chart of number of episodes of CDI per month in WGH in pts aged 15+ (Apr 2012-Jan 2015)

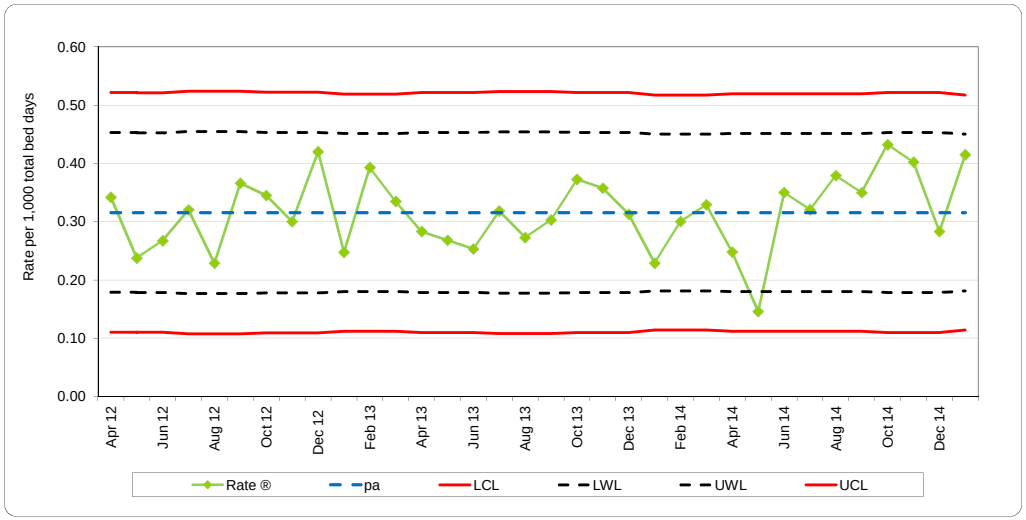


1.5 c-chart of number of episodes of CDI per month in SJH in pts aged 15+ (Apr 2012-Jan 2015)



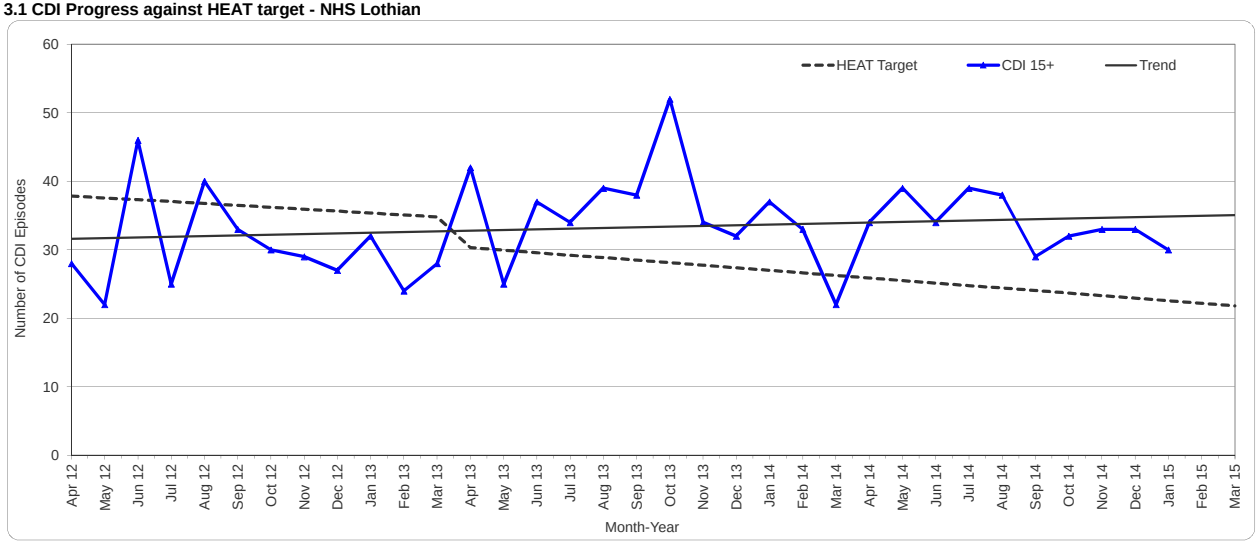
Source: IPCT
All data
No change in number of episodes at any of 3 main sites.

2.1 u-chart - NHS Lothian *Staphylococcus aureus* Bacteraemia rate per 1000 OBDs (Apr 2012-Jan-2015)



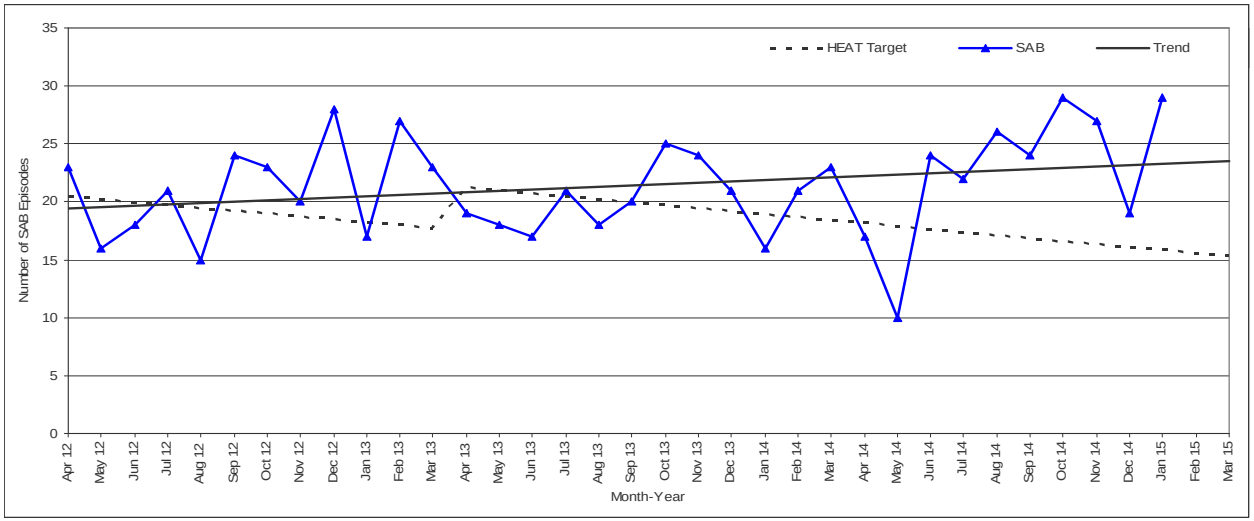
Source: IPCT
All data
No change in rate.

3.1 CDI Progress against HEAT target - NHS Lothian

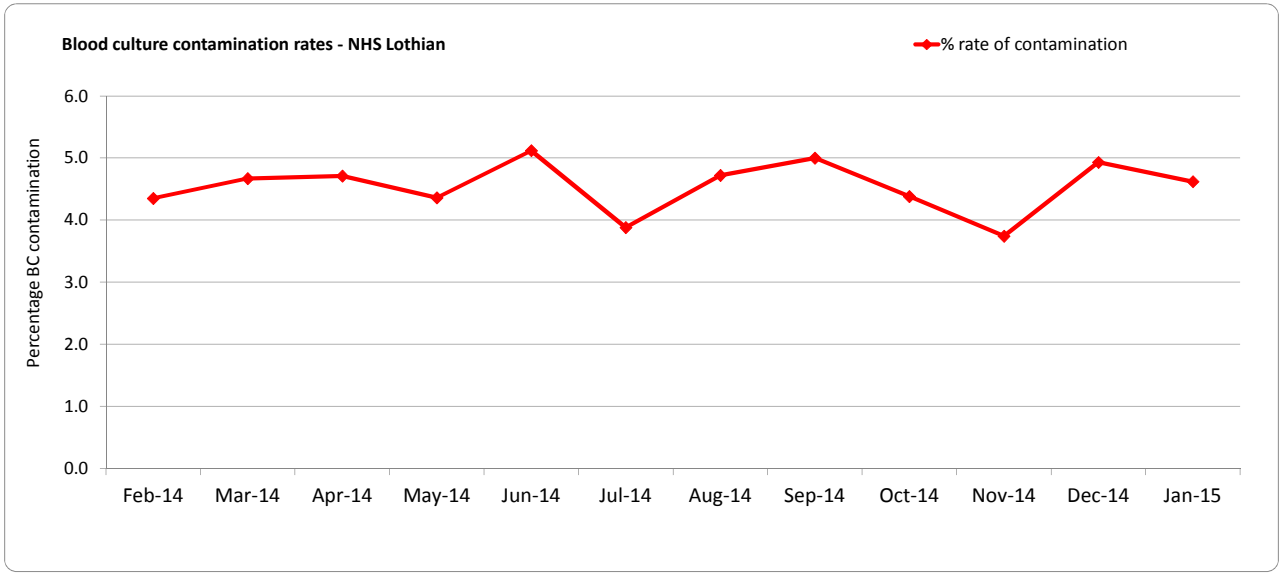


Source: IPCT
All data
Number of CDI and SAB episodes not in line with meeting HEAT target.

3.2 SABs progress against HEAT target - NHS Lothian



3.1 Blood culture contamination rates - Feb 2014 - Jan 2015



Source: IPCT
All data
No change in rate over last year.

3.2 Ward closures

No up to date aggregate data are currently available.

3.3 Number of wards that have exceeded CDI trigger levels (April to Jan 2015)

LocationDescription	2014-04	2014-05	2014-06	2014-07	2014-08	2014-09	2014-10	2014-11	2014-12	2015-01	Grand Total
RIE Ward 107	1	1	2	0	1	1	1	2	1	2	12
RIE Ward 206	0	3	0	0	1	1	1	2	2	0	10
WGH ARAU Beds	1	1	1	2	1	0	2	0	1	1	10
RIE Ward 105	1	0	0	3	1	0	0	2	1	0	8
WGH ARAU Trolleys	1	2	0	2	1	0	1	0	1	0	8
WGH Ward 8	1	4	0	0	0	0	0	1	0	1	7
WGH Ward 27	1	0	0	3	0	1	0	0	0	1	6
WGH Ward 43	1	1	2	0	0	0	0	0	1	1	6
RIE Ward 108	4	0	0	0	0	1	0	0	0	0	5
RIE Ward 208	3	0	0	0	1	0	0	0	0	1	5
SJH Medical Assessment Unit	1	0	1	0	2	0	0	0	1	0	5
WGH Ward 56	0	0	0	0	1	2	0	0	1	1	5
AAH Charles Bell Pavilion 1	0	0	0	0	0	0	0	1	1	2	4
GP: Tranent Medical Practice	0	0	0	1	0	2	0	0	1	0	4
RIE Ward 203	2	2	0	0	0	0	0	0	0	0	4
RIE Ward 207	0	0	1	0	0	0	1	2	0	0	4
WGH Ward 2	1	0	0	0	0	0	2	0	1	0	4
WGH Ward 24	0	0	1	1	0	0	2	0	0	0	4
WGH Ward 42	0	0	1	0	2	0	0	0	1	0	4
WGH Ward 53	0	0	0	0	0	1	2	0	1	0	4
WGH Ward 8 Unit	0	1	0	1	0	0	2	0	0	0	4
GP: Parkgrove & East Craigs Medical Centre	0	0	2	0	0	0	0	1	0	0	3
RIE Combined Assessment Area 4	0	2	0	0	0	1	0	0	0	0	3
RIE Ward 120	0	0	0	0	0	2	0	0	0	0	2
WGH Ward 15	2	0	0	0	0	0	0	0	0	0	2

Source: IPCT
All data
These represent clinical areas where there have been > 2 CDI in the given time period.

4.1 Monthly medication error Datix reports - all NHS Lothian sites

	Financial year 2014/15											
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Number of medication error reports	247	217	213	257	214	218	260	215	212	214	177	
Number related to gentamicin	2	2	1	5	2	0	2	-	-	-		
% related to gentamicin	0.81%	0.92%	0.47%	1.95%	0.93%	-	0.77%	-	-	-		

Source: Datix, All data
The antimicrobial policy changed in Feb 2015. Caution small numbers for gentamicin. See additional notes below.

4.2 Monthly medication error Datix reports - Royal Infirmary of Edinburgh

	Financial year 2014/15											
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Number of medication error reports	65	50	42	64	59	68	73	54	50	49	35	
Number related to gentamicin	-	2	-	2	2	-	-	-	1	-		
% related to gentamicin	-	4.00%	-	3.13%	3.39%	-	-	-	2.00%	-		

Chart 4.1 NHS Lothian Medication error Datix reports

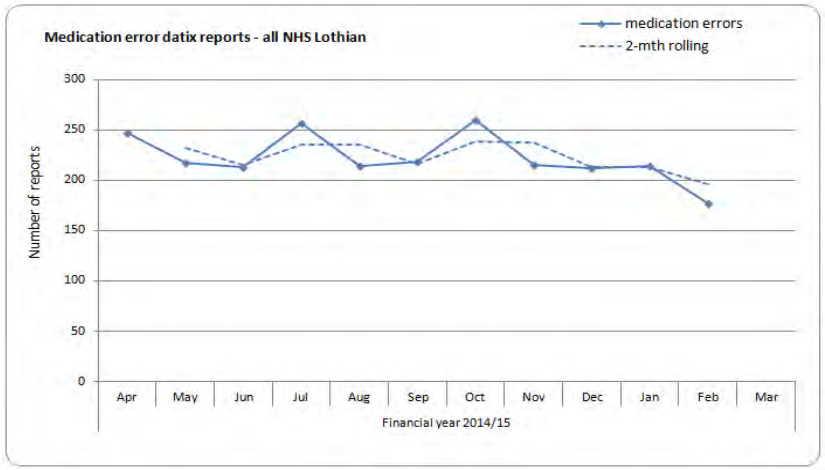
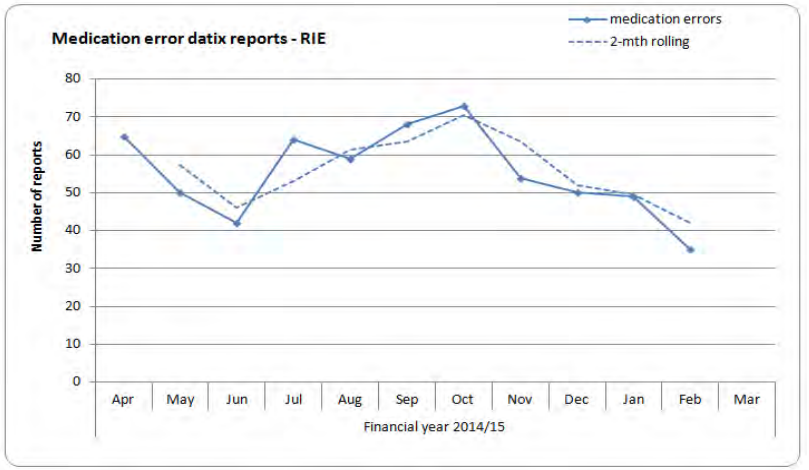


Chart 4.2 RIE Medication error Datix reports



4.3 Monthly medication error Datix reports - Western General Hospital

	Financial year 2014/15											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of medication error reports	81	68	63	69	51	61	59	57	59	61	47	
Number related to gentamicin	-	-	1	2	-	-	-	-	-	-		
% related to gentamicin	-	-	1.59%	2.90%	-	-	-	-	-	-		

Source: Datix, All data
The antimicrobial policy changed in Feb 2015. Caution small numbers for gentamicin. See additional notes below.

4.4 Monthly medication error Datix reports - St John's Hospital

	Financial year 2014/15											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of medication error reports	15	23	15	26	18	18	26	16	22	23	20	
Number related to gentamicin	-	-	-	-	-	-	-	-	-			
% related to gentamicin	-	-	-	-	-	-	-	-	-	-	-	-

Chart 4.3 WGH Monthly medication error Datix reports

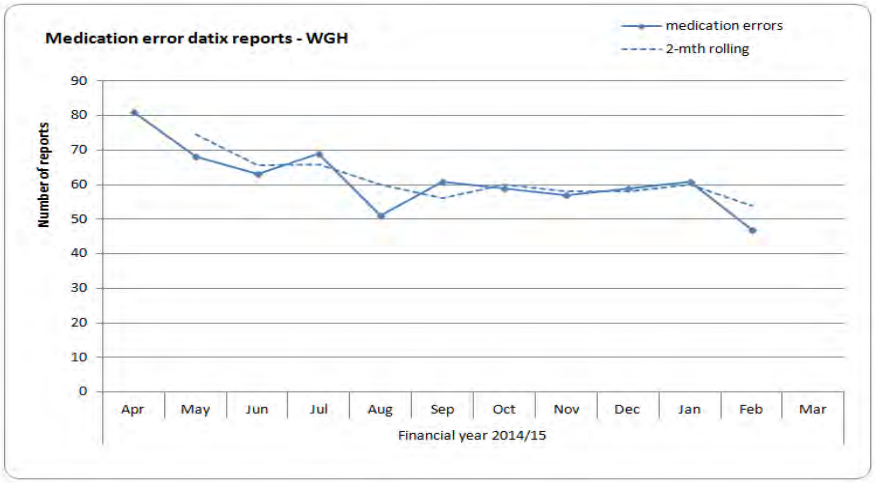
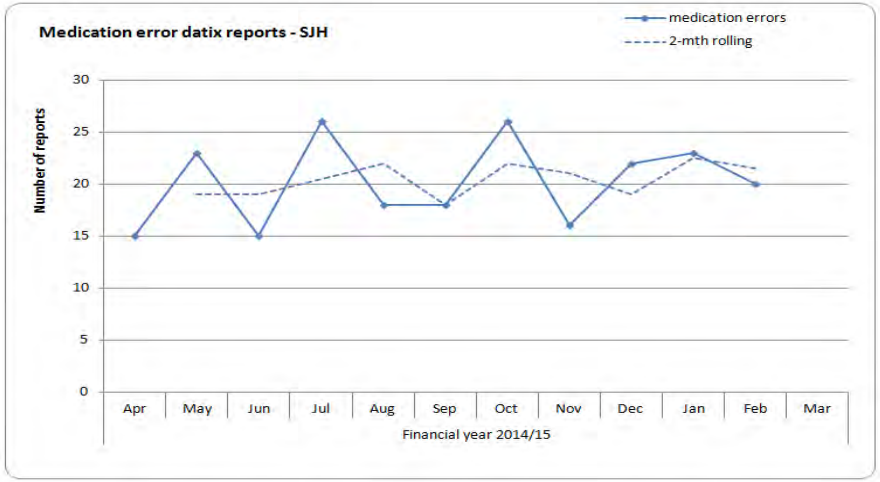


Chart 4.4 SJH Monthly medication error Datix reports



Adverse events - medication adverse events in and number related to gentamicin

Source: DATIX; data extracted 02/03/2015
Date: 02/03/2015
Notes:
1: Data as at 02/03/2015.
2: Adverse events are recorded in 'real-time', therefore the total number of medication error reports for February (to date) are assumed to be accurate. However, it is not mandatory to record the drug involved when initally recording a medication adverse event and this is often only added to the database once the adverse event has been investigated. For this reason, gentamicin adverse events for February have not been shown as the number currently held on the database is likely to change.

NHS LOTHIAN

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	1	2	2	0	1	1	4	3	4	1	3	1
MSSA	22	15	8	24	21	25	20	26	23	18	26	26
Total	23	17	10	24	22	26	24	29	27	19	29	27

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	9	10	8	10	15	18	9	14	10	11	10	4
Age 65 plus	13	24	31	24	24	20	20	18	23	22	20	17
Total	22	34	39	34	39	38	29	32	33	33	30	21

Hand Hygiene Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
AHP	96.60	95.25	96.48	96.93	95.50	96.94	96.74	93.90	94.81	95.18	94.69	n/a
Ancillary	88.41	93.02	94.07	91.45	91.60	90.08	90.77	94.66	91.64	93.02	88.81	n/a
Medical	92.73	93.32	92.94	92.85	94.96	93.22	93.69	94.37	93.60	90.56	93.18	n/a
Nurse	98.30	98.47	98.39	98.58	98.11	98.46	98.22	98.18	98.15	98.38	98.47	n/a
Board Total	96.36	96.71	96.79	96.75	96.75	96.71	96.69	96.62	96.37	96.03	96.29	n/a

Cleaning Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	95.95	96.65	95.96	96.14	96.44	96.25	95.60	96.10	95.70	95.10	94.95	95.40

Estates Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	97.06	96.49	96.47	97.05	96.93	96.46	96.80	96.40	97.20	97.10	96.65	96.60

ROYAL INFIRMARY OF EDINBURGH

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	1	1	0	0	0	1	1	0	1	0	2	0
MSSA	5	0	0	3	3	4	5	2	1	1	4	7
Total	6	1	0	3	3	5	6	2	2	1	6	7

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	2	5	1	1	2	6	2	2	2	2	1	0
Age 65 plus	4	10	12	6	9	6	6	2	8	5	5	6
Total	6	15	13	7	11	12	8	4	10	7	6	6

Cleaning Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	96.92	96.99	96.51	96.83	97.09	97.07	96.60	97.01	96.63	96.72	96.27	96.55

Estates Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	95.69	96.29	95.74	96.08	96.92	96.63	95.82	96.33	97.98	96.10	95.45	95.47

WESTERN GENERAL HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	0	1	1	0	0	0	0	2	1	0	0	1
MSSA	4	1	1	2	1	2	4	3	5	1	1	3
Total	4	2	2	2	1	2	4	5	6	1	1	4

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	2	3	3	4	6	5	2	7	2	2	4	3
Age 65 plus	2	8	10	4	6	4	7	10	5	9	4	3
Total	4	11	13	8	12	9	9	17	7	11	8	6

Cleaning Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	97.19	97.69	97.32	97.16	97.52	96.87	95.01	96.33	94.02	93.55	92.89	93.42

Estates Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	99.01	99.07	98.77	99.35	99.04	98.31	97.86	98.24	97.75	97.73	98.17	97.83

ST JOHNS HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	0	0	0	0	0	0	1	1	0	0	0	0
MSSA	0	0	0	0	2	0	0	0	0	0	1	0
Total	0	0	0	0	2	0	1	1	0	0	1	0

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	1	0	0	1	1	0	0	0	2	1	0	1
Age 65 plus	2	3	2	4	1	5	1	1	5	3	1	3
Total	3	3	2	5	2	5	1	1	7	4	1	4

Cleaning Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	94.79	96.26	95.02	95.83	95.13	95.05	93.83	95.43	95.38	95.02	95.76	95.92

Estates Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	93.87	95.00	95.66	95.82	94.42	93.51	94.75	95.29	95.63	95.43	95.53	95.01

LIBERTON HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	1	0	1	1	1	0	3	0	0	0	0
Total	1	1	0	1	1	1	0	3	0	0	0	0

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	0	0	1	3	2	0	1	0	0	0	1	1
Total	0	0	1	3	2	0	1	0	0	0	1	1

Cleaning Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	94.27	95.69	96.19	95.65	97.67	97.61	96.83	97.70	97.02	96.71	96.87	96.77

Estates Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	92.23	95.86	95.50	93.47	96.93	95.94	93.66	95.12	97.43	98.11	98.04	97.99

ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	1	0	0	1	0	1	1
Total	0	0	0	0	0	1	0	0	1	0	1	1

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	94.94	94.42	95.03	94.50	95.18	95.20	93.67	94.21	95.13	95.83	94.11	94.47

Estates Monitoring Compliance (%)

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Board Total	99.77	99.20	98.56	99.28	99.19	99.87	97.59	97.21	98.29	99.00	96.61	97.91

COMMUNITY HOSPITALS

Community Hospitals include the following hospitals and care facilities

- Astley Ainslie Hospital
- Corstorphine Hospital
- Ellen's Glen House
- Ferryfield House
- Findlay House
- Marie Curie Hospice Edinburgh
- Midlothian Community Hospital
- Roodlands Hospital
- Royal Edinburgh Hospital
- Royal Victoria Hospital
- St Columba's Hospice
- St Michaels Hospital
- Tippethill Hospital

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	0	0	0	0	0	0	0	0	1	0	1	0
MSSA	0	0	0	1	0	0	0	1	0	0	0	0
Total	0	0	0	1	0	0	0	1	1	0	1	0

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	0	0	0	0	0	0	0	0	1	2	2	0
Age 65 plus	0	1	0	3	2	0	1	0	0	2	0	1
Total	0	1	0	3	2	0	1	0	1	4	2	1

OUT OF HOSPITAL INFECTIONS

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
MRSA	0	0	1	0	1	0	2	0	1	1	0	0
MSSA	12	13	7	17	14	17	11	17	16	16	19	15
Total	12	13	8	17	15	17	13	17	17	17	19	15

Clostridium difficile Infection **Monthly Case Numbers**

	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015
Age 15-64	4	2	4	4	6	7	5	4	3	4	3	0
Age 65 plus	5	2	6	4	4	5	4	5	5	3	9	3
Total	9	4	10	8	10	12	9	9	8	7	12	3

APPENDIX 3

ACTION PLAN TO REDUCE PATIENT HARM FROM *CDI* - Version 26.02.2015

ACTION	TASK	RESPONSIBILITY	Timescale	Progress/commentary
1. Early diagnosis	Review of local CDI policy to mirror national guidance	IPCN GLs	Oct-14 27/2/18	Review Completed Document circulated at UHS ICC no comments received. In progress for upload to intranet
	Development of CDI management SOP/Pathway	Lead IPCN	Oct-14	Complete
	Introduction of Clinical Risk Assessment for each CDI inpatient	IPCT	Nov-14	Complete
2. Surveillance	Retrospective RCA of a sample of cases since April 2014	IPCT & Additional Support	Oct-14	Complete
	Analysis of retrospective RCA findings	IPCT& EB	Nov-14	First analysis of data has identified that more work required. More detailed analysis not possible. Agreed that no further work on this at present – prioritise learning from cluster. Complete
	Introduction of Root Cause Analysis for every CDI in-patient to improve learning/prevention and to correctly attribute cases.	IPCT & Clinical Teams	Feb -15	Testing. 1/12/14 - Revisions made. To discuss at IPCT business meeting. Further revisions made following meeting with ICD. Revised version sent to IPCN Team. Revisions and processed to be discussed and finalised on 04/02/15 at IPCT Business Meeting. Complete
			April-15	Reliable reattribution not currently happening as currently no consensus on the criteria for a consistent and reliable approach and evidence for reattribution
	Continue CDI Ward Rounds for every CDI in-patient. Findings to be collated in ICNet to allow feedback and data reports. This will measure compliance with CDI key	IPCT & Clinical Teams	Jan -15 Revised	CDI Ward Rounds on going. Data reports to be set up in ICNet by Jan 2015. Delayed due to sickness and absence of ICNET editor

	prevention and control factors.		Mar 15	Ward rounds undertaken but not all supported by Medical Microbiologists.
	Commence monthly review of CDI themes with dissemination of key learning to clinical teams involved in the patients care.	IPCT & Clinical Teams	Nov-14 Revised Date April 2015	Testing. The increased incidence at the RIE recently has allowed a clear pilot of this process. Agreed structure going forward to be discussed at Professional meeting 26/02/15
	Engagement with GPs. Development of RCA letter to be sent for community CDIs, requesting drug history. Letters to be sent back to IPCT to add to data analysis systems	IPCT & Clinical Teams	Ongoing	On-Going. 1/12/14 - Discussed with AMT Pharmacists. Dates being arranged to carry out visit to GP reps meetings throughout 2015. Revisions made to letters following feedback from GPs. However GP group advised they are not willing to endorse this approach Discussed at CHP ICC and agreement by members to continue to issue the GP letters.
	Review available data in relation to CDI, antimicrobials and other risk factors. Test improvements to the way data are reported at all levels.	EB JD LT FC NO	Feb- 15	Requires input from clinical teams, SPSP, AMT. Links also to action in relation to ICNet. First mock-up of infection report to CMG in Feb, Ongoing issues to resolve: IC net, attribution of infections, infrastructure to support production of report. LB and NO met to agree mock-up infection report. To be discussed at CMG on 11/02/15. Format approved at CMG and will be introduced in new reporting year commencing 1st April 2015

3. Education	No-C Diff-vember awareness campaign in acute sites	IPCT, JC	Nov-14	Complete. Good attendance from each acute site at awareness sessions. Posters now being updated and distributed.
	NHS GG&C presentation on restricted ABx Guidelines	AS	Oct-14	Complete
	Development of local CDI module to be completed by clinical staff. Completion of module will count as HAI element in eKSF complete.	Lead IPCN	Nov-14	Module development now complete. Awaiting finalisation of CDI nursing/medical documentation to add into module. This has to be agreed by SLWG. Can be published following final version of CDI policy. Deadline date for comments for this is 13/02/15.
	Adhoc education sessions in specific areas	IPCT	On-going	
4. SICPs/TBPs	Gap analysis of QIDs Infection Control Audits in comparison to the National Infection Prevention & Control Manual.	Lead IPCN & SPSP	Sep-14	Complete
	Implement changes to address gap & move towards National audits for SICPs compliance: Baseline audit required initially.	Co-ordinated by Lead IPCN	Nov 14- April 15	SICPs baseline audits in progress, delays due to staff shortage. Bank Nurse support in place. Meeting between NO/ /AH to discuss relaunch of SICPs and staff ownership of on-going audit 20/1/15. NO advised AH the changes required within QIDS. NES supporting education to support change 3 dates have been organised 2 at RIE (20 & 27th Feb. 2015 and 1 at WGH 6th March 2015). Baseline within acute settings will be complete by end Feb. 2015 including RHSC. Roll out plan for baseline audits to CHP settings being organised anticipated to be complete by April 2015. Presentation provided to Essential Nursing Care Seminar on SICPs and TBPs on 24.2.15 advising on current compliance rates. Presentation has been

				shared with Chief Nurses to raise awareness. Anticipate handover to clinical team and go live on QIDS system by 01/04/15. SICP audits will be completed using the HPS monitoring tool on a quarterly basis by clinical teams. The IPCT will also QA areas of good practice and areas of concern on a quarterly basis. Geographical leads currently working on communication and roll out plan to support transitions
	Re-launch of SICPs & TBPs as per National Infection Prevention & Control Manual		April 15-Nov.15	Liaising with Patient Safety re content and frequency of audits .. Content agreed and publication pending Anticipate go live date for National audits within QIDS as 1st April 2015
	Education & roll out required subsequently for all in-patient areas.		April 15-Nov.15	Support and education sessions from IPCNs to their local ward/department areas to help staff undertake the new audits reliably. Geographical leads currently working on communication and roll out plan to support transitions
	Trial of Integrated Care Pathway for the Patient with Diarrhoea trailed in Ward 27 at WGH. Feedback from staff on its use required.	IPCT, HAI QIF, Clinical Staff	Dec-14	The trial was discontinued. IPCT delivered education sessions to ward staff throughout Oct and Nov. During this period, Charge Nurse identified that most of the components within the pathway were already within the CDI risk assessment doc therefore this would result in duplication.
5. Environmen	Actichlor Plus Refresher Training. Audit to take place in December to assess knowledge gained and products available.	Lead IPCN & Ecolab	Dec-14 April 15	Initial training completed, review meeting with Actichlor Rep and Lead IPCN held on 8.12.14. Encompass system, follow up and education now underway. Trial at SJH to test system process with wifi and trial at RIE in ward involved in increased incidence of CDI. Report will be available in 4 weeks time.

	Publish revised Cleaning Matrix	Robert Aitken	Dec-14	Presented at UHS ICC Jan -15. Publication date TBC
	Review of existing cleaning schedule template as part of 90 Day Workout	IPCT, HAI QIF, Clinical Staff, Patient Safety	Nov-14	Ward 107 & 105 at RIE testing new template for daily, weekly and monthly cleaning schedules. Education delivered to ward on these throughout November. Updated weekly and monthly cleaning schedules are being used in both ward areas.
6. Antimicrobials Stewardship	Review antibiotic policy & associated tools to improve antimicrobial stewardship	AMT	Feb-15	Planned implementation of new policy on 02/02/15 Gentamcin Kardex has been approved at ADTC and presented at Clinical documentation on 17.12.14. Crit care testing from 19.1.15 New guidelines commenced as planned 2 Feb 2015
	Discussion with GPs on CDI risk factors and prescribing habits	IPCT / AMT	May 14 - Oct 14	On-going. Number of meetings carried out during 2014 - Dates being arranged to carry out visit to GP reps meetings throughout 2015
	Better links between IPCT and Anti-microbial team. E.g. Commence IPCN representation at AMT meeting & presentation of RCA data	IPCT	Ongoing	Lead IPCN joined AMT. AMT audit nurses due to attend next IPCT business meeting. Complete
	Scoping work to improve PPI prescribing	SE	Dec-14	
	AMT audit nurse support in the completion of RCAs for CDI	AMT audit nurses	Ongoing	AMT audit nurses due to attend next IPCT business meeting.

NHS LOTHIAN

1.9

Board Meeting
1 April 2015

Executive Director: Nursing, AHPs & Unscheduled Care

SUMMARY PAPER - UNSCHEDULED CARE

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• NHS Lothian's unscheduled care performance against the 4 hour standard for the month of February 2015 was **91.58%** (87.17% during January)**.**	3.1.1
• During February 2015 there were 64 twelve hour breaches along with 235 eight hour breaches.	3.2.2
• The overall number of Delayed Discharges across NHS Lothian has decreased from 196 during December 2014 to 161 during February 2014	3.4.1
• The Scottish Government announced that official statistics on Accident and Emergency (A&E) activity and waiting times are to be published each week. These will cover the 32 Emergency Departments in Scotland that provide a 24-hour consultant led emergency medicine service only. (Note: excludes the WGH) The first publication was on Tuesday 3 March covering the week ending Sunday 22 February.	4.1 – 4.3
• A Pan-Lothian review of stroke services is to be undertaken during 2015. This builds on the unscheduled care workshops held during 2014 where a number of outputs were identified.	5.1
• Work continues to develop the new front-door model at the WGH.	6.1 – 6.4
• All additional beds funded by *winter* or other temporary funding (as well as those opened on an unfunded basis) will need to close As winter ends in March 2015. A winter de-brief session has been arranged for 16 April	7.1 – 7.4
• The final quarterly return on NHS Lothian's 2014-15 LUCAP is due to be submitted to the Scottish Government by 20 April 2015.	8.1

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17 March 2015.
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NHS LOTHIAN

Board Meeting
1 April 2015

Executive Director: Nursing, AHPs & Unscheduled Care

UNSCHEDULED CARE

1. Purpose of the Report

1.1 The purpose of this report is to provide the Board with an update on Unscheduled Care performance and our measurement against agreed national targets as well as an update on this year's winter planning approach.

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

2. Recommendations

2.1. To note unscheduled care performance.

2.2. Note the effect of winter on overall performance

2.3. To note the additional resource dedicated to supporting effective service delivery during winter 2014/15, namely:

2.4. To note the range of strategic measures being proposed to maintain and improve performance while operating within financially sustainable levels

3. Performance

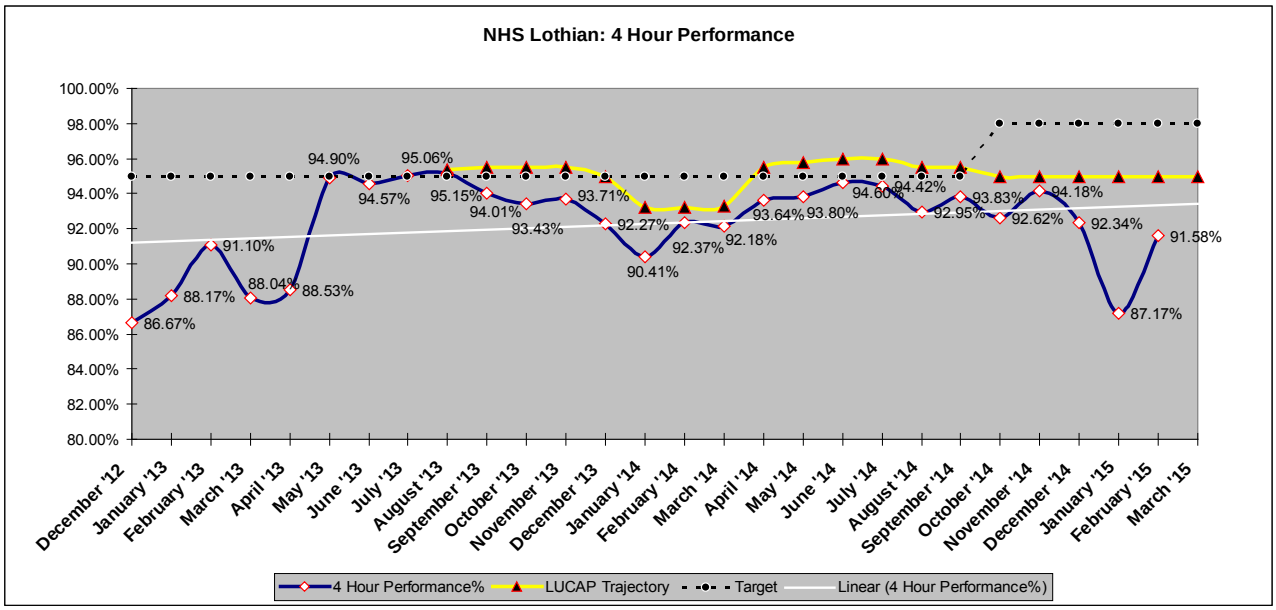
3.1 The 4 Hour Standard

3.1.1 NHS Lothian's unscheduled care performance against the 4 hour standard for the month of February 2015 was **91.58%** (87.17% during January)**.**

3.1.2 The performance across individual sites for February 2015 was as follows (January figures are shown in brackets)***:***

- RIE **91.98%** (84.96%)
- WGH **84.02%** (80.98%)
- StJ **91.13%** (87.98%)
- RHSC **98.24%** (95.59%)

3.1.3 The latest compliance data for NHS Lothian shows that our overall performance at the end of February falls short of the revised agreed LUCAP 2014 trajectory of 95% [The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter - See graph below.]

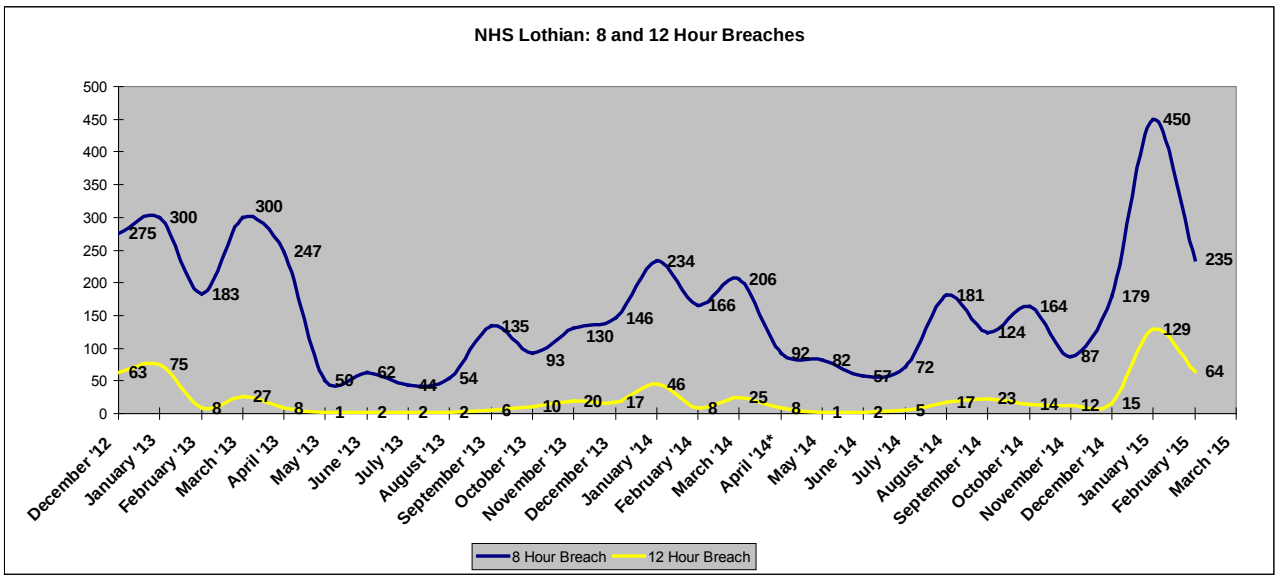


3.2 8 and 12 Hour Breaches

3.2.1 A key measure of patient safety and improved patient experience can be considered against NHS Lothian's unscheduled care performance in terms of the number of 8 and 12 Hour Breaches.

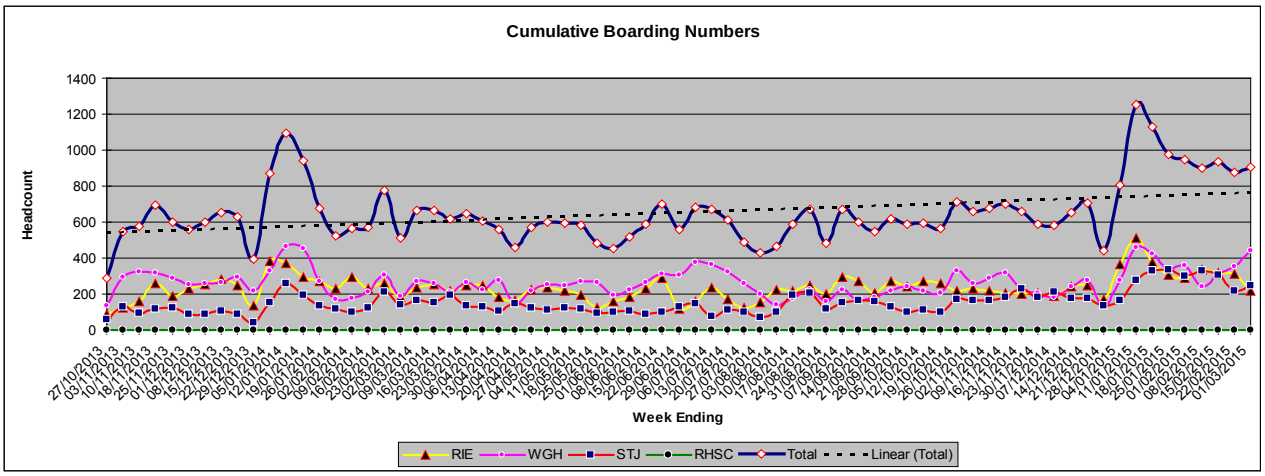
3.2.2 During February, both the number of 8 hour and 12 hour breaches reduced by approximately 50% from the peaks noted during January 2015.

The graph below plots NHS Lothian's performance against both (Dec 12 – Feb 15).



3.3 Boarding of Patients

3.3.1 The following graph shows the number of patients 'boarded out' across the system on a weekly basis since October 2013. From a high of 1,252 at week ending 11 January 2015, the cumulative boarding number has reduced to 905 at week ending 1 March 2015. However the overall trend continues to rise over this period, largely due to the spikes in January 2014 and again in January 2015.



3.3.2 Information on boarding is currently undertaken on a 'snapshot' daily basis by the Site and Capacity Team. The primary function of this data is for daily operational use to support the safe management of flow and ensuring patients are safely under a consultant at all times.

3.4 Delayed Discharge Performance

3.4.1 Using the latest Monthly Census data, the following tables outline the delayed discharge numbers in more detail. The overall number of Delayed Discharges across NHS Lothian reduced from 196 during December 2014 to 160 January 2014.

3.4.2 The number of delayed discharges is at a similar level to that recorded at the same time last year.

Monthly Census at: 15th January 2015

2014/15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Overall Total	136	173	185	177	210	178	195	164	196	160		
Edinburgh	97	133	139	133	147	114	151	108	141	101		
East Lothian	25	19	30	25	30	43	30	37	31	36		
Midlothian	7	13	11	13	18	10	3	8	8	6		
West Lothian	5	4	4	5	9	8	9	9	12	15		
Non-Lothian	2	4	1	1	6	3	2	2	4	2		

2013/14	April 2013	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Overall Total	107	121	109	129	112	133	155	131	155	164	142	156
Edinburgh	62	85	71	91	87	102	130	97	113	119	108	118
East Lothian	30	28	29	30	21	22	15	24	22	19	16	17
Midlothian	12	4	6	7	4	6	5	7	7	12	10	14
West Lothian	2	3	1	1	0	2	2	1	9	12	5	4
Non-Lothian	1	1	2	0	0	1	3	2	4	2	3	3

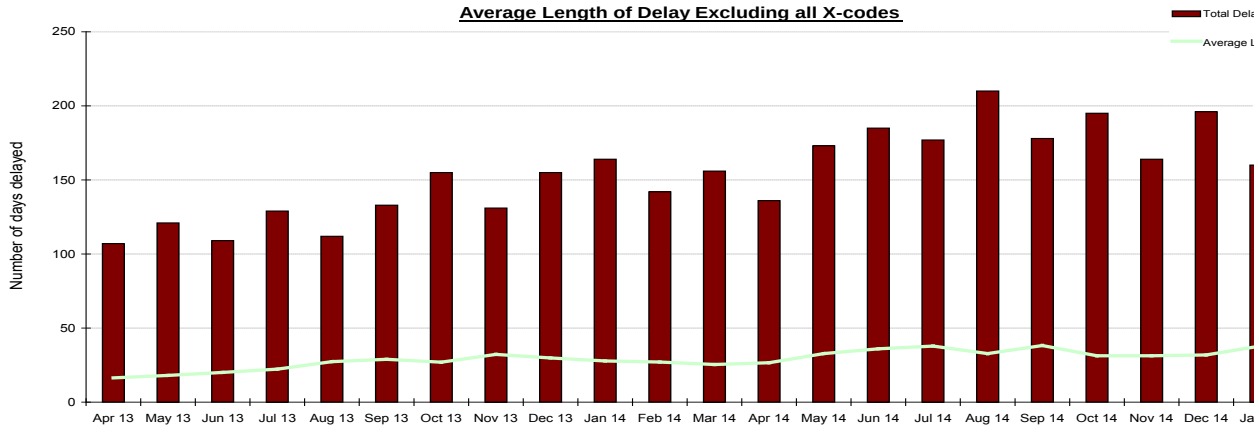
[1] Includes Non-Lothian patients
[2] Total excludes: 9, 24DX, 24EX, 25X, 26X, 42X, 46X, 51X and 100 ISD coded delays

3.4.3 Using the latest Monthly Census data (as at January 2015) the following table details the number and description of the delays by Council Area.

Main Reason	Description	Grand Total
City of Edinburgh	11A - Awaiting commencement of post-hospital social care assessment	3
	11B - Awaiting completion of post hospital social care assessment	14
	24A - Awaiting place in Local Authority Residential Home	7
	24B - Awaiting place in Independent Residential Home	2
	24C - Awaiting place in Nursing Home (not NHS funded)	10
	24D - Awaiting place in Specialist Residential Facility for under 65 age groups	3
	24F - Awaiting place availability in care home (EMI/Dementia bed required)	21
	25D - Awaiting completion of social care arrangements -in order to live in own home	10
	25DOT - Health OT assessed POC under 14hours	17
	25E - Living in own home - awaiting procurement/delivery of equipment	3
	25F - Specialist Housing Provision (including homeless patients)	8
	67 - Disagreement between patient/carer/family and health/social work	3
City of Edinburgh Total		101
East Lothian	-	1
	11A - Awaiting commencement of post-hospital social care assessment	8
	11B - Awaiting completion of post hospital social care assessment	1
	24A - Awaiting place in Local Authority Residential Home	4
	24C - Awaiting place in Nursing Home (not NHS funded)	14
	24F - Awaiting place availability in care home (EMI/Dementia bed required)	1
	25D - Awaiting completion of social care arrangements -in order to live in own home	2
	25DOT - Health OT assessed POC under 14hours	2
	25E - Living in own home - awaiting procurement/delivery of equipment	1
	25F - Specialist Housing Provision (including homeless patients)	1
	67 - Disagreement between patient/carer/family and health/social work	1
East Lothian Total		36
Midlothian	11B - Awaiting completion of post hospital social care assessment	3
	24C - Awaiting place in Nursing Home (not NHS funded)	1
	24E - Awaiting place in Specialty Residential Facility for over 65 age groups	1
	25F - Specialist Housing Provision (including homeless patients)	1
Midlothian Total		6
Non-Lothian	11A - Awaiting commencement of post-hospital social care assessment	1
	24D - Awaiting place in Specialist Residential Facility for under 65 age groups	1
Non-Lothian Total		2
West Lothian	24C - Awaiting place in Nursing Home (not NHS funded)	3
	25D - Awaiting completion of social care arrangements -in order to live in own home	12
West Lothian Total		15
Grand Total		160

3.4.4 The total number of delays along with the average length of delay, by month, is illustrated in the following chart.

Average Length of Delay



	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Total Delays	136	173	185	177	210	178	195	164	196	160		
Average LOS/days	27	33	36	38	33	38	31	31	32	38		

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Total Delays	107	121	109	129	112	133	155	131	155	164	142	156
Average LOS/days	16	18	20	22	27	29	27	32	30	28	27	25

[1]Total includes Non-Lothian

4. Performance Reporting

4.1. On 17 February the Chief Statistician announced that Official Statistics on Accident and Emergency (A&E) activity and waiting times are to be published each week by

the Scottish Government. These statistics are based on the weekly information already provided to the Scottish Government (Winter Planning Team).

4.2. The publication will include aspects of performance such as performance against 4 hours as well as 8 hour and 12 hour breaches. The publication will cover the 32 Emergency Departments in Scotland that provide a 24-hour consultant led emergency medicine service only. (Note: excludes the WGH)

4.3. This new weekly publication has no impact on the current monthly A&E release produced by ISD. Basic validation and quality assurance checks will be carried out prior to publication. The first publication was on Tuesday 3 March covering the week ending Sunday 22 February. Subsequent publications will follow from 9.30am each Tuesday

5. Pan-Lothian Review of Stroke

5.1. A Pan-Lothian review of stroke services is to be undertaken during 2015. This builds on the unscheduled care workshops held during 2014 where a number of outputs were identified, these being:

- an integrated stroke unit on each main acute site,
- thrombolysis only in ED at RIE and SJH,
- the need to redefine the rehab pathway, and
- to shift the balance of care wherever we can towards the community and home.

5.2. In addition, recent analysis has identified the current gaps in terms of capacity and resource across each of the acute sites. This has provided a useful baseline from which to consider how we can deliver what we need to deliver, but within the current resources.

5.3. Outcomes from this work will be reported to the Efficiency and Productivity Group and the Strategic Planning Committee.

6. New Medical and Surgical Models (WGH)

6.1. Work continues to develop the new front-door model at the WGH. While still in its infancy, the new model is already supporting improved emergency admission rates for SAU and MAU. The WGH has also seen its weekday “share” of unscheduled care activity increase from 17.8% in Oct-Dec 2014 to 22.2% in January 2015 (1,459 attendances) and 23.8% in February 2015 (1,812 attendances). However 999 ambulances continue to arrive at the WGH front-door which removes the small number of senior medics from seeing new patients resulting in long waits for first assessment.

6.2. The Day Medicine hotline has been developed in partnership with local GP representatives to enable front-door services to better plan their daily medical workload. This is an essential part of the new model and will push activity to earlier in the day when the hospital is better equipped to respond to demand.

6.3. The Urology GP Hotline was implemented during March allowing primary care access to scheduled appointments similar to the Day Medicine model.

6.4. Work continues with Bed Bureau and the Transport Hub to develop a system that better matches patient need to the range of transport options available through NHS Lothian.

7. Winter

7.1. For the purposes of planning, 'winter' is defined as January, February and March 2015.

7.2. Winter has proved to be a challenging time, in particular our performance against the 4 hour Emergency Access standard. This poor level of performance is also reflected in our level of boarding as well as our Delayed Discharge profile. However, these challenges are not isolated to NHS Lothian as most Boards in Scotland have struggled to meet their performance targets

7.3. As winter ends in March 2015 all additional beds funded by *winter* or other temporary funding (as well as those opened on an unfunded basis) will need to close and remain closed as funding is not available via the 2015/16 financial plan.

7.4. A winter de-brief session has been arranged for 16 April 2015, led by the Directors responsible for Unscheduled and Scheduled Care.

8. LUCAP

8.1. The final quarterly return on NHS Lothian's 2014-15 LUCAP is due to be submitted to the Scottish Government by 20th April 2015.

8.2. During 2014-15, NHS Lothian's LUCAP has sponsored 94 individual actions operating under 5 main strategic banners, namely:

1. Making The Community The Right Place and Developing The Primary Care Response.
2. Flow and the Acute Hospital
3. Assuring Effective And Safe Care 24/7 At The Hospital Front Door.
4. Promoting Senior Decision Making.
5. Cross Cutting Themes

8.3. In turn these actions have bee implemented across a plethora or acute, primary care and social care settings to help manage unscheduled care service delivery and performance

8.4. Following NHS Lothian's Local Unscheduled Care Action Plan (LUCAP), submission to the Scottish Government, a total of £1,120k was provided to NHS Lothian in support of unscheduled care. A further sum of £1,050k (non-recurring) was also received from the Scottish Government to specifically support initiatives in partnership with local councils to tackle our discharge from hospital performance.

8.5. While yet to be confirmed by the Scottish Government, it is anticipated that a similar approach will be required for 2015-16.

9. Key Risks

9.1. The failure to deliver against the 4 hour emergency care access standard, particularly throughout the winter period will compromise patient safety and experience.

9.2. High numbers of patients with delayed discharges will impact on hospital flow, performance and patient safety and experience.

9.3. The need to deal with current demand and capacity issues while also securing the necessary additional capacity (beds/ workforce) for winter 2014-15

9.4. The need to plan the reduction of winter beds as quickly and efficiently as possible that does not impact on overall performance.

9.5. The financial impact of winter, especially if the additional bed capacity, is beyond that recognised in the current financial plan.

10. Risk Register

10.1. Risks are noted within the NHS Lothian corporate risk register for Unscheduled Care.

10.2. Risk Registers are now in place for Unscheduled Care on each acute hospital site and at a corporate level.

11. Resource Implications

11.1. The Scottish Government has released additional investment (£2.17M) to NHS Lothian in support of our on-going commitments within LUCAP and for tackling issues of delayed discharge

11.2. The resource implications for unscheduled care, including winter, are regularly reviewed with Finance colleagues and through Unscheduled Care

11.3. The anticipated costs of supporting services during winter are currently estimated as £3.6 M.

Neil Wilson
Unscheduled Care Manager
17 March 2015.
neil.wilson@nhslothian.scot.nhs.uk

NHS LOTHIAN

1.10

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

EDINBURGH PARTNERSHIP COMMUNITY PLAN 2015-18

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

Acknowledge the extensive wok of partners in developing the Community Plan	3.2 3.7 6.1
Welcome the associated strategic priorities which resonate with NHS Lothian's corporate objectives	3.4 3.5 5.1
Note the submission for approval to the Edinburgh Partnership Board with subsequent approval then being sought from the Scottish Government	3.9

Alex McMahon
Director of Strategic Planning, Performance Reporting & Information
18 March 2015

NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

EDINBURGH PARTNERSHIP COMMUNITY PLAN 2015-18

1. Purpose of the Report

1.1 The purpose of this report is to inform the Board of the new Edinburgh Partnership Community Plan 2015-18 which was submitted to the Edinburgh Partnership Board on 19 March (Appendix 1).

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

2. Recommendations

2.1 Acknowledge the extensive wok of partners in developing the Community Plan

2.2 Welcome the associated strategic priorities which resonate with NHS Lothian's corporate objectives

2.3 Note the submission for approval to the Edinburgh Partnership Board with subsequent approval then being sought from the Scottish Government.

3. Background

3.1 At the Edinburgh Partnership Board meeting on 11 September, the Board approved the project plan for the preparation of a new Community Plan (CP).

3.2 The preparation of the new CP was tasked to the Edinburgh Partnership Lead Officers Group (EPLOG). Subsequently, at its 4 December meeting, the Board noted the steady progress being made and considered an initial draft version of the new Community Plan.

3.3 The Board agreed to a second phase of drafting to last until the 20 February 2015, and thereafter, presentation of the final draft plan to the Board at its 19 March 2015 meeting.

3.4 Edinburgh's Partnership's four community planning strategic outcomes remain as:

- Edinburgh's economy delivers increased investment, jobs and opportunities for all.
- Edinburgh's citizens experience improved health and wellbeing with reduced inequalities in health.
- Edinburgh's children and young people enjoy their childhood and fulfil their potential.
- Edinburgh's communities are safer and have improved physical and social fabric.

3.5 Each strategic outcome has a number of associated strategic priorities. Opportunities have been taken to rationalise the previous existing priorities from 34 to 12. These are:

- Reducing unemployment and tackling low pay
- Shifting the balance of care
- Reducing alcohol and drug misuse
- Reducing health inequalities
- Improving early support
- Improving outcomes for children in need
- Improving positive destinations
- Reducing antisocial behaviour, violence and harm
- Reducing reoffending
- Improving community cohesion, participation and infrastructure
- Increasing availability of affordable housing
- Reducing greenhouse gas emissions

3.6 Each strategic priority is accompanied by a series of partner 'commitments to action' which have been agreed by community planning partners. It is proposed that these commitments will form the Board's main focus of attention and scrutiny, over the period April 2015 to March 2018

.

3.7 The Plan also highlights opportunities to improve the delivery of community planning and achieve continuous improvement, through better partnership working.

3.8 The SOA 'Short Life Working Group' has also made good progress to prepare a refreshed Community Plan Performance Monitoring Framework, which includes:

- a proportionate schedule of regular performance monitoring reports to the Edinburgh Partnership Board
- a schedule of SOA Indicators, with each indicator linked to a relevant strategic priority and strategic community planning outcome
- an established numerical baseline for each Indicator, and
- three year performance targets.

3.9 The draft plan was submitted to the Edinburgh Partnership Board of 19 March., Following approval of the final designed version, the Edinburgh Partnership Community Plan 2015-18 will be submitted to the Scottish Government and National Community Planning Group for review, comment and approval

4. Risk Register

4.1 The new Community Plan proposes establishing an Edinburgh Partnership Board Risk Management Approach. In keeping with good governance practice, the Edinburgh Partnership Board seeks to manage risks which are relevant to the delivery of the Plan and achieving the Board's agreed priorities. By ensuring that the Board has a good understanding of relevant risks, the Board will be better placed to make decisions on how to mitigate any potential negative impacts.

5. Impact on Inequality, Including Health Inequalities

5.1 Redrafting activity over the last few months has focussed on ensuring that the new plan reflects the partnership cross cutting agendas on poverty and inequalities, prevention, reducing alcohol and drug misuse, and sustainability

5.2 The City's emerging commitment to locality planning which will improve co-production, joint resourcing and service delivery, and community and citizen engagement is a theme that runs throughout the plan.

6. Involving People

6.1 As part of at redevelopment process a large stakeholder event was held in October focusing on the emerging key priorities

6.2 An executive summary 'easy read' version will be produced. The dissemination of the plan will form part of a communications and marketing plan to ensure continuing engagement and involvement.

7. Resources

7.1 There are additional resource considerations.

Linda Irvine
Strategic Programme Manager
Mental Health and Wellbeing
18 March 2015

List of Appendices

Appendix 1: Edinburgh Partnership Community Plan 2015-18 available at http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx

NHS LOTHIAN

1.11

Board Meeting
1 April 2015

Chairman

COMMITTEE CHAIRS AND MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the appointment of George Walker to replace Ricky Henderson as Chair of the Edinburgh Shadow Integration Joint Board.

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

2 Recommendations

2.1 To appoint George Walker as Chair of the Edinburgh Shadow Integration Joint Board.

3 Discussion of Key Issues

3.1 Ricky Henderson leaves Lothian NHS Board before 9 April 2015. George Walker has agreed to serve as Chair of the Edinburgh Shadow Integration Joint Board.

4 Key Risk

4.1 If an appointment is not made to the Edinburgh Shadow Integration Joint Board there will be problems in achieving appropriate representation and a quorum.

5 Risk Register

5.1 There are no implications for NHS Lothian's Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 Not required as this is an administrative matter.

7 Involving People

7.1 The members and Committee Chairs involved have been consulted.

8 Resource Implications

8.1 There are no resource implications.

Peter Reith
Secretariat Manager
18 March 2015
peter.reith@nhslothian.scot.nhs.uk

AUDIT & RISK COMMITTEE

The draft minutes of the meeting held on 19 February 2015 are attached.

The Board is referred to the minutes of the meeting, but there were no significant items for escalation / reporting to the Board, although the Board should note that a number of key measures remain outside the risk appetite agreed by the Board. These are detailed in the Board pack

Items for noting by the Board in this report are:

Medicines Management – Internal Audit Report

The Committee was very pleased to receive an extremely comprehensive action plan from Sarah Ballard-Smith, detailing the range of follow up actions arising from the Internal Audit in 2014. The Committee congratulated Sarah and her team.

Corporate Risk Register / High Risks

The RMSG had substantially revised the Corporate risk register and this was welcomed. It was however suggested that the remaining Top Risks (many with scores of 20) should be cross-referred to the Board Approved Risk Appetite, as this will further focus attention on the High Risk, Low Appetite Issues – which should be the focus of the Committee / Boards attention. It is hoped this will then provide focus for deeper dive reviews of those risks, and enable the Committee / Board to agree how to carry or mitigate these risks appropriately

Internal Audit – Co-sourcing

The Committee noted the early positive feedback regarding the new cosourcing arrangements, and also (with some amendments) approved the approach to reviewing the success of the arrangement over the next few months, and how this should be assessed against the other alternatives available, to enable a decision to be made regarding the more permanent solution.

Finally, the Committee welcomed Julie McDowell as the new Chair.

Jeremy Brettell

Committee Chairman: February 2015.

DRAFT

NHS LOTHIAN

AUDIT & RISK COMMITTEE

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Thursday 19 February 2015 in the 5th Floor Telepresence Suite, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

The meeting was preceded and followed by a closed meeting of members only.

Present: Mr J Brettell (in the Chair); Ms J McDowell; Mrs A Meiklejohn and Cllr R Henderson (from 10.30am).

In Attendance: Ms S Ballard-Smith (Nurse Director) (Item 41.2); Ms H Berry (Interim Chief Internal Auditor); Mr A Boyter (Director of Human Resources & Organisational Development) (Item 41.3); Dr D Farquharson (Medical Director); Ms C Grant (Audit Scotland); Mr B Houston (Chairman); Ms B Livingston (Financial Controller); Mr D McConnell (Audit Scotland); Mr C Marriott (Deputy Director of Finance); Mr D Proudfoot (Deputy Chief Internal Auditor) and Mr C Graham(Committee Administrator).

Apologies for absence were received from Mr M Ash; Mrs M Bryce; Mr Davison; Mrs Goldsmith; Cllr D Grant; Cllr C Johnstone and Mr A Payne.

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.

40 Minutes of the Previous Meeting

40.1 Minutes of the previous meeting held on 8 December 2014– The Committee approved the circulated minutes as a correct record.

41 Matters Arising

41.1 Running Action Note - The Committee accepted the Running Action Note. It was noted that all actions listed were either complete or in progress. There were no items to pick up not covered elsewhere on the agenda and any actions that were now complete could be removed.

41.2 Medicines Management: Safe Handling & Security of Medicines within the Clinical Area - Ms Ballard-Smith reported that the short-life medicines management working group had now become a substantive group given the gravity of the ongoing work. There would be regular meetings to ensure progress against the comprehensive action plan established following the 2014 Internal Audit. This included much work around assurance and self assessment. The development of a best practice guide and standard operating procedures was also underway.

41.2.1 It was noted that one change would be the reporting arrangements in relation to the areas for improvement. The original action plan had shown reporting to the Area Drug and Therapeutics Committee; however it was now felt more appropriate that reporting is to the Chief Nurses Committee.

41.2.2 The Chair asked Ms Ballard-Smith if she was happy that everything had been done not to create a 'beast' with its own life. Ms Ballard-Smith stated that whilst she was anxious about the level of work requiring to be sustained, she was confident that as part of the ongoing health and safety audit cycle, the 'beast' would diminish over time. It was also noted that senior pharmacy colleagues were part of the group and that there were meetings with the Director of Pharmacy on a regular basis.

41.2.3 The Chair stated that he was really impressed at the level of focus this now has and that this item would no longer need to be on the Audit and Risk agenda as the outcomes of the work would surface with other Board committees.

Ms Ballard-Smith left the meeting.

41.3 Listening and Learning from Feedback and Complaints

The Chair welcomed Mr Boyter to the meeting.

41.3.1 The Committee received the extensive report from Dr Dorothy Armstrong, who had been commissioned to undertake a review of the feedback and complaints processes following a series of discussions at Board level which had been concerned about the robustness of the current arrangements.

41.3.2 The review had been conducted by Dr Armstrong along with the Director for HR&OD and the Director for Unscheduled Care. The report had now been circulated to the Board as part of the timetable for as many people in the organisation as possible to comment on recommendations.

41.3.3 Four separate consultation days have already started where Dr Armstrong has been presenting. These exercises finish on 27 February 2015. The results plus a report will be pulled together into a paper for the April Board meeting with recommendations and an action plan on how to move forward. A fifth session has been organised with staff currently working within complaints for as they will have their own particular take on the report and views on how best to run the service. It was noted that there is likely to be organisational change on a personal basis as a result of the review. There will also be a paper to the April Board on the functionality and robustness recommendations.

41.3.4 The Chair expressed concern about the CRaFT members reading the report to find that they are not fit for purpose. Mr Boyter stated that many staff in the team are well aware of the issues. The department is continuing to struggle with a significant sick absence rate partly as a result of the pressure people are under. Also the introduction of prison service complaints without additional resource has caused a major impact.

41.3.5 The Chair stated that whilst the report gave a good high level overview, the papers to the Board should include more specifics. Mr Boyter confirmed that the report to the Board would also have a detailed action plan, not just high level direction for signing off.

41.3.6 It was noted that the issues around feedback and complaints have been known for a couple of years and it was general accepted that the system was fundamentally broken and required a proper plan to be in place to address fixing it. The difficulty

was restoring confidence in the system once the action plan was in place and was starting to be delivered. Also who would be delivering the action plan, would this be the people who have already tried to fix the system and if so are there the skills and abilities to make the required changes? It was appreciated that in future this may not necessarily be the same people that are currently working in the service.

41.3.7 Mr Houston added that he thought this was a good report although high level. There were concerns that the focus appeared to be on complaints handling not patient feedback and that there was not nearly enough consideration of how to convert feedback into doing things differently through continuous improvement. Mr Boyter stated that this was a fair view and it was hoped to address the link to continuous improvement within the April Board Papers.

41.3.8 The Chair thanked Mr Boyter for his update. The Committee noted the report and also noted that papers on Feedback and Complaints would be received at the April Board meeting.

Mr Boyter left the meeting.

42 Risk Management

42.1 Review of NHS Lothian Corporate Risk Register - Dr Farquharson gave an update on the review of the Corporate Risk Register. It was noted that the proposed changes had been discussed by the Corporate Management Team in January. Following this and further discussions with the Chief Executive and the Risk Management Steering Group a substantially revised Risk Register had emerged, this included the proposal that some risks be removed from the corporate register and transfer to divisional registers with the leads responsible ensuring these risks are not lost.

42.1.1 The Committee welcomed the revised register; however it was suggested that the remaining Top Risks – e.g. feedback & complaints; violence & aggression (many with scores of 20) should be cross-referred to the Board Approved Risk Appetite, as this will further focus attention on the High Risk, Low Appetite Issues which should be the focus of the Committee/Board's attention. This would then provide focus for deeper dive reviews of those risks and enable the Committee/Board's to agree how to carry or mitigate these risks appropriately.

42.1.2 There was discussion on the removal of workforce sustainability from the Corporate Risk Register top category and the feeling that this may cause discomfort to some as a recurring issue of concern to the Board. Dr Farquharson would take this back to the Risk Management Steering Group for further discussion.

42.1.3 The Committee also discussed the financial risks associated with the integration agenda. It was noted that Mr Marriott was currently working on this area and would feedback as appropriate.

43 Internal Audit Reports

43.1 Internal Audit Progress Report February 2015 - Ms Berry summarised the work carried out since December 2014 and it was noted that delivery of the full plan was still scheduled for delivery by June 2015. Presently there were seven reports complete and five in progress.

43.1.1 Ms Berry outlined the proposal to defer the acute prescribing review by a few months. The Chair asked for assurance that this could be done without undue risk. Ms Berry stated she was comfortable as deferring this internal audit would allow some recent changes made in the area such as the introduction of the JAC Pharmacy Management system time to bed in before the review. The Chair welcomed management engagement in designing the controls.

43.1.2 Ms Berry also notified the Committee of issues with the Workforce Planning Nursing and Midwifery Review. There had been a number of difficulties with the report. The broad scope of the audit included within the Terms of Reference led to internal audit and management having different expectations from the audit and as a result, the draft report did not meet management's expectations. Looking forward, the audit should be re-performed, which would include upfront discussion with management to agree a narrower terms of reference. Ms Berry thought the focus should be on the consistency of use of workforce planning tools across nursing and midwifery, and how they inform longer-term planning, linked to delivery of the Board's strategy. One area included in the original terms of reference that might be excluded would be e-rostering; this area could be a single audit on its own. Ms Berry said her preferred approach would be stop further work on the 2014/15 audit, to refocus the terms of reference and start a new audit in 2015/16.

43.1.3 Mr Marriott added that it had been agreed with external audit to do work around the supplementary staffing in nursing. This would be reported back as part of annual audit cycle, making sure duplication was avoided.

43.1.4 Ms Berry stated that building this into a long term workforce plan would need certain staff skills profile and that she would have discussions with Mr Payne and the Director for Unscheduled Care on this.

43.1.5 The proposed changes to the acute prescribing review and Workforce Planning Nursing and Midwifery Review were agreed.

43.1.6 The Committee discussed the progress against outstanding management actions. Ms Berry reported that 36 actions had been brought forward, a further 17 were added totalling 53 management actions. 17 of these were now complete bringing the number back to 36, with 14 past the due date. The split shown on page eight of the progress report was noted.

43.1.7 The Chair asked about the management action in relation to Bed Management November 2013. He requested an update on the details behind the delay with the management action. If Internal Audit were comfortable that the delay was down to realistic management reasons then this would be good information for the Committee to have, if Internal Audit were not comfortable then the management responsible could come for discussion with the Committee. Ms Berry stated she would confirm the reason for the delay and report back to the next meeting.

43.1.8 There was discussion on the tracker spreadsheet used by Internal Audit to record all outstanding actions. This spreadsheet is emailed out to all lead directors and nominated contacts to provide updates and evidence for information. Once comments are received, Internal Audit can go back to management for further updates.

43.1.9 The Chair stated that there needed to be something pulling all details together so that for anything outstanding the status is known, there is a revised date for management action and an assurance that nothing will be forgotten about. The Chair proposed that if management determine the original date and Internal Audit then subsequently renew this with management, then any dates Internal Audit are uncomfortable with should be notified to the Committee the same applies to any missed revised date, in addition the responsible manager would be expected to attend the Audit and Risk Committee meeting. Ms Berry would update the management actions with revised date and rationale as appropriate.

43.2 Vehicle Fleet Management (January 2015) - Ms Berry reported that the findings of the report were broadly positive. With the exception of the first control objective all objectives had been met and were operating effectively. There were areas for improvement relating to fleet management processes. It was noted that management had agreed all the report's findings and were happy with all actions proposed to be taken.

43.2.1 The Committee agreed to accept the report

43.3 Staff Records Management (January 2015) - Ms Berry reported that in general controls were in place to manage staff records. The areas for improvement were around keeping guidance up to date; maintenance of staff records and the introduction of eESS. Dr Farquharson added that in terms of GMC registration, he now received monthly GMC lists for revalidation. It was noted that a risk remained for the nursing profession. Ms Berry confirmed that she remained confident of receiving management responses in the appropriate timescale.

43.3.1 The Committee discussed the implementation of eESS and whether implementation was on track and going to deliver and what success may look like.

43.3.2 The Committee agreed to accept the report

43.4 Summary of reports where all the control objectives are GREEN: Clinical Governance; NHS Waiting Times – The Committee noted the reports.

43.5 Draft Internal Audit Plan 2015/16 - Ms Berry outlined the areas for focus for 15-16 in the context of the three year plan. It was noted that this had been accepted by the Corporate Management Team. The proposed internal audits were listed in appendix one of the report. The Chair asked Ms Berry to highlight any audits that may have areas of contention:

- *Annual Stock Taking* – It was noted that internal audit had previously attended stock-takes on behalf on external audit. External audit was no longer allowed to direct internal audit to do so and, following consultation with Finance, internal audit did not plan to attend the stock-takes in future years. Internal audit would attend in the current financial year, and will provide management with a written report summarising the results of the observation and any improvement actions.
- *Corporate Governance Review* – The Chair asked whether this review should be scheduled earlier. Ms Berry stated that this was under 2016/17 as at the moment the arrangements were going through a new period of change and that there would need to have been a few meetings so that emerging themes and any room for improvements can be seen. Cllr Henderson stated that there was no need to be overly concerned with this just now as the integration schemes and plans would be fully implemented from April 2016 so a later review would probably be better. Ms Berry added that there was flexibility to bring the plan back before 2016/17 to reconsider the planned reviews.

43.5.1 There was discussion on the Internal Audit Universe at Appendix 4 of the report. The Chair suggested that it would be helpful to cross reference the plan and include information on the date a review was last undertaken and the rating which was received.

43.5.2 Ms Berry informed the Committee that between now and April 2015 work would start on having discussions with Directors and drafting Terms of Reference (ToRs) for the proposed internal audits. Ms Berry asked whether the Committee would wish to have sighted of the detailed ToRs. The Chair stated that visibility of what is in scope and the control objectives being audited should come to the Committee for oversight. It was suggested that it would also be helpful to have the plan cross referenced to the internal audit universe and to the risk registers to bring all the information together in a more helpful way. Ms Berry would look into achieving this.

43.5.3 It was noted that in relation to the timescale for audits, dates were still to be agreed with management. Ms Berry stated her intention would be to have an equal number of reports coming to the Committee each meeting; however there may be some movement with this once the dates are agreed with management.

43.5.4 The Committee considered the Charter included as Appendix 5 of the Plan. The purpose of the Charter was to set out key areas which Internal Audit are supposed to communicate and outline Internal Audit roles and independence, a lot of this was already in NHS Lothian's Standing Financial Instructions. The Chair pointed out that in the Charter engagement with the organisation's management did not come across strongly. Ms Berry stated she would look at improving this.

43.5.5 The Committee also discussed the 11 KPIs outlined on page six of the report. The Chair asked if these were determined by the Internal Audit team or agreed as reasonable through engagement with management. Ms Berry stated that the suggested KPIs were ones used by Scott Moncrieff and that she would be happy to look at any of these again. These had been picked as they are the ones considered typically important and easy to measure. The Chair suggested a rewording in relation to issuing of reports and the need for clearer grading. Ms Berry would take this forward with management.

43.5.6 The Committee agreed to accept the draft internal audit plan for 2015/16. However it was also agreed that Ms Berry would bring the revised Charter, as discussed with management, to the next Committee meeting for sign off.

43.6. Future of Internal Audit Services - Ms Berry gave some background to the paper. The Chair asked Mr Proudfoot to leave the meeting for the duration of the Committee's discussion. Mr Proudfoot stated that he had read through the paper and was fully supportive of its contents and that the Internal Audit team were currently comfortable with the co-sourcing arrangements.

Mr Proudfoot left the meeting.

43.6.1 The Committee discussed the proposals in the paper and noted the early positive feedback regarding the new co-sourcing arrangements. The Committee approved the proposed approach to reviewing the success of the arrangement over the next few months but requested this should be assessed against the other alternatives available, to enable a decision to be made regarding the more permanent solution. There were some amendments which the Committee requested:

- The KPIs on efficiency and effectiveness should have more prominence within the report
- The report should make clear that there would be a decision-point at the end of the assessment period, to decide which option (in-house/outsource / co-source) should be pursued. The assessment should be undertaken by someone independent of the process – perhaps Alan Payne.
- The period of time over which the assessment should take place should be discussed and agreed with Craig Marriott and partnership.

43.6.2 Ms Berry stated that a checkpoint would tie in with the time period. The timescale would be agreed in discussion with Mrs Goldsmith and Mr Marriott.

Mr Proudfoot returned to the meeting.

44 Counter Fraud (Assurance)

44.1 CFS Referrals & Operations February 2015 - Mr Proudfoot introduced the summary of CFS referrals and operations as at February 2015. He advised that 1 referral and 5 operations were currently open.

44.1.1 Mr Proudfoot gave an update on the national fraud initiative which is UK wide and matches data from different public sector bodies, focusing on two main areas - payroll information and trader creditors. The data matching then produces a list of potentially fraudulent areas for the organisation. At the beginning of the calendar

year NHS Lothian received 12,500 data matches suggesting potential fraud, 1100 of these were recommended matches in relation to payroll, UK visa, creditors. In previous years there had been one or two actual cases of error not fraud and previously of 15,500 matches 14% were checked, picking up duplicate payments etc. This is good as it shows the system works. The pleasing thing to note was that overall matches were down by 3,000 and that the 12, 500 matches include previously reported matches back again. These matches would be checked in details over the next few months.

44.1.2 Mr Proudfoot also reported on progress with monitoring and tracking of surgical equipment, which had previously been highlighted to the Committee in relation to opportunity for potential fraud. It was noted that within other Health Boards significant amounts of equipment was being stolen and CFS was actually in the process of taking a case to the Procurator Fiscal. Alerts have been issued to Boards. Mr Proudfoot stated that he had met with colleagues within HSDU and identified that fraud could happen. The HSDU have good processes for controlling equipment once in their control but a less degree of control once it moves to other areas. Work was currently ongoing with Callum Gordon to look at the three options for managing this and the best system to implement.

44.1.3 The Committee accepted the CFS Referrals & Operations report.

45 External Audit (Assurance)

45.1 External Audit Annual Plan 2014/15 - Mr McConnell ran through the Plan covering the period from now until the end of June 2015. He set the Plan in the context of auditing standards and highlighted specific risk areas. It was noted that appendix 1 listed the outputs for the year's salient points and that the 2014-15 audit will produce the audit certificates, the signed accounts and the annual audit report all at the same time. Mr Marriott added that bringing the documents together collectively will be challenging but extremely useful.

45.2 Ms Grant covered the area of Materiality. It was noted that this included more detail than has been available in the past.

45.3 Mr Marriott asked Mr McConnell to outline the process in relation to a Section 22. The Board did not want to be in the position of receiving a Section 22 and it was important for the Committee to understand how these work.

45.4 Mr McConnell explained the Section 22 process, whereby the auditor general can note for Parliament, specific matters from audit on a whole range of things; this generally means that something is amiss.

45.5 A Section 22 report can be prepared with the auditor working with auditor general to accompany the accounts when they go to Parliament. The decision can happen after the accounts are audited by the auditor.

45.6 Ms Grant added that it would normally be know internally if there were any discussions in relation to a Section 22 and this would allow the Board to have early sighting of any issues.

46 Corporate Governance (Assurance / Decision)

46.1 Nugatory Payment: Fine under Health & Safety Legislation - Ms Livingston notified the Committee of the £40,000 Health and Safety fine against the Board which was paid in December 2014 and related to an incident in 2009. As this amount was above the delegated limit of £20,000 this had to go to the Scottish Government for retrospective approval. The court fine was paid right away and a paper is being prepared with the estates department. The Committee noted that as previously mentioned, following the review of the corporate risk register, it was recommended that this entry is now removed.

46.2 Governance Statement Guidance (19 December 2014) - Mr Marriott introduced the paper. It was noted that different elements in relation to the Governance Statement had been issued to committees in template form and to the Executive Directors with a timetable to come back to Internal Audit as part of the review. It was acknowledged that the Chair of the Audit and Risk Committee signs off the Governance Statement and it was therefore important that submissions for the Governance Statement were cross referenced to provide the confidence that appropriate arrangements are in place. Mr Houston added that the Board now had two additional Governance Committees in place – the Acute Hospitals Committee and the Strategic Planning Committee.

46.2.1 Mrs McDowell noted the increased focus on organisational culture as a prerequisite for the effective operation of risk management systems and requested that the Staff Governance Committee be asked to include in its annual statement an assurance about its review of NHS Lothian's performance on initiatives subsequent to the Bowles report on organisational culture.

47. Any Other Competent Business

47.1 Audit and Risk Committee Chair – Mr Houston and the Committee members thanked Mr Brettell for his contributions both towards the Committee as Chair and also the Board in his role as a Non-Executive Board Member. Under Mr Brettell's charge the Committee has improved its scope, work and processes and Mr Brettell's insight and scrutiny have been pivotal to this transformation. The Committee also welcomed Ms McDowell as the new Chair.

48. Date of Next Meeting

48.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 20 April 2015 at 9:00 in Waverley Gate, Edinburgh. Committee members only were asked to attend by 8.45 for the scheduled 15-minute pre-meeting.

HEALTHCARE GOVERNANCE COMMITTEE

1.13

The draft minutes of the meeting held on 27 January 2015 are attached.

1. Key Issues Discussed

1.1 Person Centred Culture

The review of the Customer Relations and Feedback Team was discussed and was felt to be timely in view of the disappointing response rates to complaints. A draft paper would be produced, reviewed by the Director of Human Resources, submitted to the Board and then consulted upon in a series of workshops in February 2015.

The Additional Needs and Diversity Information Task Force update was presented to the Committee by Professor Bhopal. The recommendations in the paper, in particular the need to integrate local authority and health information systems, were supported by the Committee.

The Person Centred Culture report gave assurance to the Committee on an area where assurance had been previously lacking. Update reports and a final paper on the strategy would be submitted to the Healthcare Governance Committee before being submitted to the Board.

1.2 Safe Care

The Vale of Leven Inquiry report and the Healthcare Associated Infection update were considered. It was noted that Lothian continued to struggle to meet *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection HEAT targets. The Lothian antimicrobial prescribing policy had been revised and disseminated in a very short period of time, the main changes being recommendations around gentamicin and vancomycin usage, designed to reduce the use of antibiotics associated with acquisition of *Clostridium difficile*.

It was noted that Lothian had become an outlier in the prescribing of broad spectrum antibiotics, and that significant antimicrobial team input would be required to inform, educate and support a change in practice.

Lothian had made progress against all the recommendations from the Vale of Leven Inquiry, and work was being undertaken to ensure all requirements were met.

The End of Life Care update was considered by the Committee including the new approach replacing the Liverpool Care Pathway, which worked in the context of a deterioration protocol supported by the Palliative Care Guidelines and the Palliative Care Managed Clinical Network.

1.0 Key Issues on the Horizon

2.1 Health and Social Care Integration

It was noted that the Healthcare Governance Committee was mentioned directly in three of the draft integration schemes, and indirectly in the fourth. The implementation of measures to give assurance were most important in terms of this Committee and would need to be clear.

Dr Richard Williams
Vice Chair of the Healthcare Governance Committee
24 February 2015

NHS LOTHIAN

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 am on Tuesday 27 January 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr M. Bryce, Non-Executive Board Member (chair); Ms S. Allan, Non-Executive Board Member; Ms A. Meiklejohn, Chair of the Area Clinical Forum, Non-Executive Board Member; Dr R. Williams, Non-Executive Board Member.

In Attendance: Ms J. Bennett, Clinical Governance Manager; Professor R. Bhopal, Chair of the Additional Needs and Diversity Information Task Force (item 50.3); Ms P. Brooks-Young, Clinical Nurse Specialist in Palliative Care (item 52.2); Ms L. Cowie, Chief Nurse, Edinburgh CHP; Dr D. Farquharson, Medical Director; Mr J. Forrest, West Lothian CHCP Manager; Ms M. Fraser, Complaints Manager; Mr B. Houston, Board Chairman; Ms M. Johnson, Director of Unscheduled Care; Professor A. McCallum, Director of Public Health and Health Policy; Mr P. McLoughlin, Strategic Programme Manager (item 52.2); Professor A. McMahon, Director of Strategic Planning (item 52.3); Ms B. Pillath, Committee Administrator (minutes); Professor A. Timoney, Director of Pharmacy; Mr S. Wilson, Director of Communications.

Apologies: Ms S. Ballard-Smith, Nurse Director; Mr A. Boyter, Head of Human Resources; Dr B. Cook, Associate Medical Director; Mr J. Crombie, Director of Scheduled Care; Mr T. Davison, Chief Executive; Ms P. Eccles, Partnership Representative; Ms W. Fairgrieve, Partnership Representative; Ms C. Garrod, Patient and Public Representative; Ms N. Gormley, Patient and Public Representative; Mr A. Joyce, Employee Director, Non-Executive Board Member; Mr D. Small, Joint Health and Social Care Integration Manager, East Lothian; Mr F. Toner, Non-Executive Board Member.

Chair's Welcome and Introductions

Dr Bryce welcomed members to the meeting and members introduced themselves. Dr Bryce advised that Ms Catherine Garrod and Ms Irene Garden had retired from their roles as Public Representative on the Committee and thanked them for their contribution to the work of the Committee during the last four years.

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.

45. Patient Story

45.1 Ms Johnson read out a letter from the relative or a patient who had had a stroke, commending the professional and compassionate care received by the patient and his family who lived outwith Edinburgh. They were especially comforted by the regular updates on the patient's condition, ensuring that they could be with him when he died.

46. Committee Cumulative Action Note and Minutes from Previous Meeting (25 November 2014)

46.1 The updated cumulative action note had been previously circulated.

46.2 The minutes from the meeting held on 25 November 2014 were approved as a correct record subject to the amendment of a typographical error at item 40.1.3 and the replacement of 'purchased by' with 'provided with' at item 40.3.3.

47. Matters Arising

48. Emerging Issues

48.1 Patient Flow

48.1.1 Ms Johnson highlighted patient safety concerns because of the rising number of 8 and 12 hour delays to admission for patients as well as increased boarding across all sites. She noted that NHS Lothian's performance was similar to elsewhere in Scotland with all areas mostly at capacity. Winter capacity beds were available at the Western General Hospital and St John's Hospital. Work was ongoing with the City of Edinburgh Council to re-open the closed Pentland Hills Nursing Home as Gyle Muir with 120 beds. 30 beds were currently available.

48.2 Mental Welfare Commission Reports

48.2.1 It was agreed that all future Mental Welfare Commission Reports should be submitted to the Healthcare Governance Committee for information.

49. Corporate Risk Register

49.1 The risk register had been previously circulated. Dr Farquharson advised that there had been a full review of the register, and the updated version would be available at the next meeting. This document was considered regularly by the Audit and Risk Committee and changes made to ensure it reflected the current status. This included work on determining which risks would be managed at clinical, executive or board level, to ensure the relevant risks were considered and the most constructive level.

50. Person Centred Culture

50.1 Customer Relations and Feedback Team Report – Quarter 2

50.1.1 A paper had been previously circulated. Mr Wilson acknowledged that the figures shown in the paper were disappointing and response and acknowledgement rate and time had not improved. This was due to a number of factors including problems with accurate date stamping of the large number of prison correspondence, and the level of sick leave currently in the Complaints team necessitating the use of bank staff who did not necessarily have the relevant complaints skills. This situation was awaiting the outcome of the ongoing review and the implementation of an improved process.

50.1.2 Dr Bryce sought assurance that lessons were being learned from the complaints upheld by the Scottish Public Services Ombudsman and that analysis was done on themes and recommendations. Mr Wilson advised that CRAFT ensured that the individual services met the recommendations that were required by the Scottish Public Services Ombudsman, including training in the individual areas, but that there was currently no process for sharing learning on an organisational level. Ms Johnson agreed that locally complaints were taken seriously and resulted in improvements and change locally.

50.1.3 Dr Williams noted in general practice, significant adverse event reviews were undertaken by individual practices for each complaint received, but learning was not shared with general practice or primary care.

50.1.4 Mr Wilson acknowledged that there was a disparate between complaints and learning; the current set up was that CRAFT was an administration team and there was no resource or expertise to offer shared organisational learning. This was being considered as part of the review.

50.2 Customer Relations and Feedback Team Review Update

50.2.1 Mr Wilson advised that the previously circulated paper was an update on the current status of the review. There was now a commitment to review not only the CRAFT Team, but also how the organisation as a whole deals with and learns from complaints.

50.2.2 To carry out a review, Dorothy Anderson, whose background was with the Scottish Public Services Ombudsman, had been employed to speak to the relevant people, look at complaints and contact complainants for feedback, and would write a paper on how the service had responded to complaints and make recommendations for improvement. This paper would be reviewed by Alan Boyter and would then be discussed at a series of workshops in February 2015 before a final paper would be submitted to the Board. The solution would be to provide the best standard of service based on the recommendations, and will include systems for thematic learning and service improvement.

50.2.3 Ms Johnson commended the intention to engage with a wide range of staff as part of this review, but noted that a lot of work would still be required following the review on implementation, training and support for the new process, and that time and commitment would be required before any results would be seen, and any improvement needed to be sustained. Mr Houston added that this was a long standing and major issue, and that there would be a real determination and commitment to making the new process work, but noted that the process had not yet been outlined or agreed at this stage.

50.2.4 Mr Houston suggested that the draft paper be considered by the Board in February 2015 before the workshops had taken place to ensure that the direction was agreed. Ms Johnson and Mr Wilson agreed to find out whether the paper was at a stage for this to be done and if so to submit it as a late paper to the Board.

50.3 Additional Needs and Diversity Information Task Force Update

50.3.1 The Chair welcomed Professor Bhopal to the meeting. Professor Bhopal spoke to the previously circulated paper.

50.3.2 Professor McCallum advised that the work being carried out by the additional needs and diversity task force had been linked to the work on the 'easy read' patient information. The task force committee had been impressed with this work and felt that it should be routine for all patients. Mr Wilson advised that this was the aim and that a paper would be brought to Healthcare Governance Committee in the future on funding and implementation. **SW**

50.3.3 In response to a question from Ms Meiklejohn, Professor Bhopal advised that ensuring information on ethnicity and additional needs of patients had a positive impact on clinical practice was reliant on both gathering sufficient data and on education of clinicians on how to use this information. A paper would be submitted to the Board following analysis on how information for the new indicators could be collected in Lothian. This would be followed by analysis of individual areas and a public meeting. Following this work, further work would be done on how information could be used to improve policy and practice.

50.3.4 Dr Williams noted that the task force had presented a paper to the General Practice Prescribing Committee previously about collecting patient data in primary care and making it available to secondary care services, and project was supported. Professor Bhopal advised that this had not been successful and needed better clinical and managerial involvement and interest.

50.3.5 In response to a question from Ms Allan, Professor Bhopal confirmed that local authority representatives were members of the task force, and that the need for work on how to integrate systems for data collection in local authorities and health as part of integration in the future was necessary.

50.3.6 The recommendations in the paper were supported by the Committee and it was agreed that a further update paper would be received in Spring 2016.

50.4 Person Centred Culture Report

50.4.1 Ms Johnson advised that the previously circulated paper was to share the progress of this work, the type of data that was being collected and its uses so that this could be discussed before the final paper was submitted to the Board. The work being done covered complaints and other forms of patient feedback and would be built on systems already in place in NHS Lothian. These systems were described in detail in the paper.

50.4.2 Reporting on the current pilots was already generating a lot of information, and ways of presenting and using this data were being considered. It was proposed that responses to the 'overall experience' question in the patient survey be included as part of the Quarterly Report to the Board and the Healthcare Governance Committee. This Committee would also receive quarterly reports with more detailed local information. This proposal would be discussed further when the final paper was submitted to the Board.

50.4.3 Dr Bryce commended this excellent, evidence based work and noted that it would give assurance on an area where this had previously been lacking. Ms Johnson advised that building up the process would take time, but that this was the right place to start and was a good vehicle for improving patient care across all sites.

50.4.4 Dr Williams suggested that a question could be added to the patient survey about what they thought of the amount of time they had to wait to be seen, and also a question about the patient's communication with their GP would be useful. Ms Bennett agreed that waiting times were regularly sited in complaints and that this could be added into the feedback requested. Ms Johnson agreed that feedback with GP could be included in surveys given to outpatients or patients with long term conditions.

50.4.5 Ms Johnson noted that with Health and Social Care Integration work needed to be done to integrate person-centred culture work with the Joint Boards as both areas were integrated in the patient's experience of care received, and not separate.

50.4.6 Ms Cowie noted that the Older People in Acute Hospitals (OPAH) Inspections carried out by Healthcare Improvement Scotland included analysis of patient experience, and this information was now being collected in primary care areas in Lothian. This information could link in with the person-centred culture work.

50.4.7 Ms Johnson noted that there were a number of local measures for collecting patient feedback in different departments. The person-centred work would start in the middle and as part of the process would gradually start to include the initiatives already in place.

50.4.8 Professor McCallum noted that she would like to see a clear process for training of staff in collecting information and was keen to implement the process step by step to ensure that the necessary analytical skills and software where available and properly utilised.

51. Safe Care

51.1 Vale of Leven Inquiry Report and Lothian Response and Healthcare Associated Infection Update

51.1.1 The Lothian response to the Vale of Leven Inquiry, and the Healthcare Associated Infection Update had been previously circulated. Ms Johnson took these two items together.

51.1.2 Staphylococcus aureus *and* Clostridium difficile *Infection*:

51.1.3 Ms Johnson advised that NHS Lothian would not meet either of these HEAT targets for the year 2014/15. The CDI priorities action plan had been previously circulated showing what work was being done to make improvements here. Work had also been done on revision of the antimicrobial prescribing policy which had been considered by a range of clinicians in acute services and would be launched on 2 February 2015. The policy took into account calculation of drug doses, tracking side

effects and training of staff. Dr Liz Bream had developed a set of performance metrics to monitor any unintended adverse effects of the change in policy.

51.1.4 Dr Williams noted that NHS Lothian was an outlier for primary care prescribing of broad spectrum antibiotics associated with *Clostridium difficile* Infection, and that without further antimicrobial team resource to support change, this was unlikely to improve.

51.1.5 There had been a cluster of cases of *Clostridium difficile* Infection at the Royal Infirmary of Edinburgh involving 15 cases. The infection control team became aware of the cluster very early on as the surveillance system was very robust. A formal Incident Management Team meeting was convened to manage the situation. Immediate work undertaken focused on improving environmental issues, single use equipment, and standard infection control precautions. The incident had now been closed, and a formal debrief would be held to develop recommendations based on the lessons learned. There was some early evidence that there may have been some cross transmission of infection in this cluster, and this was being investigated.

51.1.6 *Ebola preparedness:*

51.1.7 Ms Johnson advised that a small number of patients had been admitted to be screened for Ebola.

51.1.8 The Infectious Diseases Unit was prepared to receive patients with suspected Ebola, but the design of the unit was such that a room on each side of the patient would need to be closed to remove the risk of transmission. If the patient was symptomatic and positive a number of beds would need to be emptied, the consequence of which would be significant problems for patient flow. This would be while arrangements could be made to transfer the patient to a specialist unit in London.

51.1.9 The Infectious Diseases team had handled suspected Ebola patients well, and the staff were confident with use of the relevant personal protective equipment. There had been positive feedback on the process from Health Protection Scotland. Long term the focus would be on training of all staff in the Infectious Diseases Unit and also in the Emergency Department including an ongoing training cycle. 50% of Infectious Diseases staff were trained so far.

51.1.10 *Vale of Leven Inquiry Report and Lothian Response:*

51.1.12 The previously circulated paper showed NHS Lothian's status against the recommendations from the Vale of Leven Inquiry. Some progress had been made on meeting the requirements on all issues, and work was being done to make the further improvements required. Ms Johnson noted that mechanisms to detect and appropriately escalate cases of infection were very robust, but that more work was required on areas such as environment and cleanliness, staff training and patient care documentation.

51.1.13 *Healthcare Environment Inspectorate visit to the Western General Hospital:*

51.1.14 Ms Johnson advised that the requirements made in the report on the HEI visit in November 2014 were regarding provision of hand gel, hand washing facilities, bed

spacing, dealing with blood spillages, cleaning, and mattresses. Many of these issues had been previously highlighted. The report showed that there were unacceptable levels of cleanliness in some areas, but Ms Johnson emphasised that this was not the case in all areas.

51.1.15 An improvement plan was in place which included increasing the levels of cleaning and training on roles and responsibilities. The recommendations from the report were being shared across all areas to ensure the same standard was in place. Health Protection Scotland had been approached to ask for any further suggestions for improvement.

51.1.16 Ms Johnson noted that Lothian's own internal inspection regime did identify or escalate the problems with cleanliness; the inspection process was under review to ensure that all areas were covered and that the responsibility for regular inspection lay with the charge nurse of the ward. There was also are requirement for escalated problems with estates and buildings to be responded to more quickly.

51.1.17 Mr Houston asked if it would be possible to get an idea of where Lothian was against the ideal in terms of cleanliness, and what work would be needed to meet this target. Ms Johnson agreed that this would be useful but would be a significant piece of work carried out ward by ward, she agreed to consider this and discuss further at the Board.

51.2 Common Themes from Quality and Safety Reviews

51.2.1 Dr Farquharson noted that the previously circulated paper used four recent reports to analyse common themes. The intention was to use these themes as a checklist of things to consider when improving services. Dr Bryce suggested the checklist could also be used to help focus challenging of proposals and Board and Committee papers and it was suggested that it could be useful when reviewing the Healthcare Governance assurance needs and that the Board could do a piece of work on how these themes could be used efficiently by the Board.

51.2.2 Ms Bennett noted that represented clearly in the four reports and on the checklist was the need to hear and understand the patient and staff voice and experience. Professor McCallum noted that there was also a focus on learning, improvement, and embedding of new processes and noted that these areas are integral.

51.3 Public Protection Update

51.3.1 A paper had been previously circulated. Ms Johnson noted a recent increase in activity in the public protection team. She also noted that this area had been removed from the risk register, as the internal position was considered to be strong.

51.4 Significant Adverse Event Report

51.4.1 A paper had been previously circulated. Ms Bennett noted that work was being done on what resources would be required to step up the approach of better management of adverse events across NHS Lothian, and what further skills and resources would be required to support staff to feel confident in having difficult conversations and giving bad news. There was awareness that staff were second

victims in adverse events. A pilot of 'huddles' to learn from events in maternity services had had very good results. These were some of a number of steps to full implementation of the culture of learning from adverse events rather than reacting punitively.

51.4.2 Dr Farquharson drew attention to the recent consultation on the proposed Statutory Duty of Candour and noted that this was against the open and understanding culture that contributed to learning from adverse events. NHS Lothian had responded to the consultation highlighting that this proposal could be against many of the improvements in culture that the organisation was aiming to make. It was important to be open and to consider roles all the time, not only following an event.

51.4.3 Dr Bryce commended this work as progressive and evidence based. Dr Williams suggested that any sharing of learning in primary care would also be helpful.

52. Effective Care

52.1 Quality Report

52.1.1 A paper had been previously circulated. Dr Farquharson noted that many of the areas included in this report had been covered as part of the agenda for this meeting.

52.1.2 Ms Bennett noted that one of the themes of the report was electronic prescribing; Dr Williams noted that the Area Drug and Therapeutics Committee had raised a concern that the development of electronic prescribing was not in the eHealth Strategy. Dr Bryce agreed to write to eHealh to raise this concern, and Professors McMahon and Timoney agreed to discuss this issue outwith the meeting.

MB / AMcM / AT

52.2 End of Life Care Update

52.2.1 Dr Bryce welcomed Mr McLoughlin and Ms Brooks-Young to the meeting and they spoke to the previously circulated paper. Mr McLoughlin noted that this paper was written in the context of withdrawal of support from the Scottish Government of the Liverpool Care Pathway, and the issue of new guidance providing a framework for local action. The new approach which would not rely on a single pathway and which worked in the context of the deterioration protocol was supported by the Palliative Care Managed Clinical Network.

52.2.2 Dr Bryce noted that part of the plan was to have dedicated communications support to ensure that the public could understand the processes in the context of the negative coverage of the Liverpool Care Pathway in the media. Mr McLoughlin agreed that the principles in the national statement needed to be reinforced. Mr Wilson noted that the positive impact would be felt when patients and families felt the benefits first hand and fed back. Ms Brooks-Young noted that a consultation was being done with patients and carers to obtain real time feedback and ensure that the process was right for them.

52.2.3 Dr Williams felt that this was a more acceptable approach which used appropriate terminology. He asked that the paper could be presented to the GP Sub-

Committee. Mr McLoughlin noted that discussions with the Local Medical Committee had been supportive.

52.2.4 The Committee supported the recommendations made in the paper.

52.3 Draft Health and Social Care Integration Schemes – Clinical and Care Governance

52.3.1 Professor McMahon spoke to the previously circulated paper which included the four draft schemes that had been signed off as draft by NHS Lothian and by the local authorities and which was currently out for consultation. The final drafts would be submitted to the Board in March 2015.

52.3.2 The cover paper highlighted key areas of importance for the Healthcare Governance Committee. It was noted that there was a section on clinical governance in each of the schemes and that the Healthcare Governance Committee was mentioned directly in three of them and indirectly in the fourth. The role of the Committee would continue and the Medical and Nurse Directors would continue their responsibilities for medical, nursing and AHP.

52.3.3 Ms Allan noted that the links between NHS Lothian and the integrated joint boards on an operational level would only become clear when these were in place and working. Mr Forrest noted that the implementation of measures to give assurance were most important in terms of this Committee. Professor McMahon noted that the Community Health (Care) Partnerships would be disestablished as a result of this legislation.

53. Exception Reporting Only

Members noted the following items for information:

53.1 Bowel Screening Annual Report;
53.2 Healthcare Improvement Scotland Report on Learning from Significant Adverse Events;
53.3 Tissue Viability Annual Report;
53.4 Tissue Governance Unit Report;
53.5 Independent Healthcare Evaluation Report.

54. Other Minutes: Exception Reporting

54.1 Area Drug and Therapeutics Committee, 5 December 2014

54.1.1 Dr Williams noted that he had highlighted in the summary of the minutes for this meeting that the business case for further resources for the Antimicrobial Team had been supported by the ADTC and by the Medical Director, Director of Nursing and Director of Public Health, but had been turned down due to financial constraints. As this was a key area for patient safety and reducing the risk of *Clostridium difficile*, this outcome was disappointing. Ms Johnson agreed to ask for the case to be reconsidered. **MJ**

54.2 Members noted the minutes from the following meetings for information:

54.2.1 Clinical Management Group, 14 November 2014;
54.2.2 Lothian Infection Control Advisory Committee, 9 December 2014;
54.2.3 Health and Safety Committee, 21 October 2014;
54.2.4 Public Protection Action Group, 19 December 2014;
54.2.5 Divisional Dental Committee, 18 December 2014;
54.2.6 Organ Donation Sub-Group, 18 December 2014;
54.2.7 Acute Hospitals Committee, 15 July 2015.

55. Any Other Competent Business

55.1 Older People in Acute Hospitals Inspections

55.1.1 Ms Johnson noted that a Healthcare Improvement Scotland Older People in Acute Hospitals (OPAH) Inspection would take place as an announced visit on 14 April 2015 followed by an unannounced visit the subsequent 4-6 weeks. There would be an update paper on preparedness for this at the next meeting. **MJ**

55.2 Acute Prescribing

55.2.1 Professor Timoney advised that a paper on strengthening acute prescribing processes would be submitted to the next meeting. **AT**

56. Date of Next Meeting

56.1 The next meeting of the Healthcare Governance Committee would take place at **9.00 am** on **Tuesday 24 March 2015** in **Meeting Room 7, Second Floor, Waverley Gate**.

56.2 Further meetings in 2015 would take place on the following dates:
- 26 May 2015;
- 28 July 2015;
- 22 September 2015;
- 24 November 2015.

FINANCE & RESOURCES COMMITTEE

The draft minutes of the meeting held on 21 January are attached.

Key issues discussed included:

- The Committee considered the financial position and received a progress report on the financial plan, and how financial balance might be delivered for 2015/16.

- The Committee considered the capital programme and approved the outline Capital programme for 2015/16 – 2019/20. In particular the Committee endorsed the development of a programme which aligned and supported the Board's Strategic Plan.

- The Committee approved the proposal to declare RHSC and associated NHS properties surplus immediately upon achieving financial close for the project.

- The Committee received assurance on the Payments Verification process for Independent Practitioners.

Key issues on the horizon:

- Continued oversight of the delivery of a very challenging financial plan.

- Conclusion of the master planning for the WGH and significant business cases for East Lothian Community Hospital, the Eye Pavilion, Capacity and St John's Hospital.

- Oversight of the due diligence process for IJBs.

Susan Goldsmith
Executive Lead

DRAFT

NHS LOTHIAN

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9:00am on Wednesday 21 January 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Mr J Brettell; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson (from Minute 59); Mr B Houston (from Minute 64) and Mr P Johnston.

In Attendance: Mr I Graham (Director of Capital Planning & Projects); Ms M Gray (Project Manager, Reprovision of Leith Walk Surgery) (for item 57); Professor A K McCallum (Director of Public Health & Health Policy); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager) and Mr D White (for item 57)

Apologies for absence were received from Mrs Kay Blair; Professor J Iredale and Ms M Johnson.

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.

54. Minutes of the Previous Meeting

54.1 The Minutes of the previous meeting held on 12 November 2014 were approved as a correct record.

55. Running Action Note

55.1 The Committee received a previously circulated running action note detailing outstanding matters arising, together with the action taken and the outcomes.

55.2 Mrs Goldsmith advised the Committee that the anticipated paper on the Provision of an Endoscopy Decontamination Facility for the Western General Hospital and the paper on the Lessons Learned from the St John's Hospital Business Case would be brought to the March meeting. **AKM/SG**

56. Matters Arising

56.1 Royal Hospital for Sick Children / Department of Clinical Neurosciences Programme to Financial Close – Mrs Goldsmith introduced a previously circulated report giving an update on progress towards financial close for the Royal Hospital for Sick Children and Department of Clinical Neurosciences development at Little France.

56.1.2 The Committee noted that following a meeting with the Board Chairman and the preferred Bidder, IHFL, there was only one outstanding issue around the final agreement between the Contractors which was still under discussion in respect of an inflation claim under the terms under the preferred Bidder appointment by the design and build contractor. If this could be resolved it was anticipated that financial close could be achieved within the following two weeks. Any agreed payment would be a one-off capital cost leading to a slight increase in revenue payments.

56.1.3 Mr Brettell sought confirmation on the delegation to approve the final terms of the non-profit distribution project agreement and associated documentation and Mrs Goldsmith confirmed that the circulated paper contained all the requisite details.

56.1.4 After discussion the Finance & Resources Committee agreed to adopt the entire wording laid out in Appendix 1 to this minute, in advance of financial close, which was required as a formal minute of the Committee with authority to complete the financial close of the project delegated to the Chief Executive or the Director of Finance.

57. Reprovision of Leith Walk Surgery

57.1 Mr White introduced a previously circulated report inviting the committee to approve the initial agreement for the reprovision of Leith Walk Surgery.

57.1.1 Mr White explained that the Leith Walk Surgery currently operated from two converted Georgian houses located at 60 and 26 Leith Walk, rented from the landlord who was the former senior partner of the practice and sole owner of both premises. The landlord had retired from the practice in late 2013, and the remaining partners had not yet been able to secure a tenancy agreement with him. This uncertainty continued with no obvious sign of resolution regarding tenure.

57.1.2 Mr White explained that the background of uncertainty, together with the constraints of the existing premise which were increasingly unfit for purpose, had led to the practice pursuing opportunities for replacement premises. The circulated initial agreement detailed the strategic context and the case for change.

57.1.3 The Committee noted that the practice provided services to a practice population of 7,800 at October 2014, an increase of 13% in the last 3 years. 6

of the 15 practices in North East Edinburgh, including Leith Walk Surgery, were declaring restricted lists.

57.1.4 It was noted that the City of Edinburgh Council local development plan identified an additional 20,000 people from planned developments by 2024 in the North East area and a considerable number of these were within the catchment area for Leith Walk Surgery.

57.1.5 Mr White advised that nearby commercial premises had been identified which would be suitable for fit out, was in proximity to the current location and ideally situated for the practice population. The premises offered a significant improvement on the current premises and would enable reprovision of the practice with increased capacity for a further 2,000 patients.

57.1.6 Mr White explained that the City of Edinburgh Council was currently exploring an option to develop the former tram depot site on Leith Walk, adjacent to NHS Lothian premises of Inchkeith / Allander House which would offer the potential to co-locate several GP practices as well as other NHS Lothian services together with the local authority and other public sector services. Whilst this would be a long term option, the timing, phasing and delivery remained uncertain whereas the identified commercial premises would offer a solution in 2015. This did not preclude it from remaining an attractive option for other local practices.

57.1.7 Mrs Goldsmith advised that there was capital available for the fit out costs and Mr White advised that there would be some revenue savings arising from the proposal. In addition, the general practitioners had repeatedly advised that they were willing to grow the practice.

57.1.8 The Committee agreed that a more explicit commitment should be obtained from the practice to expand in the new premises although subject always to being able to recruit additional partners.

57.1.9 The Chair commented that it would be useful to see this sort of information reflected in the business case when it was submitted to the committee.

57.1.10 The Committee agreed to note the proposal to re-provide Leith Walk Surgery in fit for purpose accommodation; to note that the proposal was supported by Edinburgh Community Health Partnership Primary Care Management Group and NHS Lothian Capital Investment Group and to approve the initial agreement for the re-provision of Leith Walk Surgery.

58. Financial Position to 30 November 2014

58.1 Mr Marriott introduced a previously circulated report giving an overview of the financial position to 30 November 2014.

58.1.1 Mr Marriott advised the Committee that an in month overspend of £147k was reported in November against the revenue resource limit and the Local

Reinvestment Plan (LRP) was reporting an in-month shortfall in delivery of £1.646m in November.

58.1.2 The Committee noted that the operational position and the forecast outturn estimate had required a further review of all corporately held reserves and available flexibility which had resulted in a further £9.348m being identified to support the position, of which £1.558m had been released in November, reflecting a pro-rata share for the second half of the year.

58.1.3 Mr Marriott advised the Committee that most issues were continuing on trend and with improvements in the winter position, restrictions on administrative and clerical vacancies and additional funding made available by Scottish Government, together with savings made, should enable NHS Lothian to meet its statutory requirement of breakeven for the financial year.

58.1.4 Mr Marriott reassured the Committee that although posts in the corporate areas had been frozen, any unfilled posts which might cause operational difficulties were reviewed and Executive Directors had authority to fill such posts where necessary.

58.1.5 The Committee noted that where there was a need to fill posts, greater use was being made of staff on the Redeployment Register and maximising the use of staff in protection.

58.1.6 Mr Johnston sought an update on discussions with the Trades Unions and the Committee noted that discussions were ongoing with a view to using unregistered staff under supervision to fill some vacancies.

58.1.7 The Committee agreed to note the overview of the financial position to 30 November 2014 as laid out in the circulated paper.

59. Financial Plan 2015/16

59.1 Mrs Goldsmith introduced a previously circulated report detailing a potential recurring gap in the 2015/16 financial plan and advised that in spite of a saving delivery of around £25m in each of the previous two years, a balanced financial plan could not be presented at this stage.

59.1.1 Mrs Goldsmith advised the Committee that work was underway on a number of measures to address the position and progress was being made with more detail becoming available on Local Reinvestment Plan (LRP) proposals.

59.1.2 Mrs Goldsmith advised that non recurring LRP schemes were not being supported and it was intended to make the system more robust to ensure the achievability of schemes.

59.1.3 It was agreed that more explicit proposals would be brought to the March meeting of the Committee and a discussion of the financial plan for 2015/16 would be a main item. **SG**

59.1.4 The Committee noted that additional funding for the NHS in Scotland had been announced by the Scottish Government and Mr Johnston reported that the Integration Fund would now be on a recurring basis for 2016/17 and 2017/18. It was noted that the Scottish Government was also providing additional allocations for Primary Care and Telecare bringing its total additional investment in the NHS in Scotland to £500m over 3 years.

59.1.5 Whilst welcoming the additional funding, Councillor Henderson commented that this was not sufficient especially for Edinburgh where the Council budget was decreasing.

59.1.6 The Committee agreed to note the total recurrent gap of £67.53m within the financial plan at this stage and the key elements projected additional spend recognised within the plan. The Committee also noted the movements driving the change to the gap from the previous iteration and agreed to review progress against the LRP target for the new financial year, and consider the current assumptions for anticipated savings delivery.

59.1.7 It was agree to note the other sources of funds and mitigating actions being proposed in support of progressing to a balanced plan and to consider the financial plan in its current iteration in advance of a final report on a 5 year plan to be prepared to for the next Committee meeting on 2 March before final Board sign off on 1 April 2015.

60. Property and Asset Management Investment Programme 2015/16 – 2019/20

60.1 Mrs Goldsmith introduced a previously circulated report giving an overview of the draft 5 year Property and Asset Management Investment Programme.

61.1.1 The Committee noted that the capital programme was being managed to budget and currently the forecast for 2014/15 showed a projected underspend of £1.2m relating to slippage on the Royal Hospital for Sick Children and Department of Clinical Neurosciences Project. Discussions were ongoing with the Scottish Government Health & Social Care Directorates to determine whether this could be reinvested in the NHS Lothian programme or had to be returned centrally to underpin the national position.

61.1.2 It was noted that to aid the development of a programme which aligned with and supported the Board's Strategic Plan strategy, Masterplans had been commissioned for all major sites. Each of these Masterplans was at a different stage of development and the draft 5 year programme captured the strategic priority projects arising from the Strategic Plan.

61.1.3 The Chair commented that the capital planning process now felt better constructed and was coming together well. He suggested that it would be useful to see more investment in Invest to Save Programmes.

61.1.4 Professor McCallum reminded the committee of the importance of revenue being brought in from research and development work being carried out at new facilities.

61.1.5 Mr Graham commented that there had been requests for a Primary Care Masterplan and the Committee agreed to support such a development. **SG**

61.1.6 The Committee agreed to note the current position with the 2014/15 Property and Asset Management Investment Programme; to agree the draft Property and Asset Management Investment Programme for 2045/16 – 2019/20 and to note that the plan would be submitted as part of the draft 5 year Local Delivery Plan with a balanced position. The timing of capital projects not yet fully approved would require to be managed to ensure delivery of this in 2015/16 and beyond.

62. Disposal of Royal Hospital for Sick Children and Associated Properties

62.1 Mr Graham introduced a previously circulated report seeking Committee approval to declare the Royal Hospital for Sick Children at Sciences, Edinburgh; 10 Chalmers Crescent; Teviot House and 25 Hatton Place surplus to Lothian Health Board's requirements.

62.1.1 Mr Graham advised that the title of the property at the Royal Hospital for Sick Children was complex and it would be some time before the property could be marketed. He advised that valuation work still required to be undertaken on the properties.

62.1.2 Mr Brettell sought assurances that NHS Lothian was not going to require these properties in the future and Mrs Goldsmith confirmed that these were properties that would not be required and were appropriate for disposal.

62.1.3 The Committee noted that the paper would also go to the Edinburgh and Lothian's Health Foundation Finance Committee as some properties were in the ownership of the Foundation.

62.1.4 The Committee agreed to approve that the Royal Hospital for Sick Children, 10 Chalmers Crescent; Teviot House and 25 Hatton Place be declared surplus to Lothian Health Board's current requirements immediately upon achieving financial close on the reprovision project for the Royal Hospital for Sick Children and Department of Clinical Neurosciences.

62.1.5 It was agreed that thereafter the properties should be trawled around other government bodies and, if no interest was noted, marketed for sale taking cognisance of the current market climate and the Scottish Government's property transaction guidance. It was noted that property and specialist advisors would be engaged in line with national guidance to maximise the Board's return from these disposals.

63. Provision of a Central Endoscopy Decontamination Facility for the Royal Infirmary of Edinburgh

63.1 Professor McCallum introduced a previously circulated report together with the business case for the development of a central endoscopy decontamination facility on the Royal Infirmary of Edinburgh site. She explained that the development would provide a decontamination facility which complied fully with the Medical Device Directive and would meet the increasing demands on endoscopy services.

63.1.1 Mr Brettell queried a previous decision by the Committee in 2012 to approve a business case for endoscopy decontamination facility for the Western General Hospital and the Royal Infirmary of Edinburgh.

63.1.2 Professor McCallum explained that both projects had been agreed but work at the Western General Hospital had been stopped in order to prioritise the work at the Royal Infirmary of Edinburgh.

63.1.3 The Chair commented that the Committee should be kept fully informed when business cases it had approved were delayed or not proceeded with. Mr Graham apologised that whilst the delay had been included in the business case tracker, it had not been expressly flagged up to the Committee.

63.1.4 Dr Farquharson asked if this facility would reduce reliance in external providers and Professor McCallum confirmed that it would, but that this had not been factored into the business case.

63.1.5 The Committee approved the business case for provision of centralised endoscopy decontamination facilities for the Royal Infirmary of Edinburgh to ensure compliance with current health service guidelines in order to deliver a robust and reliable service to patients requiring a diagnostic procedure and to achieve joint advisory group accreditation.

63.1.6 The Committee noted that an equivalent new central decontamination unit for endoscopes at the Western General Hospital was also planned to address the same critical issues, the standard business case for which would be considered at the March meeting. It was noted that it was anticipated that this project would have a larger capital outlay and bigger revenue impact than the Royal Infirmary of Edinburgh project. **AKM**

64. Royal Edinburgh Hospital Phase 1 Addendum Full Business Case

64.1 Mrs Goldsmith introduced a previously circulated report together with the full business case addendum for the Royal Edinburgh Hospital Phase 1. This addendum outlined the changes since the full business case was presented to the Committee in August 2014 and the Scottish Government Health and Social Care Directorates in October 2014, in particular detailing the reduction in the unitary charge.

64.1.1 The Committee noted that the Scottish Government had provided assurance that the agreed level of revenue support would be provided regardless of the outcome.

64.1.2 The Committee agreed to note that financial close was achieved subject to the proposed changes to the shareholding agreement being ratified by all parties and agreed the submission of the final business case addendum to Lothian NHS Board for approval and onward submission to the Scottish Government Health and Social Care Directorates. **SG**

65. Payment Verification in Primary Care Financial Year 2013/14

65.1 Mrs Goldsmith introduced a previously circulated report providing the Committee with assurance that a system of post payment verification had been undertaken by the Practitioner's Services Division in line with the partnership agreement, payment verification protocols in circular CEL15 (2013) and that payment verification managers confirmed that payments made to family health services practitioners (general medical practitioners, general dental practitioners, community pharmacists and optometrists) were in line with relevant regulations.

65.1.1 The Committee noted that a review of this process and of the detailed payment verification reports provided by payment verification managers from the Practitioners Services Division had been undertaken within the Primary Care Contractual Organisation including finance on behalf of NHS Lothian by way of a meeting with the relevant payment verification manager. Payment verification managers had not highlighted any significant risk for NHS Lothian in terms of these payments.

65.1.2 The Committee agreed to accept the report confirming that the payments made to family health services practitioners were appropriate as follows:

General Medical Practitioners - made in the quarter ending 31 March 2014
General Dental Practitioners - made in the quarter ending 31 March 2014
Community Pharmacists - made in the quarter ending 30 September 2013 & 31 December 2013
Optometrists – made in the quarter ending 31 March 2014.

65.1.3 The Committee agreed to note the actual recoveries made in the fourth quarter of 2013/14 by Practitioner Services Division as detailed in the Partnership Agreement Key Performance Indicator Report circulated with the paper.

65.1.4 It was noted that the Practitioner Services Division and Primary Care Contractor Organisation were addressing any issues that arose with particular contractors as agreed at the quarterly meetings and noted that a similar report would be taken to the Primary Care Joint Management Group and Community Health and Care (Partnerships) where requested to inform their Subcommittees.

66. Quality and Outcomes Framework 2013/14 - Minutes of Quality and Outcomes Framework Payment Verification Group 21 May 2014

66.1 The Committee noted the previously circulated minutes of the Quality and Outcomes Framework Payment Verification Group meeting on 21 May 2014. In particular the high level of achievement by Lothian GP practices in what was a voluntary scheme was noted.

66.1.1 The Committee also noted that the detailed pre-payment review undertaken at the May meeting had been on the practices using the national quality and outcomes framework calculator payment system, prior to adjustment for these special circumstances practices.

66.1.2 Following this adjustment, and the inclusion of the practices not using the Quality and Outcomes Framework calculator software, the anticipated achievement payment was £18.8m. A few practices had outstanding adjustments when the data for the Information Services Division was finalised so the Lothian average achievement rate as reported by the Information Services Division was 97.75% for 124 practices. The total 2013/14 achievement payment made for these practices was £18.6m.

67. Property and Asset Programme 2014/15 Business Case Monitor

67.1 Mr Graham introduced a previously circulated report providing a detailed overview of the major capital projects.

67.1.1 Mr Davison advised the Committee that Scottish Enterprise and the University of Edinburgh was seeking to re-brand the Bioquarter to include the Royal Infirmary of Edinburgh Campus. There was some concern that this could cause confusion but there was also a need to include development space in the Bioquarter in the Royal Infirmary of Edinburgh Masterplan. The Committee noted that a paper would be brought to the next meeting of Lothian NHS Board. **SG**

67.1.2 The Committee agreed that there should be a discussion at the next meeting on the opportunities for expanding the Little France Campus. **SG**

68. Date of Next Meeting

68.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 11 March 2015 at 9:00 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.

69. The Chair advised members that this had been Mr Brettell's last meeting of the committee and he expressed his thanks to Mr Brettell for his work as a member of the Committee.

APPENDIX 1

LOTHIAN HEALTH BOARD

RHSC & DCN PROJECT

Certified true copy extract from the minutes of the meeting of the Finance & Resources Committee of Lothian Health Board held on 21st January 2015 at Waverley Gate, Edinburgh

1. **Present**

Mr G Walker (Chair)
Mr J Brettell
Mr T Davison
Dr D Farquharson
Mrs S Goldsmith
Mr P Johnson

2. **Apologies**

Mrs K Blair
Cllr. R Henderson (for lateness)
Mr B Houston (for lateness)

3. **Quorum**

Pursuant to Appendix 2 (Terms of Reference) of the NHS Lothian Standing Orders for the proceedings and business of Lothian Health Board dated 2nd April 2014, the Chairman noted that a quorum was present. Accordingly the Chairman declared the meeting duly convened.

4. **Declaration of Interests**

No declaration(s) of interests were raised in relation to any of the matters to be discussed.

5. Minutes of Lothian Health Board dated 6th August 2014

It was noted at the Finance & Resources Committee Meeting that:

5.1 At the open session of Lothian Health Board (the "**Board**") meeting on 6th August 2014, the Board had formally agreed as follows:

5.1.1 Agreed to approve the submission of the full business case to the Scottish Government Health & Social Care Directorate Capital Investment Group;

5.1.2 Agreed that, subject to the approval of the full business case by the Scottish

Government, the approval of the final terms of the NPD Project Agreement and associated contract documentation be delegated to the Finance & Resources Committee; and

5.1.3 Agreed that, subject to the approval of the final terms of the NPD Project Agreement by the Finance & Resources Committee, the signing of the NPD Project Agreement and associated contract documentation in respect of the Project at financial close be delegated to the Chief Executive or the Director of Finance for NHS Lothian

6. Resolutions of the Finance & Resources Committee

6.1 The delegated authority from the Board for the Finance & Resources Committee to approve the final terms of the NPD Project Agreement and associated documentation and for the Chief Executive or Director of Finance of the Board to sign the NPD Project Agreement and associated documentation within the parameters set out in the full business case, were considered by the Finance & Resources Committee.

6.2 After discussion, the Finance & Resources Committee **FORMALLY RESOLVED AS FOLLOWS**, in connection with the Government's NPD initiative for the design, build, finance and maintenance of a project to re-provide services from the Royal Hospital for Sick Children, Children and Adolescent Mental Health Service and Department of Clinical Neuroscience in a single building adjoining the Royal Infirmary of Edinburgh at Little France ("the **Project**"):

6.2.1 In accordance with the minute of the Board dated 6th August 2014, the Finance & Resources Committee delegated its authority to approve the final terms of the NPD Project Agreement and associated documentation to the Chief Executive or Director of Finance of the Board and authorised the Chief Executive or Director of Finance of the Board to continue to negotiate and agree the terms of the Documents (as defined below) in connection with the Project subject to:

(a) the approval of the final business case for the Project by the Scottish Government; and

(b) the first full year Annual Service Payment at financial year 2014 prices not exceeding £17 million (excluding the effect of any movement in interest rates between now and financial close).

6.2.2 In accordance with the minute of the Board dated 6th August 2014, the Finance & Resources Committee authorised the Chief Executive or the Director of Finance of the Board, upon approval of the final terms of the NPD Project Agreement and associated documentation on behalf of the Finance & Resources Committee by the Chief Executive or the Director of Finance of the Board in the manner contemplated by paragraph 6.2.1 above (which approval the Chief Executive or the Director of Finance of the Board shall evidence in writing), to approve, sign, seal, execute, deliver and/or initial (as required) the following documents (together the "**Documents**"), signature of which is or may be required in order to reach financial close of the Project:

Item	Document	Description
1.	NPD Project Agreement	Means the project agreement in accordance with the Government's NPD initiative for the design, build, finance and maintenance of a project to re-provide services from the Royal Hospital for Sick Children, Children and Adolescent Mental Health Service and Department of Clinical Neuroscience in a single building adjoining the Royal Infirmary of Edinburgh at Little France (the "**Project**") between Lothian Health Board (the "**Board**") and IHS Lothian Limited (company number SC493676) ("**Project Co**")
2.	Funder's Direct Agreement	Means the funder's direct agreement between the Board, Project Co, and M&G Investment Management Limited (company number 00936683) (the "**Intercreditor Agent**").
3.	Contractor's Collateral Agreement	Means the contractor's collateral agreement between the Board, Project Co, Intercreditor Agent, Prudential Trustee Company Limited (company number 01863305) (the "**Security**

		Trustee") and Brookfield Multiplex Construction Europe Limited (company number 03808946) (the "**Contractor**").
4.	Service Provider Collateral Agreements	Means the service provider collateral agreement between the Board, Project Co, Intercreditor Agent , the Security Trustee and Bouygues E & S FM UK Limited (company number 04243192) (the "**Service Provider**").
5.	Key Sub-Contractor Collateral Agreement – M & E	Means the key subcontractor collateral agreement between the Board and TUV SUD Limited (company number SC215164).
6.	Key Sub-Contractor Collateral Agreement - Architect	Means the key subcontractor collateral agreement between the Board and HLMAD Limited (company number 05047778).
7.	Key Sub-Contractor Collateral Agreement – Structural Engineer	Means the key subcontractor collateral agreement between the Board and Robert Bird & Partners Limited (company number 04472743).
8.	Key Sub-Contractor Collateral Agreement – Acoustic Consultant	Means the key subcontractor collateral agreement between the Board and Acoustic Logic Consultancy (UK) Ltd (company number 06487654).
9.	Key Sub-Contractor Collateral Agreement – Transport Consultant	Means the key subcontractor collateral agreement between the Board and Ove Arup & Partners Limited (company

		number 01312453).
10.	Key Sub-Contractor Collateral Agreement – Fire Engineer	Means the key subcontractor collateral agreement between the Board and WSP UK Limited (company number 01383511).
11.	Key Sub-Contractor Collateral Agreement – Planning Consultant	Means a key subcontractor collateral agreement between the Board and Ironside Farrar Limited (company number SC109330).
12.	Key Sub-Contractor Collateral Agreement – Mechanical, engineering and electrical	Means the key subcontractor collateral agreement between the Board and Mercury Engineering Limited (company number IE225667), or an alternative member of the Mercury company group to be confirmed by financial close of the Project.
13.	Key Sub-Contractor Collateral Agreement - Lifts	Means a key subcontractor collateral agreement between the Board and Schindler Ltd (company number 00662746).
14.	Key Sub-Contractor Collateral Agreement – Piling	Means a key subcontractor collateral agreement between the Board and Balfour Beatty Ground Engineering Ltd (company number 00594086).
15.	Key Sub-Contractor Collateral Agreement – CDMC	Means a key subcontractor collateral agreement between the Board and Brookfield Multiplex CDM Services Europe Limited (company number 06324496).

16.	Independent Tester's Contract	Means an independent tester's contract between the Board, Project Co, the Contractor, the Intercreditor Agent, the Security Trustee and EC Harris LLP (registered under number OC368843)
17.	Insurance Proceeds Account Agreement	Means the insurance proceeds account agreement between the Board, Project Co, Sumitomo Mitsui Banking Corporation Europe (company number BR000486) **(the "Account Bank")** and the Security Trustee.
18.	Parent Company Guarantee for Construction Contract	Means the guarantee between the Contractor, Project Co, the Board and Brookfield Multiplex PTY Limited (Australian Company Number 147 631 472).
19.	Parent Company Guarantee for Services Contract	Means the guarantee between Energy and Services SA (company number RCS Versailles 775 664 873), the Contractor, Project Co and the Board.
20.	Other Documents	Means any other documents to be delivered by the Board pursuant to those listed above, together with all consents, waivers, undertakings, notices, letters, certificates and documents to be signed and/or initialled by the Board in order to achieve financial close for the Project.

6.2.3 The Finance & Resources Committee authorised the performance of the Documents by the Board following the finalisation, execution and delivery of the same.

6.2.4 The Finance & Resources Committee authorised the Board Secretary to provide a certificate to Project Co (as defined in the NPD Project Agreement) setting out the names and specimen signatures of the persons named in paragraph 2.2.2 above who are authorised to sign, seal, execute, deliver and/or initial (as required) the Documents on behalf of the Board.

6.2.5 The Finance & Resources Committee authorised the Chief Executive of the Board or his nominated representative, to provide to Project Co the following certified copies of the Board's:

(a) standing orders;

(b) standing financial instructions; and

(c) scheme of delegation,

The above resolution of Lothian Health Board's Finance & Resources Committee remains in full force and effect and has not been rescinded or varied.

Douglas Weir
Corporate Services Manager
29 January 2015

STRATEGIC PLANNING COMMITTEE **1.15**

The minutes of the meeting held on 15 January 2015 are attached.

Key issues discussed included:

- Proposals for the Clinical Change Cabinet to be established
- The process to progress primary care priorities around people, premises and IT arising from the Board Development Day
- Update on progress with Strategic Plan priorities

Key issues on the horizon are:

- The Strategic Plan update to the February Board meeting
- E-health proposals to increase productivity, efficiency and effectiveness

Brian Houston/ Alex McMahon

Chair/Executive Lead

DRAFT

NHS LOTHIAN

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 10am on Thursday 15 January 2015 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chair); Mrs J Anderson; Mr A Boyter; Mrs P Eccles; Dr D Farquharson; Professor J Iredale; Ms M Johnson; Mr A Joyce; Professor A K McCallum; Professor A McMahon; Mrs A Meiklejohn; Mrs A Mitchell and Dr R Williams.

In Attendance: Mr D A Small; Mrs L Tait; Mr D Weir and Mr S R Wilson.

Apologies for absence were received from Mrs S Ballard-Smith, Mrs K Blair, Mr J Brettell, Mr J Crombie, Mr T Davison, Mrs S Goldsmith, Ms D Milne and Ms E Mc Hugh.

84. Declaration of Financial and Non Financial Interest

The Chairman reminded members they should declare any financial or non-financial interest 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.

85. Minutes of the Previous Meeting held on 11 December 2014

85.1 The minutes of the previous meeting held on 11 December 2014 were approved as a correct record.

86. Matters Arising

86.1 Clinical Change Cabinet – The committee noted the copy of the letter issued by the Chief Executive to a range of clinical colleagues and managers inviting them to participate in the Clinical Change Cabinet. Full details of those invited would be circulated to members. **AMcM**

86.1.1 It was recalled that the Clinical Change Cabinet had been established on the back of a recent successful flowopoly event where following discussion with a number of key and interested parties it had been agreed there would be benefit in getting people together to discuss difficult issues. The focus of the initial meetings of the Clinical Change Cabinet would be around eradicating boarding, improving discharge arrangements and managing end of life care.

86.1.2 It was noted a meeting had been held earlier in the day with clinicians to expand the discussion on managing end of life and senior clinical colleagues were willing to help take forward further discussions.. A paper would be provided for the first meeting of the Clinical Change Cabinet. There would be linkages with the individual patient treatment requests (IPTR) and Scottish Medicines Consortium

(SMC) agendas and this was already work in progress. It was noted that currently pathways did not generally include the option of alternatives to active treatment .

86.1.3 The committee discussed the proposed membership of the Clinical Change Cabinet. The first impression had been that it was too large a list with too many Waverley Gate representatives. It was noted as the work of the Cabinet progressed the membership would be reviewed on an iterative basis.

86.1.4 Staff Side representatives stressed the need to recognise broader partnership engagement in the Cabinet with involvement being required at the outset of the discussions. Mrs Anderson advised that she had already discussed this issue with the Chief Executive and Professor McMahon undertook to also feedback the comments made at the meeting to him. **AMcM**

86.1.5 It was noted similar site based meetings would be held and these would be less management and more clinically focussed and include colleagues from primary care. The role of the Site Directors would be important to ensure proper engagement with Integration Joint Boards (IJBs). The engagement of the IJB would ensure processes did not become too acute-centric.

86.1.6 The committee noted that any service redesign proposals would need to give proper thought to primary care implications as well as the whole patient pathway. It was reported that around 6 General Practitioners had been invited to join the Cabinet and this should ensure those important linkages were considered from the outset.

86.1.7 The point was made that an important part of the success of the Cabinet model would be to retain flexibility around dynamics as well as sponsoring local meetings to take responsibility for cascading outcomes throughout the organisation using appropriate contacts. The importance of not over engineering the process at the point of establishment was stressed.

86.1.8 In terms of the selection of people invited to participate in the Cabinet it was reported a number of constituents had been asked for nominations. This had been a deliberate attempt to engage with people who were not normally involved in such discussion fora. Membership would be fluid dependant upon the topic under debate. The Clinical Change Cabinet proposals were noted and supported.

86.2 <u>Policy Choices Update</u> – It was noted positive feedback had been received following the previous meeting with volunteers having been identified to take forward some of the workstreams. Discussions would be held between Public Health and Strategic Planning colleagues to prepare the work and paper that needed to go to the Clinical Change Cabinet as well as ensuring broader partnership engagement. A meeting was diaried for the following day to maintain traction in this area. **AMcM/AKM**

87. Next Steps from the Board Development Day held on 14 January 2015

87.1 An update of the discussion held at the previous days Board Development Session was provided for the benefit of those committee members who had not attended the event.

87.1.1 The Chairman sought feedback on the event from a primary care perspective. The view had been that the event had gone well with primary care colleagues having welcomed the opportunity of the engagement at Board level. It would be important however to evidence quick change and benefits from the day otherwise its effectiveness would be called into account. It was felt despite suggestions made at the meeting that the point had been reached where more than quick fixes were required as this would be regarded as tokenism. The point was made that the means to address the small grant issues referred to at the meeting were already in place. Primary care colleagues had felt that the summing up of the event had been overly focussed on the hospital sector. An alternative view was put forward suggesting that the summing up had been appropriate as it provided explanations around the current expenditure profile and why this was necessarily the case.

87.1.2 The committee noted that during the discussion the previous day it had been pointed out that GP and other medical recruitment was outwith the control of the Health Board. The point had been made that following the Greenaway Report that changes would be made in the way medical services were provided in future. It would not therefore be possible to provide GP services in the same way in future. The same message applied to the acute sector.

87.1.3 It was reported that issues around information technology had been raised frequently during the event. The Board noted that at the University of Edinburgh Sponsored Bio-informatics meeting the previous week it had been reported that there were now ways of identifying that 4% of patients, because of the drugs they were taking, were susceptible to a medicines related problem. It was stressed however to build on the benefits of this work and the proper identification of patients would require good quality IT availability.

87.1.4 The point was made that the 3 key issues facing general practice around premises, people and IT had not emerged as strongly as would have been desired on the day of the Board Development Session and this had been slightly disappointing.

87.1.5 The committee were advised following the meeting a list of key issues had been agreed. The small grant issues required to be progressed and there was already a mechanism for this happening. In the longer term there would be a need to reconfigure services around GP localities including care homes. A key workstream would be to support and develop roles in GP practice. New GP premises development needed to continue through business cases which needed to address revenue funding issues. It was anticipated the next new GP practice would be in North West Edinburgh. The importance of sustaining LUCS was discussed. The committee was advised of the importance of developing 24/7 single points of contact for frail elderly people. Resolving the previously discussed IT issues was also a key issue that required to be taken forward.

87.1.6 The Chairman commented there was a need to be clear about how to take forward the issues raised at the Board Development Session. In terms of the Strategic Planning Committee and its management of the implementation of the strategic

plan it would be important to ensure these issues were addressed with it being noted some were already referenced in the strategic plan. A key issue was how to move from managing the delivery of the strategic plan to ensuring it was properly evaluated.

87.1.7 The committee were reminded that the development session was the first step in the start of a process. Following detailed discussion it was agreed follow-up actions and processes would be taken forward through the Primary Care Forward Group and the GP Sub-Committee. It was agreed this would be an adequate response in the first instance as it ensured discussions and agreements would go through key representative individuals. In addition a plenary group would be arranged in order to secure wider communication and buy into the messages discussed at the development session. The paper to the February Board meeting would feed in a broader set of proposals.

87.1.8 Mrs Anderson stressed the need for workforce issues to feed into the wider workforce plan as there was a danger of losing direction if issues were taken forward in small groups.

87.1.9 Ms Eccles commented in terms of IT that current issues were frustrating to people working in primary care. IT investments in future systems needed to specifically link to premises. She felt proper timelines needed to be identified for any new systems and their implementation. There were opportunities to reduce staffing numbers when IT was properly deployed. The point was made whenever new IT systems were being implemented it was important to ensure around the clock support to address any initial glitches.

87.1.10 The Chairman commented for the next meeting a paper on e-Health would be produced to lay out key propositions and how these would drive implementation. **AMcM**

87.1.11 It was noted the single page BMJ article tabled at the development session had been illuminating in respect of the vision being articulated.

87.1.12 The committee noted the update report form the Board Development Session.

88. Update on Progress with Strategic Plan Priorities

88.1 The key issues contained in the circulated paper had been discussed at the Board Development Session. It was noted that the strategic plan paper to the February Board meeting would not represent a revised strategic plan but would include propositions to drive forward the model of change within the financial context.

88.1.1 The committee noted the paper did not include a critical path analysis to allow the Board to understand the sequencing of relative priorities and any barriers and milestones in the event of timescale slippages. It was agreed that as much as possible of this work would be undertaken in advance of the 4 February Board meeting. A reasonable start for the Board paper would be to consider barriers to progress, finances and interdependencies. The point was made that the Board needed this level of information before proposals on propositions could be approved.

88.1.2 The committee agreed the recommendations contained in the circulated paper.

89. Date and Time of Next Meeting

89.1 The next meeting of the Strategic Planning Committee would take place at 10am on Thursday 12 February 2015 in meeting room 7, Waverley Gate. 2-4 Waterloo Place, Edinburgh.

STRATEGIC PLANNING COMMITTEE

The minutes of the meeting held on 12 February 2015 are attached.

Key issues discussed included:

- Update on progress on primary care priorities around people, premises and IT and national discussions on the new GP contract
- Update on progress with Strategic Plan priorities and timelines and shared responsibilities for delivery with the IJBs.
- Details of technology driven potential efficiency and productivity workstreams
- The financial context for delivery of the strategic priorities in 15/16
- The need to review the terms of reference of the Strategic Planning Committee

Key issues on the horizon are:

- Revised terms of reference for the committee to be presented to the Health Board for approval in April 2015.

Brian Houston/ Alex McMahon

Chair/Executive Lead

NHS LOTHIAN

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 10am on Thursday 12 February 2015 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chair); Mr T Davison; Ms P Eccles; Ms M Johnson; Mr A Joyce; Professor A K McCallum; Professor A McMahon; Mrs A Meiklejohn and Mrs A Mitchell.

In Attendance: Mrs L Tait and Mr D Weir.

Apologies for absence were received from Mrs S Ballard-Smith, Mrs K Blair, Mr A Boyter, Mr J Brettell, Mr J Crombie, Dr D Farquharson, Mr P Gabbitas, Mrs S Goldsmith, Professor J Iredale, Ms D Milne, Mr D Small, Mr G Walker, Dr R Williams and Mr S R Wilson.

90. Declaration of Financial and Non Financial Interest

90.1 The Chairman reminded members they should declare any financial or non-financial interest 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.

91. Chairman's Opening Remarks

91.1 The Chairman commented in view of the level of attendance at the current meeting that he would like to discuss the purpose and the role of the Committee under 'Any Other Competent Business'. He commented it was clear that the stage of development of the strategic plan had changed significantly and other aspects were now moving into play. He commented therefore by a process of natural evolution the role of the Committee had changed and it had to be recognised that other parts of the governance structure also had an overlapping role and this might explain why the attendance at recent meetings had diluted.

92. Minutes of the Previous Meeting Held on 15 January 2015

92.1 The minutes of the previous meeting held on 15 January 2015 were approved as a correct record subject to the following amendments, minute 87.1.9 to read 'Ms Eccles …… there were opportunities to release capacity when IT was properly deployed … '. A sentence would also be added to reflect that there were opportunities for patient pathways to improve patient experience.

93. Matters Arising

93.1 <u>Update on Primary and Community Care Issues</u> – The Committee noted that the strategic planning progress report to the Board would contain significant updates on

areas of primary care work as requested through the consultation process. It was noted that there had been a period of 6 – 12 months of dialogue with GP's facilitated through Dr Catriona Morton and that the GP and primary care input into the January Board meeting had been powerful.

93.2 The Committee noted that since then meetings had been held to develop issues around premises, people and IM&T. It was noted that senior IT colleagues had met with Dr Peter Shishodia and Dr Morton and identified a number of actions that required to be taken forward. It was noted one of the key aspects was that all 126 practices needed to commit to using the algorithm on how failures in IT were reported as this was not currently happening and in some instances people were contacting the provider directly meaning that e-Health were not always aware of problems. It was noted that Dr J Stein was working with practices to reinforce the position.

93.3 It was noted that work was underway in respect of the development of a service level agreement in terms of response times and that discussions would be held with the GP Sub Committee around any changes. This might require revenue resources to take the issue forward. There was a proposal to move all 126 practices onto a single server. This had worked successfully in Grampian. A pilot exercise in this regard would be undertaken within 4 – 6 practices to test effectiveness and to secure agreement in principle. The Committee noted that a primary care GP survey would be undertaken to identify what other issues there were around IM&T and the outcomes of this would be built into the process going forward.

93.4 The Committee noted that the central server would as part of its service level agreement ensure that any sign on process was enabling rather than unduly restrictive whilst recognising the need to comply with national and local security requirements.

93.5 The Committee noted in terms of ongoing investment that NHS Lothian was still awaiting advice from the Scottish Government Health and Social Care Directorate (SGHSCD) around its share of the £40m of primary care investment that had previously been trailed. It was noted that clarity was required around whether this would be released over a 3 year or a 1 year timeframe. It was noted that discussions were underway with finance colleagues in respect of the financial planning process in terms of the need to build up resources to address the issues around IM&T raised by general practitioners.

93.6 It was reported that on 23 January 2015 the Board had met with representatives from the SGHSCD and the BMA to discuss the wider primary care agenda. It was noted that positive discussions had been held around the introduction of the new Scottish GP Contract with agreement having been reached on the areas where further traction was required. It was noted in future the focus would be around doctors only doing the things that they were uniquely trained to do and the out of hours service. It was noted that this would require radical thinking about input from other staff groups to undertake the subsidiary duties and this would lead to a need for further discussions to develop primary care capacity to support people better at home. The Committee noted that the Chief Executive, Joint Director of East Lothian CHP and the Director of Strategic Planning, Performance Reporting and Information had met with Dr Morton and Dr Sian Tucker earlier in the week to discuss issues that needed to be addressed in terms of capacity and it had been agreed to look at nursing numbers and skill mix including health visitors and district nurses in order to try and

secure alignment with GP priorities. It was noted in terms of district nursing that the service could be aligned to a cluster of practices. There was also a discussion around the need to develop a more generic workforce. It was noted that further reports on progress in this area would be provided to the Strategic Planning Committee.

93.7 The Committee noted that a business plan would be submitted to the June Board meeting around how to take forward primary care issues in particular around the need to be clear about the increased capacity that would be generated from any future investment. The paper would also highlight what the nursing skill mix model would look like as well as covering investment proposals. **AMcM**

93.8 The Chairman commented that he had felt that the joint meeting with the primary care group and SGHSCD had been very positive and there had been significant radical thinking around the table especially around the GP contract. He commented however in terms of all the issues around delivering changes and the reliance on investment steps would need to be put in place to ensure that outcomes were delivered as currently there appeared to be few checks around accountability and control. It was felt there needed to be a semi-contractual expectation around future investments which would need to show benefits which could be measureable against milestones. It was noted that a degree of formality that might address this issue had been introduced under the Dental Access Programme which had to show improvements around key benchmarking criteria. The point was made that there were a number of general practitioners who for good practice reasons collected a matrix of data and that they had a frustration that there was limited scope to report back on their positive performance.

93.9 Ms Eccles commented in any service level agreement the position in respect of practice nurses would have to include governance issues around GP employed staff having access to training etc. It was confirmed that such issues would be built into agreements and that training and development should be part of ongoing business and this would be reflected through ongoing discussions. It was noted over the previous few years steps had been put in place to ensure that nurses received proper training in order to comply with their registration requirements. The suggestion was made that protected learning time had yet to be considered in depth from a strategic perspective. The point was made that any such provision for protected learning should be on a planned rather than an ad-hoc basis.

93.10 The comment was made that in the private sector contracts would not be entered into where there was a lack of control over outcomes and concerns were expressed if the new Scottish GP contract represented more of the same this would be a missed opportunity. The Chairman advised he had been encouraged by the fundamental change in the relationship referred to in the discussions around the changes to the contract. The Committee were reminded that contact and relationships with primary care had improved over recent months and would be further enhanced through continued contractual engagement. In future there would be a need to be clear what aspects of service delivery would fundamentally change through investment and the desired outcome expected from these changes. In terms of opportunities to influence change through the establishment of Integration Joint Boards it was pointed out that levers were already available through the existing CHP structure.

93.11 The Committee received the update report and agreed that a paper on key propositions for 2015/16 and 2016/17 along with details of delivery outcomes would be presented at the June 2015 Board meeting.

94. Strategic Plan Progress Report – Actions from Board Meeting on 4 February 2015

94.1 The Committee noted there had been a very positive response to the summary progress report on key propositions presented to the Board on 4 February 2015 which had included a high level critical path. The point had been raised about how to translate the detail of the plan to reflect Integration Joint Boards and their statutory requirement to produce commissioning plans. It was noted that all of the Joint Directors had been part of the process of developing the NHS Lothian strategic plan for 2014 - 2024 although it was accepted that there would be local nuances within each of the geographical areas.

94.2 The Board had also discussed the creation of the Clinical Change Cabinet and the need for Integration Joint Boards and in particular the Joint Directors to be part of this process. The focus of the Clinical Change Cabinet model would be to look at delayed discharges, boarding and the long term management of end of life conditions with it being noted that a significant amount of these decisions would come forward onto the Integration Joint Board agenda. The key focus particularly around the long term management of end of life conditions was to manage the process to the best benefit of patients and that the service model moving forward would be person centred. The key role of the Clinical Change Cabinet would be around how best to drive the agenda forward and this would play into consideration of issues around the policy choices paper produced by the Director of Public Health and Health Policy.

94.3 The point was made with the introduction of Integration Joint Boards that NHS Lothian's main primary focus would be around acute service and unscheduled care although there would be an overall requirement to keep an oversight of delivery of the rest of the agenda deliverable through the Integration Joint Board Structure. It was noted that consideration was being given currently to the level of resource that would require to be allocated to deliver the key propositions and to identify gaps with a view to supporting and progressing delivery which would be tracked through the iterative updating of the Gantt chart attached to the paper. It was noted that some projects would be complex with multi partnership engagement and were to some extent assumption based. The Committee were advised that progressing issues around policy choices was a hugely significant area of work and was the correct thing to do for the benefit of patients and there would be a need to translate this work into firmer policies. It was felt if aspects of the policy choices agenda could be implemented this would demonstrate a step change in the quality of care provided as well as addressing capacity and flow issues.

94.4 The point was made in terms of the critical path that it did not appear to include proposals around hospital closures and ongoing site disposals. The Committee noted that the critical path described a point in time and were reminded that the issues referred to were reflected in the detail of the strategic plan. A full update on the capital plan would be attached as an appendix to the final strategy document. There had been a number of issues that had not previously been on the agenda that

were beginning to emerge. The intention was that through the financial sustainability matrix that values and timescales would be set out against each proposition.

94.5 The Committee were reminded that it had previously considered a decision making matrix as well as well as a template. It was agreed there was a need for the decision making matrix to be resurrected to demonstrate the emergent broader position as well as detailing a set of principles for investment into the third sector. The Committee agreed this would be a valuable exercise as it could then be shared with stakeholders and would demonstrate transparency.

94.6 In response to a comment made by Ms Eccles about timescales for engagement it was noted a meeting had been held with communication colleagues about the need to develop engagement strategies around issues like the future of the Royal Victoria Hospital which would require either consultation or engagement. There would in parallel be a series of high level communications strategies and some of these would be taken forward by the Integration Joint Boards through their strategic commissioning plans. The Committee were advised that during a recent Non Executive walkabout visit that staff at The Royal Victoria Hospital had been unclear about the future of the site. The point was made that this had been within the context of statements having been made about IPCC beds, winter beds and assumptions around Gylemuir supporting moves in these areas. The point was made that discussions with the City of Edinburgh Council around finances were tense and that the Gylemuir facility was not funded beyond March 2015. It was agreed there was also a need to be clear about who was progressing each workstream to include support and communication requirements. The Director of Strategic Planning, Performance Reporting and Information would progress. **AMcM**

94.7 The Chairman commented as a Committee there was a need to be clear about the information requirements and whether the future role of the Committee was to manage the project plan or to ensure that processes were in place to provide assurance to the Board about the execution and monitoring of progress around the plan.

94.8 The Committee noted the update report.

95. Strategic Developments through Technology Driven Potential

95.1 The Committee noted that the purpose of the report was to highlight a number of IM&T related schemes which had the potential of delivering material net savings, underpinning the strategic plan and particularly contributing to the delivery of sustainable models of service delivery and financial sustainability.

95.2 It was noted that the Board had signed off on the strategic plan progress report on 4 February and in doing so the use of technology had been identified as a key enabler to drive service change and also to build capacity and capability, whilst driving efficiency and productivity and financial sustainability.

95.3 The Committee noted the work underway in each of the following key workstreams:-

- Speech recognition
- Video conferencing
- Basing staff at home

- Hospital electronic prescribing and medicines administration (HEPMA)
- Patient e-communication
- Primary care IT

95.4 It was noted that a number of the above proposals represented spend to save schemes. It was noted that the proposals in respect of speech recognition and patient e-communications had been agreed either through the Corporate Management Team or the Efficiency and Productivity Group and would therefore be driven forward. It was noted issues around Primary Care IM&T as well as acute requirements would require revenue funding and in that regard a process of business case production was underway.

95.5 The Committee noted that the list of areas taken forward did not represent the whole plan. It was noted in particular that work was underway to provide staff with handheld devices in order to cut down on the number of home visits required. The Committee noted that the primary care strategy addressed issues around handheld devices and electronic access to link to patients for issues like health protection advice.

95.6 The point was made that the work around the e-communication project with patients was important in that it would create the development of a patient portal which would in the longer term provide easier access to the system by patients in order to manage their own requirements. The patient portal would also allow better links and communications with staff.

95.7 The Committee noted the update report and that the Efficiency and Productivity Steering Group had asked that e-health progress work around speech recognition, video conferencing and basing staff at home to the next level.

96. Update on Financial Impact of Strategic Propositions and Decisions about Priorities

96.1 The Chief Executive and the Chairman provided the Committee with an update on discussions held at the guiding coalition event held either in the week which had been attended by Health Board Chairs and Chief Executives and well as the Director General and senior health department colleagues. The debate at the event had been formed by earlier discussion at the Board Chief Executives meeting where discussion had been held about the sustainability of financial plans. The debate had highlighted a number of common themes. It was important to remember that 4 or 5 of the larger Health Boards represented 60% of the national health spend in Scotland. From the debate it had emerged that 7 or 8 Health Boards were in a similar financial position to NHS Lothian.

96.2 The Chief Executive commented within Lothian there were many interdependencies to consider in respect of financial sustainability. The assumption was that £30m of LRP would be delivered (£20m (r) and £10m (nr)). Assuming LRP delivery and also assuming that the delayed discharge position did not worsen the belief was that there would be a recurring financial gap of £13m (1% of the baseline) going into the next year. The system was currently within touching distance of achieving non recurrent financial breakeven. It was anticipated that a balanced budget would be achieved at the point of submitting the LDP and for approval at the April 2015 Board meeting.

96.4 The Committee noted that all of the local authorities had set their budgets. It was felt that the East Lothian, Midlothian and West Lothian had set social care budgets that would deliver on requirements. The position with the City of Edinburgh Council was that they had set a budget £4m lower than the current year's budget and £9m lower than the current year's spend profile. This had a potential impact on the delayed discharge assumption underpinning the NHS Lothian balanced budget. This was significant as the Chief Executive felt that 50% of the £30m LRP target for NHS Lothian was high risk as plans were complex and relied on closing beds. The Committee noted detailed discussions had been held with Scottish Government colleagues.

96.5 The Chief Executive commented that the NHS Lothian position was therefore similar to a number of other large Health Boards. It was noted 2-3 Health Boards were sensitive to council funding proposals and this had a potential impact on the submission of balanced budgets in respect of the LDP process.

96.6 The Committee noted the update report.

97. Any Other Competent Business

97.1 **Strategic Planning Committee Role**

97.2 The Chairman commented that attendance at recent Committee meetings including the current one had reinforced his thoughts about the need to consider the ongoing role of the Committee. He noted that in the previous year most of the Board and about another 12 people had regularly attended the meeting. The view was that the strategic planning function was now in a different and improved place. Attendance at meetings remained disappointing despite a previous letter from the Chairman encouraging people to reschedule their diaries to facilitate attendance. It was noted that Mrs Mitchell had formally suggested that the time was appropriate to revisit the role and ongoing purpose of the Strategic Planning Committee and this was a view supported by the Chairman.

97.3 The Chairman commented from the perspective of the debate at the current meeting the following issues had been obvious: -

- The nature of the plan was now felt to be well articulated, developed and communicated and had gone through a period of consultation.
- A framework for the plan was now in place although the point had not yet been reached in respect of managing the delivery of the strategy.
- There were a series of near term imperatives that needed to be addressed for example financial sustainability.

97.4 Following detailed discussion it was agreed there was now a need to review the remit and membership of the Strategic Planning Committee which had been established initially to oversee the development of the strategic plan and recommend a strategic direction on behalf of the Board.

97.5 After detailed discussion at the Strategic Planning Committee it was agreed that given the Committee had overseen the development of the clinical framework and the strategic plan there was now a need for the Committee to have oversight of delivery as well as making much stronger linkages with integration and the

development of the strategic commissioning plans, as well as focusing on the future models of care and development in local, regional and national planning.

97.6 The potential membership of the Committee was discussed and it was agreed that the Director of Strategic Planning, Performance Reporting & Information would consider membership of the Committee and the frequency of the meetings and reference these in revised terms of reference which would be drawn up and considered at the next Strategic Planning Committee meeting before being submitted to the Board for approval on 1 April. **AMcM**

98. Date and Time of Next Meeting

98.1 The next meeting of the Strategic Planning Committee would be held at 10:00 a.m. on Thursday 12 March 2015 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

EAST LOTHIAN HEALTH AND SOCIAL CARE PARTNERHSIP SHADOW BOARD

The draft minutes of the meeting held on 22 January 2015 are attached.

Key issues discussed included:

- **Scheme of Integration Update**– Comments noted and draft Minutes of Shadow Board 22.01.15 to be taken into account as a contribution to the consultation.

- **Strategic Plan** – Draft plan is available through the consultation hubs of NHSL and ELC together with responses. Fifteen presentations have been made to community groups and an advert has been placed in the East Lothian Courier.
  Annual performance report will be submitted to the IJB and work is starting on the content.
  Financial plan will be added to the second consultation draft of the strategic plan and will include key specified deliverables.
  Outline business case for East Lothian Community Hospital will be discussed at the Shadow Board meeting on 26.02.15.
  East Lothian CHP Sub Committee will be dissolved legally from 1st Aril 2015 however in the meantime NHS Lothian have agreed to maintain the Sub Committee to provide NHS Governance. The CHP will therefore be dissolved at the point of the IJB being incorporated.
  Proposals for integrated management arrangements are being worked on and it is likely there will be consultation commencing sometime in February.

- **Joint Financial Planning** – A paper with specific financial data to be discussed at Shadow Board Meeting on 26.02.15.

Key issues on the horizon are:

- **Scheme of Integration Update**
- **Strategic Plan**
- **Joint Financial Planning**

Mike Ash

Chair/Executive Lead

East Lothian H&SCP

MINUTES OF SHADOW BOARD
22nd January 2015
1400 – 1600
Council Chamber, Town House, Haddington

Present:	Mike Ash, Chairman (MA) Donald Grant, Vice Chairman (DG) Shamin Akhtar (SA) Maureen Allan (MAL) Jim Goodfellow (JG) Alex Joyce (AJ) David King (DK) Murray Leys (ML) Carol Lumsden (CL) Alison MacDonald (AMac) Joanne McCabe (JM) Margaret McKay (MMcK) Alison Meiklejohn (AM) Thomas Miller (TM) David Small (DAS) Eliot Stark (ES)
Apologies:	Alastair Clubb (AC) Stuart Currie (SC) Jon Turvill (JT) Graeme Warner (GW)
Scribe:	Barbara Gilbert

1. **Welcome and Apologies** – MA welcomed everybody to the meeting and explained that NHS Lothian had reviewed the voting membership of all Shadow Boards and had nominated Alex Joyce and Professor John Iredale as new voting members for East Lothian. This meant that the Shadow Board would be losing the services of Thomas Miller and Alison Meiklejohn as voting members. MA explained the Shadow Board was in transition in terms of membership and that during this period Thomas Miller would continue to attend and so would Alison Meiklejohn. MA expressed his thanks To Thomas and Alison for their contributions to the Shadow Board.

2. **Minutes of Previous Meeting**
Agreed as accurate record however Action Plan was omitted.

3. **Matters Arising**
No matters arising were raised.

4. **Standing Items**

4.1 Chair's Report – MA reported the following: -

Members visit to Cumbria which was interesting and there had been many useful issues including working with general practice, data and use of Care Navigators.

MA had met with representatives of Scottish Care who were wishing to discuss how they could get involved in Strategic Commissioning.

Follow up meeting taking place soon between CL, MA and Scottish Care Coordinator.

MA had represented the Partnership at a Workshop on the Total Place Pilot in Musselburgh which was very relevant to the Health & Social Care Partnership.

MA circulated comments from participants from the Informal Board meeting which was held on 11th December 2014.

A Community Planning event was held by NHS Lothian which had very good inputs from Scottish Government and Audit Scotland. The IJB will obviously have a major role but more work is required to confirm the relationships involving ELC, NHSL and IJB.

4.2 Director's Report

DS reported that The NHS Board and East Lothian Council agreed in December to consult on the draft Scheme of Integration. Draft Consultation closes on 17.02.15 and it is expected that the final scheme will be presented for approval in March 2015.

Based on advice from Scottish Government it is now assumed that the formal establishment of the IJB will be in July 2015. This is set out in the revised indicative timetable.

DS reported that the bed modelling for the Community Hospital will be

updated for the Outline Business Case. The Outline business case will be ready around June 2015 and therefore this will be discussed at the Shadow Board meeting scheduled for 02.04.15. In the meantime it was agreed there should be substantial update at the Shadow Board meeting on 26.02.15.

MMcK enquired about broader engagement in the plans and it was agreed that Miriam Anderson will ensure invitations are sent out. It was noted that depending on timing, formal approval might still be required from the CHP sub committee.

It was noted that the CHP Sub Committee will be dissolved legally from 1st April 2015. In the meantime NHS Lothian had agreed to maintain the Sub Committee to provide NHS governance. The CHP will therefore be dissolved at the point of the IJB being incorporated.

Proposals for integrated management arrangements are being worked on and it is likely there will be consultation starting sometime in February.

ACTION: MA / DAS / BG

5. Items for Discussion

5.1 Scheme of Integration Update – JMcC requested that individual comments should be submitted through the ELC or NHSL websites. It should be noted this is still a work in progress as Scottish Government guidance is awaited on some key areas.

The main differences from previous drafts are the operational role of the IJB to give oversight of delivery services.

It is proposed that current committee structures in ELC and NHSL would remain, but there will be an additional scrutiny role for the IJB.

The proposed operational oversight role has a knock on effect of the role of the Chief Officer, the Management Team and on proposals for Clinical and Care Governance.

Another key issue is financial risk sharing. There has been further guidance produced by Scottish Government and the scheme will be updated. It was noted that this is a Scottish issue and all partnerships are having difficulty in addressing it. DK added that there are no additional resources and therefore the parties have to make sure this works.

MA asked what would happen if the IJB is given a budget and overspent on it, would the IJB have to sort this out? JMcC commented that lots of discussions will take place. MA asked if there is an under spend would the IJB retain it? It was noted that “windfall” savings for example drug price changes would

probably go back to Lothian Health.

MMcK enquired as to the different timing of budgets between ELC and NHSL and asked how anyone can make an overarching decision. DAS stated the strategic plan states what the IJB will "direct" the parent body to do and this needs to be in place first and it should have an influence on budget setting. It should be noted that 15/16 will be a transition year as budgets will have been set.

DK indicated that both the parent bodies should state to IJB what future years budgets will look like.

ES highlighted the contradiction between the policy direction of keeping people in their own homes whilst the bodies charged with doing that have reducing budgets.

With reference to Complaints it was noted that nothing will change for service users and that liability will stay with ELC and NHSL and this is being worked on with the Scottish Government and Central Legal Office. KM commented that it is important that complaints do not get lost in system. JMcC noted that the Chief Officer will have this role.

DAS proposed that the draft minutes of the Shadow Board to be taken into account as a contribution to the consultation.

MA formally thanked JMcC on behalf of the Shadow Board for her hard work.

5.2 **Strategic Plan** – CL gave an update on the process of consultation on the Strategic Plan and the new guidance which is being updated. The draft plan has been made available through the consultation hubs of NHSL and ELC and responses have been received. In addition fifteen presentations have been made to community groups and an advert was placed in the East Lothian Courier.

An annual performance report will be submitted to the IJB and work is starting on the content of that.

It was noted that at the last meeting the partnership was in the process of submitting a template for the Integrated Care Fund. This has now been submitted and circulated to Shadow Board members. Work is underway to develop the proposals in the template.

The second consultation draft of the strategic plan will look quite different. The financial plan will be added and the plan will include key specified deliverables.

It was noted that for 2015/16 the plan is coming in a third of the way through the financial.

There was discussion about how frequently the plan would be updated and performance monitored. It was noted that some indicators were infrequent and some monthly so frequency would depend on the indicator. Some elements of the plan would be short term and others very long term. The maximum refresh period is three years. CL welcomed comments on this subject.

DG reported he had attended the presentation to the Area Partnership in Fa'side Ward and there had been significant interest.

MMcK commented it is important that the shadow board keep to a timescale and take account of the first responses then consult on the second draft.

MMcK has sent the draft to a group of carers who gave views which were very interesting. Expectation is of significant level of responses.

ES reported a consultation was held in November and aiming to do follow up. Approximately 50 people attended this consultation which was very successful. Round two event will be held and this will be open to the independent sector.

There was discussion on the amount of the Integrated Care Fund and the newly announced Delayed Discharge funding. DG stated the amount of money received was rather disappointing as some of the partnerships with smaller populations received a similar money amount of money. ES commented this position as being a major issue.

MAL enquired what priorities had been identified for the delayed discharge funding. DAS replied that of the 73 delayed discharges on the system today almost half are waiting for care homes. 22 are waiting for nursing homes, 10 for residential care and about 11 for home care. Therefore the initial priority would be care home capacity.

MMcK commented that people who are not working within the sector would value getting a picture of the service that is already in place and what is being developed. MA suggested that this should be built into a half day discussion. AMacD commented that work has started on this. A Joint Operational group has been established.

CL reported that timelines were tight and that the partnership needs to start encompassing financial detail in the plan.

MA expressed thanks to CL for her hard work on the Strategic Plan.

5.3 Joint Financial Planning

DK spoke to the paper regarding the update of the financial plan for the IJB for 15/16. This paper developed the principles laid out in the paper presented to the Board in November 2014 and updated the Board on the current position. It had been hoped to present a more detailed analysis containing a financial position but ELC and NHSL have not yet set budgets. It was agreed that the financial issues had to be as transparent as possible and that the Board had to be able to fully understand the resources that had been made available to it and the risks and impacts that the Board's decisions would have.

DK was asked to ensure that a paper with specific financial data be brought back to the meeting of the next Board on 26th February 2015 further laying out the financial plans and proposals for 2015/16.
ACTION: DK

6. Any Other Business

MA will be on leave for two weeks as from 24.01.15. He has organised a visit to Torbay H&SCP whilst on holiday in Cornwall and he has sent a copy of the Strategic Plan.
MA would like to organise half day development sessions between now and late June in order to have more time to work together and develop shared understandings.

Shadow Board meetings will be circulated until the end of July.

MMcK suggested one of these meetings should focus on delayed discharges. This was agreed in principle.

It was also agreed that one should focus on finance.
ACTION: MA / DAS / BG

8. Dates of Future Meetings

26 February 2015 – 1400 – 1600
Council Chambers, Town House, Haddington
2 April 2015 – 1400 – 1600
Council Chamber, Town House, Haddington

EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB COMMITTEE **1.17**

The minutes of the meeting held on 13 November 2014 are attached.

Key issues discussed included:

- IPCC reconfiguration of inpatient beds now completed.
- Nursing Workforce issues within Edinburgh Community Health Partnership. Workforce planning tools are highlighting large gaps of registered Nurses in some areas. District Nursing and Health visiting are also areas with significant pressures due to recruitment and retention issues.
- Capital schemes are progressing. The bundled project Firhill, North West Edinburgh and Blackburn Partnerships have been approved by Finance and Resource and will now go to Scottish Capital Investment group.
- The standard business case for re-provision of Ratho Surgery has now been approved. The landlord will build the surgery and lease it to NHS Lothian.
- The Minor schemes to increase capacity within GP Practices continue and has generated capacity for an additional 5,000 patients.
- Winter planning update Royal Victoria and Astley Ainslie have been identified as possible areas for use for winter beds.
- Integration update 5 members from NHS Lothian board to join IJB to be named by end of November. Strategic planning and leadership groups have been formed.
- Finance update Month 7 report shows high transport costs attributed to hospital location moves

- Key issues on the horizon are:

- Integration

Shulah Allan

Chair/Executive Lead

EDINBURGH COMMUNITY HEALTH PARTNERSHIP
SUB COMMITTEE MEETING

DATE: Wednesday 13th November at 9.30am
Venue: PMR Room, SMART Centre, AAH

Present
Shulah Allan, Chair, ECHP and Non-Executive Director, NHS Lothian
David White, Assistant General Manager
Sheena Muir, Assistant General Manager, Astley Ainslie & Associated Hospitals
Wanda Fairgrieve, Lead Partnership Representative, Edinburgh CHP
Peter Gabbitas, Director of Health and Social Care
Sally Arnison, Pharmacist
Bob Martin, Finance Partner, Edinburgh CHP
Ricky Henderson, Councillor for Pentland Hills ward
Ella Simpson, EVOC Voluntary Sector
Maggie Gray, Project Manager, Edinburgh CHP
Lynda Cowie, Chief Nurse, Edinburgh CP
Eileen McGuire, Service Manager, Edinburgh CHP
Jim Brown, Individual

Apologies
Angela Lindsay, AHP Manager
Dr Ramon McDermott, GP Sub/Lothian LMC
Dr Ian MacKay, Clinical Director, Edinburgh CHP
Maureen Reid, South West LHP

Action

1. Welcome & Introductions

Apologies were noted as above.

Shulah Allan (Chair) welcomed those present. Brief introductions were made.

2. Minutes of previous meeting of 15th May

The minutes from 13th August 2014 were discussed.

Changes to be made are as follows:

- On page 1, under Item 3 it was an orthopaedic ward being relocated and not a delayed discharge ward.
- On page 1, under Item the bundle project consists of Muirhouse, Firrhill and Blackburn. Ratho is a standalone surgery.
- On page 2, 1st paragraph it was decided to remove the 2nd sentence as it wasn't clear what was being discussed.
- On page 3, under the finance update section it should state that there is a projected £4m overspend within prescribing and not prescribing for rehab.

3. Matters arising

IPCC Bed Reconfiguration
The move from Corstorphine to the Royal Victoria Hospital has been successful. The move to Liberton was completed by the 8th October 2014.

Development of localities
See attached "Development of Localities" and "Briefing to Edinburgh GPs, Locality Development"

The Committee discussed the paper which outlines the proposal on how services within health and social care could be reconfigured. The proposal is to reorganise into 4 quadrants which aligns with existing neighbourhood partnerships. It was acknowledged the work that was being carried out detailing the 154 natural communities; these have been used as a stepping stone within this process. The new proposal will build on solid foundations with few occasions of having to cut across natural communities and fit in with what other services e.g. Police and fire service are already using.

The proposal has been presented at various internal committees for feedback and is receiving positive feedback.

It was requested that the 2nd bullet point regarding potential risks was to be reworded.

There has been some concern expressed by acute services regarding the effect the changes will have on their sector. Monitoring of hospital workloads show early indications that it will have no effect. Pathways will need to be aligned to get patients discharged from hospitals.

This will be added to the agenda for next meeting for further discussions

4. LUCS Review Paper (Sian Tucker)
Not discussed

5. Workforce Report
See attached "Nursing Workforce Issues Edinburgh Community Health Partnership (CHP)
The workforce planning tools are now mandatory and work alongside the professional judgement tools. Some areas are still working with a large gap due to a problem with the number of registered nurses. There are an increasing number of complex patients who are frailer and require more complex medications e.g. syringe drivers. To carry these out they need 2 registered nurses per shift.

Sickness levels are still high but have decreased since the summer.

Staffing level at the Lanfine is the most costly as the ward contains 18 beds that are widely spread.

As per NHS Lothian policy agency staff will be banned within the service only allowing teams to book Bank staff. This may need to be breached in urgent instances e.g. if there is 1 trained nurse on shift that goes off sick.

The District Nursing Services has a high level of DN's that are at the age of retiring if they wish. Skill mixing has been carried out but more band 6

Nurses are required as caseloads are required to be held at band 6 level. There are 18 vacancies at present. The main pressure on the district nursing service is the number of insulin dependent diabetic patients requiring insulin in morning and evening. The aim is to move towards merging services from day and evening service into one service.

Health visiting service remains very understaffed which is a national problem. The funding for training, however, has been increased from 7 places to 15 places this year. This will require more practise teachers within the Service which will impact financially as these posts receive higher grading. Skill mixing is also being looked at although recruitment of Nursery Nurses has also been difficult.

6. Report on Capital Schemes

See attached "Partnership Centre Bundle – Full Business Case (FBC)

Bundled projects: (Firrhill/North West Edinburgh/Blackburn Partnership Centres) -

The Full Business Case (FBC) for the bundled projects was approved at Finance and Resources (F & R) on 12th November, and will now be submitted to the NHS Lothian Board meeting and the Scottish Capital Investment Group.

F & R recognised the investment in Primary Care, and commented on the need to use new technologies to support future delivery. F & R expressed concern regarding the revenue implications; the revenue gap for the bundled projects was noted as £0.5m. NHS Lothian has identified this as a priority against the new Primary Care fund recently announced by the Scottish Government. The allocation of additional funds for Primary Care was welcomed; however, it is not clear whether this will be recurring or a single allocation of monies. The fund provides an opportunity to address the wider implications for Primary Care and not just premises, such as the need to increase the numbers of District Nurses.

It was noted that this is a different funding scheme from the Integrated Care Fund.

Ratho – The Standard Business Case (SBC) for re-provision of Ratho Surgery was also approved at F& R on 12th November. The landlord will build the surgery at Wilkieston Road and lease it to NHS Lothian. Legal negotiations with the landlord are in progress. The new surgery is scheduled to open in summer 2016.

The leaks affecting the existing surgery have been repaired, and the surgery remains dry. City of Edinburgh Council is reassured that the upstairs landlord is being cooperative in addressing the problems.

A meeting to discuss both service delivery and the surgery premises in Ratho was held with politicians recently. A public meeting to address the same concerns is planned for early December.

GP Premises – Minor schemes at GP practices to create additional consulting space have been completed at 2 practices and are either in progress or programmed for a further 6. The fund to enable these schemes, £187k, has generated capacity for an additional 5,000 patients. This is taking pressure off Primary Care and has been a huge improvement on last year which was acknowledged by the South GP reps recently.

A further 6 practices require intermediate schemes which were approved at F & R as part of a programme Initial Agreement requiring investment of c£1.2m. Individual business cases will now be developed for each scheme. It was noted that these would take the form of capital grants awarded to the practices who are independent contractors. Capital Planning/Finance will advise on the mechanism for implementing this.

Practices requiring full re-provision of premises have been prioritised as part of NHS Lothian's Primary Care programme, including indicative capital costs and likely timing. £3m investment is required in 15/16 and £5m annually thereafter.

Premises priorities for ECHP will be refreshed following David White and Maggie Gray's current round of meetings with GPs across the city.

7. Winter Plan Update

The RVH contains 56 beds for delayed discharges and the Balfour Pavilion Astley Ainslie can be used but work needs done to make it habitable. There are 3 wards within the building, 1 of which was fire damaged and 1 ward will be ready for cleaning next week. There has been discussions regarding using an Interim Care Home but confirmation of funding is required. Staffing will come from existing posts or specific winter recruitment posts. No domestics, catering or porters will be needed at the Balfour since the services are already covered on site.

The first ward will be ready for use in mid December 2014 and the further 2 wards will be ready from January 2015.

8. Integration Update

There are still decisions to be made regarding what services will be included in the Integration plan.

There will be 5 members from NHS Lothian (and 5 from CEC) on the Integrated Joint Board(IJB) and they will be named by end of November. The integration Plan will be put forward to the Board of NHS Lothian and the Council in December 2014. If approved will go out to consultation until mid February 2015. The plan will then go to Scottish Government end of March. It is estimated that the Edinburgh IJB will be established in June.

Strategic Planning – A Strategic Commissioning Plan Committee is being established which will have a very broad remit. This Committee will be involved with planning. There will also be a steering group which will be an officers group not members of the IJB. All plans have to be ready for June 2015.

Leadership Group – This was formed 3 months ago membership includes amongst others NHS Lothian Chief Executive, CEC Chief Executive, Peter Gabbitas and finance leads . They have been working on the endorsement of approval and debating what services should be part of the IJB.

The council are proposing not to delegate the criminal justice service and keep it within CEC. They also propose not to delegate Chief Social Worker role as it is a statutory role. This post would report to CEC Chief executive and give advice to IJB.

The proposal is to merge CEC mental health Services with NHS Lothian services to manage as a single entity. The management of the services will not be devolved to the IJB at this point. Discussions are ongoing re the arrangements for Learning Disabilities and Substance Misuse services

9. Finance Updates

See attached "Financial Position to 30th September 2014"

Month 7 showed high transport costs which could be attributed to hospital location moves.

Staff have expressed concerns regarding procurement pricing and costs this is being taken forward by Michael Cambridge who is holding procurement road shows.

A.O.C.B

Nothing raised

10 D.O.N.M.

This is scheduled for 11th February 2015 at 9.30 a.m. in PMR Room, SMART Centre, AAH

MEETING	KEY ISSUES	ACTION
Midlothian CHP Sub Committee - 15 January 2015 Summary	Presentation on Young Carers Card	A presentation on the new Young Carer's Card was given. The card will be used by young carers to let all professionals know that they are undertaking a caring role.
	Integrated Care Fund	A report on the Integrated Care Fund Plan was considered. The Integrated care Fund will replace the Change Fund but it is targeted at services developments for people under 65 with long term conditions as well as older people. A plan for the fund has been submitted to the Scottish Government for approval.
	Midlothian Integration Scheme	A verbal report on the Integrated Care Fund Plan was provided. The Integration Scheme is now out for public consultation. An easy read version is available.
	Continuation of CHP beyond March 2015	NHS Lothian Board had agreed at a recent meeting that existing CHPs would be asked to continue in their current role after the 31 March 2015. This will ensure that there is continuing governance for all community health services until the Integrated Joint Board (IJB) goes live in June 2015. The Committee agreed to continue in its present role until the IJB takes over this role.
	Primary Care Premises Developments	A verbal update regarding Primary Care premises across Midlothian was given to the Committee. It was noted that it is critical that Midlothian H&SCP/Midlothian CHP seek to develop service responses which reduce the demand on primary care and use all of our collective resources to best effect.
	Performance Reports	The Sub Committee considered performance reports that had been circulated in advance of the meeting. A good performance is being maintained across all services.
	Public Partnership Forum	The Sub Committee were asked to consider the notes from the last PPF, which were tabled at the meeting. New style of PPF notes were very easy to read.

NHS LOTHIAN

Midlothian Community Health Partnership Sub-Committee
Thursday, 15 January 2015 at 14:00 - 17:00
Council Chambers | Midlothian House | Buccleuch Street | Dalkeith

MINUTES

Present:	Peter Johnston (PJ) - Chair	Chairman, Midlothian CHPs
	James Coghill (JCo)	Public Partnership Representative
	Andrew Duffy (AD)	Pharmacy Representative
	Cllr Catherine Johnstone (CJ)	CHAIR - Midlothian Council Representative
	Mandy MacKinnon (MMK)	Health Promotion Manager
	Eibhlin McHugh (EMcH)	Director of Health and Social Care
	Peter Quinn (PQ)	Public Partnership Representative
	Hamish Reid (HR)	Clinical Director ML CHP
	Allister Short (AS)	Head of Health
	George Wilson (GW)	Voluntary Sector Representative
Apologies:	Jane Cuthbert (JC)	Carers Action ML Representative
	Patsy Eccles (PE)	Lead Partnership Representative
	Julie Gardiner (JG)	Cares Action Group
	David King (DK)	Finance Business Partner
	Kaye Skey (KS)	Clinical Services Development Manager
In Attendance:	Helen Amos (HA) - Scribe	PA to Head of Health
	Julie Deeganwood	Assistant Programme Manager, NHSL
	Gail Stark	Midlothian Young Carers Project Worker

1.0 Apologies:
As above

Addition to agenda - Julie Deeganwood, Assistant Programme Manager, NHSL and Gail Stark, Midlothian Young Carers Project Worker in attendance at meeting.

Presentation on Young Carers Card
NHS Lothian in collaboration with Young Carers Services has obtained funding from Scottish Government to pilot a Young Carers Card in Midlothian. The card will be used by young carers to let all professionals know that they are undertaking a caring role. As part of the implementation of the scheme awareness training will be provided to professionals to ensure that they better understand the needs of young carers and are able to respond to them in ways that are supportive of their caring role while also ensuring that their caring role in not having a negative impact on their needs as children.

2.0 Minutes & Summary Notes of Previous Meeting
Accepted as an accurate record of meeting.

Actions:
Finance Training - it was agreed that this training would best be taken forward for the new Shadow Board rather than the CHP.

4.1 LUCS review
Request for an easy read version of the review. EMcH will follow this up.

5.1 Localities
EMcH updated the Committee on the proposal to have two localities in Midlothian (East and West). The

Scottish Government is increasingly empathising the need for professionals to strengthen joint working and engagement with local communities within localities. For the purposes of the Strategic Commissioning Plan the CHP will continue to focus on the east /west localities but will also look to develop engagement events around natural communities in Midlothian.

Prescribing - HR explained that the work of the prescribing group that the PPF had been involved in had been disbanded as this work is now incorporated into the "Effective Use of Medicines Group". PPF members to be invited to the group.

PQ asked that the Midlothian CHP should follow the example of the PPF and provide minutes that are easier to read.

3.0 Items for Decision

3.1 Integrated Care Fund

The Sub Committee considered a report which had been circulated before the meeting.

AS updated the Midlothian Sub Committee on the Integrated Care Fund Plan and noted the submission to Scottish Government on the proposed investments that would be taken forward under the fund.

The Scottish Government announced that additional resources of £100m will be made available to H&SCP in 2015-16 to support delivery of improved outcomes from H&SC Integration.

In following the previous funding allocation formula used for the Change Fund, the investment amount for Midlothian is £1.44m (1 year initially). This is an increase on the monies available through Change Fund. However, the scope of work is wider within the Integrated Care Fund.

The Midlothian Partnership has made significant progress in reshaping care for older people and will seek to build upon this in delivering improved outcomes for adults across health and social care through the Integrated Care Fund (ICF)

Decisions

The Committee noted the report.

4.0 Items for Discussion

4.1 Midlothian Integration Scheme

The Sub Committee considered a report which had been circulated in advance of the meeting.

The Integration Scheme is now out for public consultation. Over 40 comments have been received already. An easy read version of the Scheme is available.

Decisions

The Committee noted the report.

4.2 Continuation of CHP beyond March 2015

The Sub Committee considered a report which had been circulated in advance of the meeting.

NHS Lothian Board had agreed at a recent meeting that existing CHPs would be asked to continue in their current role after the 31 March 2015 when they could be dissolved. This will ensure that there is continuing governance for all community health services until the Integrated Joint Board (IJB) goes live in June 2015.

Children's Services NHS community services will not be delegated to the new IJB when it goes live. Instead it is anticipated that these services will be delegated to the IJB with Children's Social Work Service in April 2016.

However, they will remain part of the management responsibility of the Director of Health and Social Care.

The operational management of the service will be secured through this route. In terms of governance, it is anticipated that the Director will report into NHS Lothian Committee structures on Children's Services in Midlothian. Strategic Direction will be provided through the Community Planning Partnership Board and the Midlothian GIRFEC Strategic Group.

Professional leadership and governance will be delivered through the Chief Nurse function for the new partnership. .

Further detail on these arrangements will be provided prior to the IJB going live.

Decisions
The Committee agreed to continue its current governance function in relation to all community health services until the IJB goes live.

4.3 Primary Care Premises Developments
AS confirmed the increasing pressures experienced in primary care services year on year. This is a result of changing need in terms of an ageing population and people living longer with long term and increasingly complex health conditions. It has also arisen through a gradual shift in service design with a stronger emphasis on treatment at home and earlier discharge from hospital.

National policy supports the move of resources from Acute Hospital to Primary Care. However, this takes place in the wider context of shrinking public finances and workforce shortages including GPs, care workers and an ageing community nursing workforce.

Given this situation, http://www.invictusgroup.co.uk/.

Capital Investment - As part of the move to strengthen and expand Health Centre facilities in Loanhead and Gorebridge, consideration is being given to how to design improved arrangements for access to appropriate care. Initial agreement confirmed by F&R Committee and working to full business case for consideration in May 2015. Further developments to support improvements and capacity will be brought forward for consideration by NHSL, in terms of Penicuik, Danderhall and Newbattle. The direction of travel in Midlothian, supported by General Practice, is to support an extension to existing capacity to manage increased demand rather than introduce a new practice to the area.

JC asked why the Newbattle Practice does not provide District Nursing (DN) support. AS explained that the DN Service works in clusters across a number of GP practices. This is to create bigger areas of working and should not present access difficulties for patients.
AS will look into JC's concerns and feedback.

Decisions
The Committee noted the report.
AS will respond to JC on issue raised in relation to DN service

5.0 Performance Reports

5.1 Finance Report
The Sub Committee considered a report which had been circulated in advance of the meeting.

- Projecting an overspend of over £400,000. This has been caused by prescribing pressures - these have been raised with NHSL and the Scottish Government;
- Some unfunded posts, these will come to an end and put us in a better position;

- LRP should be delivered across Midlothian. There has been a huge amount of work carried out across Midlothian;
- LRP for next year is a moving target. Just under £900,000, the service must deliver a balanced budget. There will be challenging times ahead for the organisation;
- The problem with prescribing is due to an ageing population and more illnesses and the offer of more treatments, also medications increasing over the cost of inflation;
- Most prescribers are trying to prescribe within their budgets, but sometimes there is no easier solution. It was noted that NHSL is one of the best prescribing boards in Scotland.

Decisions
The Committee noted the report.

5.2 Head of Health Report
The Sub Committee considered a report which had been circulated in advance of the meeting.

AS updated members and highlighted some issues across Community Nursing and how these are being managed.

Key Points:-
- **District Nurses (DN) Service** - recruitment is an issue with an ageing workforce and further retirements in the coming year. Will continue to manage the situation as vacancies arise;
- Recruitment of Band 6 DN continues to present problems;
- NHS Lothian Innovation Board agreed to support the move towards mobile IT solutions for the DN Service across Lothian, allowing DN's to update records when out and about.

- **Review of Occupational Therapy -** how can it work across both Health and Council, an opportunity for us to improve this area.

- **MH & OP services** Midlothian Community Hospital had an unannounced visit by the Mental Welfare Commission to Glenlee Ward in November 2014. The visit report has now been received, it includes eleven recommendations which must be addressed. The Welfare Commission are looking for an update on the actions by 14 April 2015.

- **Dietetics** - Obesity is a challenge for NHSL, support for early intervention.
- A 2 year Scottish Government funded initiative to support Lothian wide for people with BMI >30;
- A Business case for the ongoing tiered model (children and adults) is in draft. £20K Health Foundation grant secured to support hard to reach population, working with Football Fans In Training and Hearts, Hibs and Livingston football clubs plans for these to start in Jan 2015.

- **Physiotherapy Service** - Longest wait is 7 weeks, still delivering less than 12 weeks, but still looking to reduce this.

- **Psychological** Therapies - struggling to make progress in this area, concerns about waiting times in excess of 18 week target. Work locally with psychological therapies to address this.

Decisions
The Committee noted the report.

5.3 Clinical Director's Report
The Sub Committee considered a report which had been circulated in advance of the meeting.

Prescribing
The wide range of prescribing work which is going on across Midlothian and across Lothian; the core aim is to maintain our position as an organisation which is responsible for high quality and

cost effective prescribing.

This requires a multi-disciplinary approach with input from and joint working between GP's, GP Practice Staff, Community Pharmacies, Primary Care Pharmacy Staff, Finance, Management and our Patients. The real cost savings generated by this work are of benefit to all in the system. The Midlothian Prescribing Intervention Project (MEPIP) has generated savings of approx 53K this year.

X-ray Service
X-Ray Service at Midlothian Community Hospital has been available since March last year with 5 mornings a week 09:30 - 13:00 Monday - Friday. The service has proved popular with good uptake. Radiology colleagues have indicated that recently demand for the service has exceeded available appointment capacity on occasions. AS has commenced a dialogue with management colleagues in Radiology regarding this.

Lothian prescribing plan, range and depth of work across all of Lothian and in Midlothian. Need to consider how to use this money to the most beneficial way for patients, but not growing year on year.

JC advised that PPF can support by raising awareness to the public regarding prescribing.

Decisions
The Committee noted the report.

5.4 Joint Health Improvement Partnership
MMcK reported key highlights from the JHIPs Q3 progress report:

- Mitigating the impact of welfare reform: Ninety frontline staff in Midlothian have attended briefing sessions and provided with tools to support and refer individuals affected by welfare reform.

- Building capacity in Midlothian community organisations
  a) To increase access to fruit and vegetables;
  b) Increase the number of people who know how to cook healthy meals on their budget. A further six community organisations are now taking an active role in the delivery of these objectives;
  c) Development of a Community Empowerment Project (hosted by MVA).

Next steps for the JHIP include implementing the NHSL Health Inequalities Strategy locally in Midlothian. This includes working closely with the HSC Partnership to strengthen the role in mitigating health inequalities using Health Scotland's Health Inequalities Framework.

Decisions
The Committee noted the report.

The Chairman advised the Sub Committee that this would be Mandy MacKinnon's last attendance at the CHP Sub committee in her current role. On behalf of the Sub Committee he thanked her for her assistance and wished her good luck in her new role at Waverley Gate.

6.0 Carers Forum

6.1 No representative present.

7.0 Public Partnership Forum

7.1 The Sub Committee were asked to consider the notes from the last PPF, which were tabled at the meeting. New style of PPF notes were very easy to read.

He also reported that Peter Gilfoyle attended the last meeting and the PPF were very happy that

they were updated with what is happening in Midlothian.

The Newtongrange Community Council receives regular updates from the PPF at its meeting. This is a good way to keep the community updated.

8.0 Midlothian Partnership Forum

A report from the Partnership was noted.

Decisions

The Committee noted the report.

9.0 AOCB

There will be a new publication "Business Directory" for Newtongrange. This is another way of getting information to the community.

10.0 Date of 2015 Meetings:

19.03.15 @ 14:00 - 17:00 in Council Chamber, Midlothian House, Buccleuch Street, Dalkeith
21.05.15 @ 14:00 - 17:00 in Council Chamber, Midlothian House, Buccleuch Street, Dalkeith

Meeting finished at 15:40

*** = paper attached** **V = verbal report** **# = paper to follow** **P = presentation**

West Lothian

Community **H**ealth and **C**are **P**artnership

MEETING	KEY ISSUES	ACTION
West Lothian CHCP Board 3 February 2015	Health and Social Care Integration	Draft Integration Scheme noted and consultation exercise underway.
	Integration Joint Strategic Plan	Noted requirement to develop Strategic Plan and establish a Strategic Planning Group.
	Integrated Care Fund	Noted the new fund that would be set up from April 2015.
	Review of Lothian Unscheduled Care Service	Approved the terms of the report and that a report would be brought back to Board at the conclusion of that project.
	Care Governance	Noted the good performance, high standards and positive inspection reports for Children & Family services from January to December 2014.
	Financial Governance	Noted information regarding financial performance to 31 December 2014.
	Staff Governance	Noted Council Staff Health Profiles, Smoke Free Lothian proposals and Mentally Healthy Workplace
	Director's Report	Noted SG timescales in relation to Community Justice delivery, new Food for Thought course, Reablement and Crisis Care inspection and examples of award-winning work.
	Clinical Governance	Terms of report noted.

DRAFT

MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 3 FEBRUARY 2015.

Present – Frank Toner (Chair), Brian Houston, Jane Houston, John McGinty, Anne McMillan, Ed Russell-Smith

Apologies – Janet Campbell

Absent – Alison Mitchell

In Attendance – Jim Forrest (CHCP Director), Marion Christie (Head of Health Services), Carol Mitchell (Assistant Director of Finance, NHS Lothian), Dr Elaine Duncan (Clinical Director); Ian Buchanan (PPF)

1. ORDER OF BUSINESS

The Chair ruled in terms of Standing Order 13.2 that Agenda Item 12 (Clinical Governance) would be taken in private at the end of the meeting, since its consideration may involve disclosure of sensitive personal information regarding the general practice concerned.

2. DECLARATIONS OF INTEREST

Councillor Frank Toner declared a non-financial interest as he was the council's appointment to the Board of NHS Lothian as Non-Executive Director.

3. MINUTE

The Board approved the minute of its meeting held on 9th December 2014 as a correct record.

4. CHCP RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decision

To note and agree the Running Action Note.

5. NOTE MINUTE OF MEETING OF THE CHCP SUB-COMMITTEE

The Board noted the minute of the CHCP Sub-Committee held on 9th October 2014.

6. MINUTES OF MEETINGS OF THE PRIMARY CARE JOINT MANAGEMENT GROUP

The Board noted the minute of meeting of the Primary Care Joint Management Group held on 13th November 2014.

7. HEALTH AND SOCIAL CARE INTEGRATION

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director presenting the draft West Lothian Integration Scheme that had been produced in line with the Public Bodies (Joint Working) (Scotland) Act 2014 for information and providing an update on activity to progress the consultation exercise on to the draft Scheme.

The report recalled the background to the Public Bodies (Joint Working) Scotland Act 2014 which established the legal framework for integrating health and social care in Scotland. It also provided an overview of the requirements on local authorities and health boards to delegate some of their functions to the Integration Authority.

The Act allowed local authorities and health boards to integrate health and social care services in two ways; Option 1 Corporate Body or Option 2 Lead Agency. The draft Integration Scheme for West Lothian had been developed on the basis of Option 1, which was the preferred approach being taken in almost all areas across the country.

The report explained that the minimum local authorities and health boards had to delegate was broadly adult social care services, adult community health services and a proportion of adult acute services. The Act prescribed what health and social care services must and may be integrated under the legislation. The Act limited the functions in the must do list to services provided to people over the age of 18. The Draft Integration Scheme for West Lothian had been prepared on the basis that only the prescribed functions and services would be delegated. Separate governance arrangements would have to be agreed for those services not delegated.

The Draft Integration Scheme had been approved to go out to consultation by the Council Executive on 22 December 2014 and by Lothian NHS Board on 14 January 2015. The Draft Integration Scheme would now undergo a period of consultation with a prescribed list of consultees as set out in the regulations. The consultation period would run from 15 January to 20 February 2015.

Following the consultation period, the revised Integration Scheme would be brought back to Council Executive and Lothian NHS Board prior to formal submission to the Scottish Government by 31 March 2015 for approval by Scottish Ministers.

Decision

To note the draft Integration Scheme and consultation exercise underway relating to it.

8. INTEGRATION JOINT STRATEGIC PLAN

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director advising of the requirement on the Integration Joint Board to develop a Strategic Plan and outlining the process to be followed.

The report recalled the requirements of the Public Bodies (Joint Working) (Scotland) Act and explained how the regulations required the Integration Joint Board to establish a strategic planning group, which would be involved throughout the process of developing, consulting on and finalising a Strategic Plan.

The development of the Strategic Plan must be clear about the national and local outcomes to be delivered and must include the formal establishment of locality arrangements for the partnership area. The arrangements would draw together professionals, staff, the third and independent sectors, carers and services users to lead the planning and delivery of services for their local community, based on their experience and knowledge of local needs and feed the detail into the Strategic Plan.

The report emphasised that the Integration Joint Board would not assume responsibility for the planning, resources and operation delivery of all integrated services until such time as the Strategic Plan and locality arrangements had been prepared and were considered fit for purpose by the Health Board and Local Authority. To avoid unnecessary delay, the Strategic Planning Group would be established at the earliest opportunity.

Decision

To approve the contents of the report.

9. INTEGRATED CARE FUND

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director advising of the West Lothian partnership submission to the Scottish Government's Integrated Care Fund.

The report recalled that the Scottish Government had announced that additional resources of £100m would be made available to health and social care partnerships in 2015-16 to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen the approach to tackling inequalities. The resource would build upon the Older People Challenge Fund which would continue as planned until April 2015. The allocation to West Lothian from the additional resources would be £2.85m; which

represented an increase of more than £1m in the Older People Change Fund.

The new Integrated Care Fund would be accessible to local partnerships to support investment in integrated services for all adults. Funding would help partnerships to support investment in integrated services for all adults and allow them to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity was common in adults under 65, as well as in older people. The Integrated Care Fund would include strands that would lead to reduced demand for hospital emergency hospital activity and hospital admissions.

Like the Older People Change Fund, the Scottish Government expected local partnerships comprising NHS, local authorities, third sector and independent sector to develop a local Integrated Care Fund plan and to oversee its delivery. The Integrated Care Fund Plan for West Lothian, which was based on the Reshaping Care for Older People partnership, was provided as an appendix to the report.

The partnership proposed to take a programme management approach to the Integrated Care Fund Plan. Information on the four main work streams that would be used to develop and implement strategic change were listed in the report. The work streams would review current arrangements and performance with a view to advising on the short term investments to be made within the Integrated Care Fund and making recommendations on the most efficient way to ensure critical activity could be sustained following the end of the Integrated Care Fund. The report emphasised that expenditure for many of the activities within the programme budget were supplemented from mainstream revenue budgets.

The Board noted that arrangements for monitoring and scrutiny of progress and performance would be developed in line with the review of integration structures and processed and would be embedded within community and locality planning mechanisms.

Decision

To note the terms of the report.

10. REVIEW OF LOTHIAN UNSCHEDULED CARE SERVICE

The Board considered a report (copies of which had been circulated) by the Head of Health Services inviting consideration of the Review of Lothian Unscheduled Care Service report published by NHS Lothian in August 2014.

The report had been commissioned to understand how Lothian Unscheduled Care Service contributed to unscheduled care delivery and identify opportunities to develop the role. The report explained that a previous review had focussed on an aspiration for further integration and

how in contrast, the August 2014 review had pragmatically suggested a rebranding and a focus on core business, with core business being defined as providing urgent medical care in the Out of Hours period, i.e. a Primary Care Out of Hours Service.

The report explained how LUCS provided out of hours care for 70% of the week yet there was a lack of recognition and engagement in decisions made about the out of hours period. At the heart of the review was the changing nature of Primary Care in hours, and national and local GP shortages. A range of actions were proposed to differentiate NHS Lothian and strengthen the value of career development of urgent medical care out of hours to address that. New national standards for Primary Care Out of Hours services would provide a valuable benchmark. There was a pressing need to strengthen clinical management structures in LUCS. There was also a requirement to consider whether the service could continue to sustain the number of four day weekends, with consideration to be given to ending the four day weekend and introducing a separate one day holiday.

The report provided the board with an overview of the consultation that had taken place including extensive engagement with staff and internal stakeholders. Three general staff meetings had also been held to discuss the findings of the review. A summary of the points raised by staff were given within the report.

The Board was asked to consider the conclusions arising from the report which were listed in the report and to note that the review would be discussed in the appropriate governance bodies including all CHP Sub Committees and that a final report would be submitted to the East Lothian Sub Committee following that.

Decision

1. To approve the terms of the report.

2. To note that the review would be discussed in the appropriate governance bodies including all CHP Sub Committee and that a final report would be submitted to the East Lothian Sub Committee following that.

3. To note that a report would be brought back to the Board at the conclusion of that project.

11. CARE GOVERNANCE

The Board considered a report (copies of which had been circulated) by the Head of Social Policy outlining the grades achieved by Children & Family services during the period January to December 2014.

The Board noted that the Care Inspectorate graded services as part of fulfilling their duty under section 4(1) of the Regulation of Care (Scotland) Act 2001 and published inspection reports to provide information to the public about the quality of care services. A list of the key principles which

the Care Inspectorate must exercise was provided in the report.

The report provided the board with an overview of the current grading scheme for inspections which had been introduced during April 2008 and explained the six-point grading system where scores ranged from 6 (Excellent) to 1 (Unsatisfactory).

A list of the Children & Families Services which had been inspected during the last year was provided in the report. An appendix to the report provided a breakdown of the grades achieved by each service.

The report concluded that the inspection had confirmed how well the council delivered social work services. The grades demonstrated a positive performance and gave reassurance that the needs of service users were being well met by high performing services.

Decision

To note the good performance, high standards and positive inspection reports for Children & Family services during the period January to December 2014.

12. FINANCIAL GOVERNANCE – 2014/15 REVENUE BUDGET – MONITORING REPORT AS AT 31 DECEMBER 2014

The Board considered a report (copies of which had been circulated) by the Head of Social Policy and Head of Health Services providing a joint report on financial performance in respect of West Lothian Community Health and Care Partnership (WLCHCP) based on figures for the period 31 December 2014.

The report advised that the anticipated out-turn for the CHCP council services was forecast to breakeven and the CHCP health services was forecast to have an overspend of £265,000.

Decisions

1. To note the information in the report regarding financial performance in the CHCP to 31 December 2014.

2. To note that the CHCP Council services outturn for the year was forecast to breakeven.

3. To note that the CHCP health services outturn for the year was expected to have an overspend of £265,000.

4. To note that service managers were taking management action to address areas of financial pressure within their own service area to ensure spend was contained within the budget available.

13. STAFF GOVERNANCE

The Board considered a report (copies of which had been circulated) by the Head of Social Policy and the Head of Health Services providing an update on staff issues within the CHCP.

The report explained that the council worked continuously to support employees to achieve and maintain health working lives which was illustrated through the attainment of the gold standard in the Scotland's Health Working Lives Initiative. The council promoted active health initiatives and encouraged effective management and support of employees who were experiencing ill health. The council, through elected members and the senior management team, accepted responsibility as an employer for the health, safety and welfare of its employees whilst at work.

The main activities to be undertaken in 2013/17 to achieve this priority outcome were provided in the report. In order to progress the activities, services were currently pulling together health profiles for staff within their area to ensure a more preventative approach could be taken to promote healthy lifestyles and reduce sickness absence.

The report then moved on to provide the Board with an update on the implementation of the NHS Lothian Smoke Free Policy which would be implemented from 31 March 2015. From that date, there would be no provision for smoking tobacco on any of NHS Lothian's grounds. The policy adhered to the core principles of smoke-free, a commitment to providing a health environment and protecting people from the harmful effects of passive smoking. The policy did not restrict the individuals' choice of whether to continue to smoke or not; it only restricted where and when people smoked.

In line with national guidance, Electronic Nicotine Delivery Systems (ENDS also known as E-cigarettes and vaporisers) that resembled cigarettes, cigars or pipes would be treated as if they were tobacco-containing products and banned from NHS grounds. Balancing the current evidence and seeking to uphold current smoking restrictions, the use of ENDS that did not resemble cigarettes would be permitted in grounds at a reasonable distance from buildings.

The policy would be made available on NHS Lothian HR Online and staff and the public would be informed of changes through an agreed publicity campaign. Staff would be able to discuss what the changes meant locally through road shows and local newsletters.

Finally, the report concluded with information on the Mentally Healthy Workplace Training for managers which was designed to encourage good practice in promoting positive mental health and wellbeing. The programmes were highly interactive and held over one day.

Decision

To note the information provided in relation to:-

1. Council Staff Health Profiles

2. Smoke Free Lothian proposals

3. Mentally Healthy Workplace

14. DIRECTOR'S REPORT

The Board considered a report by the CHCP Director (copies of which had been circulated) providing an update on key areas of work in which the partnership had been involved since the last meeting of the Board.

Decision

To note the information and work undertaken in relation to:-

a) The Scottish Government timescales relating to the future model for Community Justice delivery.

b) New 'Food for Thought' course.

c) Re-ablement and Crisis Care Inspection.

d) Award Winning Work.

15. PRIVATE SESSION

In accordance with the Chair's earlier ruling, the remaining item of business was taken in private.

16. CLINICAL GOVERNANCE

The Board considered a report by the Clinical Director providing details of a current situation with a General Practice in West Lothian.

The report advised that in September the West Lothian CHCP was notified of issues regarding the performance of a partner in a West Lothian GP practice. The issues centred on clinical practice and known health issues which could be affecting the doctor's performance. The CHCP had investigated the points raised and found the concerns to be valid. It also found practice systems to be poorly organised hampering the efficient running of the practice. In addition to the performance issues and health concerns, there had been a breakdown in the working relationships with other doctors at the practice and the remaining partner had submitted their resignation in December 2014.

Discussion had been held to discuss the future of the practice, which had circa 5000 patients. Continuity of care and patient safety were key to the discussions. Given the issues, consideration had been given to whether or not the doctor could continue to meet his contractual requirements. Although mechanisms for the withdrawal of a GP's contract existed, they were not straightforward and legal advice had been sought.

The CHCP had undertaken further work to assess the practice and had identified a development plan to support the improvements required. The doctor recognised the development needs of the practice and due to his personal circumstances, he had been considering a number of options for both himself and the future of the practice.

In order to facilitate his return to work, NHS Lothian had offered a package of support which would enable the doctor to return to project work and supported clinical practice when he was fit to do so. NHS Lothian would transfer the practice to section 2c status (management under the CHCP) for a period of time with a view to returning the practice to GMS (General Medical Standards) status after the development work had been carried out. The Lead GP for West Lothian and the West Lothian Practice Manager trainer would provide support to the practice on an in-house consultancy basis. The locum doctors at the practice had indicated that they would be prepared to stay on at the practice on salaried contracts with the CHCP which would ensure continuity of care and stability, allowing practice development work to progress.

Decision

1. To note the terms of the report.

2. To be assured that West Lothian CHCP, Primary Care Contracts Organisation, Central Legal Office and HR were working in collaboration to achieve the best outcome in the complex situation.

West Lothian

Community **H**ealth and **C**are **P**artnership

MEETING	KEY ISSUES	ACTION
West Lothian CHCP Sub Committee Meeting 12 February 2015	Early Years – Covalent Report	Terms of report noted together with the work being undertaken to improve results.
	Family Nurse Partnership (FNP)	Report on background of the service and progress made noted. Successful integration of the service into West Lothian area noted.
	Young Mother's Service Evaluation	Terms of report noted; communication and relationship with FNP noted. Concern expressed re the high number of domestic abuse cases. Support for continuation of work being undertaken.
	Psychology Of Parenting Evaluation	Terms of report and progress being made noted.
	Early Years Collaboration	Report along with progress and collaboration with other agencies noted.
	Early Learning & Child Care	Terms of report noted; service exceeding expectations.
	Concurrent Planning	Terms of report noted.
	Healthy Weight Report	Report and statistics noted. Healthy Families Healthy Children Programme in place with 19 schools participating.
	Community Planning Partnership Audit	Findings and recommendations noted.

West Lothian Council

NHS Lothian

West Lothian
Community Health and Care Partnership

DRAFT

Minutes of the West Lothian Sub Committee held on 12 February 2015 1400 – 1600,
Strathbrock Partnership Centre.

Present	Frank Toner (FT)	Chair, West Lothian CHCP
	Jim Forrest (JF)	Director, West Lothian CHCP
	Jennifer Scott (JS)	Head of Social Policy, WLC
	Alan Bell (AB)	Senior Manager, Community Care Support & Service
	Andreas Kelch (AK)	GP PCCF Rep
	Gill Cottrell (GC)	Chief Nurse
	Jane Kellock (JK)	Senior Manager, Children & Early Intervention
	Ian Buchanan (IB)	Public Partnership Forum Rep
	Mary Vest (MV)	H & WB Co ordinator
	Susan McKenzie (SMc)	S W Team Manager
	Paula Huddart (PH)	Group Manager EY & EI
Apologies	Marion Christie (MC)	Head of Health / General Manager, WLCHCP
	Lindsay Seywright (LS)	West Lothian College
	Chris Stirling (CS)	SJH Site Director
	Elaine Duncan (ED)	Clinical Director CHCP
	Lorraine Gillies (LG)	Community Planning Development Manager
	Mary-Denise McKernan (MMc)	Manager, Carers of West Lothian
	Jane Houston (JH)	Partnership Lead
	Alistair Shaw (AS)	Head of Service WLC
	Pat Donald (PD)	Acting AHP Manager
	Moira Niven (MN)	Deputy Chief Executive
	Julie Cassidy (JC)	Public Involvement Co-ordinator
In Attendance	Marjory Brisbane	Admin Manager (Minutes)

1. APOLOGIES
As above.

2. ORDER OF BUSINESS INCLUDING NOTICE OF URGENT BUSINESS
As agenda

3. ANY OTHER BUSINESS FOR TODAY
No other business notified.

4. DECLARATION OF INTEREST
FT declared he is chair of the CHCP and non executive member of NHS Lothian.

5. DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE
The minutes of the meeting held on 18th December 2014 were approved as being an accurate record.

6. CONFIRMATION OF ACTION POINTS
Action points confirmed

ACTION

7. MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING
No minutes available. Minutes to be circulated to members prior to next Sub Committee

8. MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP
Noted minutes of 13/11/14

9. MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT
No minutes

10. MINUTES OF COMMUNITY PLANNING STEERING GROUP
Noted minutes of 12/08/14

11. EARLY YEARS – COVALENT REPORT
JK talked to the report stating there are 17 indicators covering the Early Years Life Stages work. JK ran through relevant indicators raising various points. NHS data under infant mortality rate was out of date it generally takes months to obtain this data and difficult to record up to date figures. Breast feeding is lower than the Scottish Government target but work continues to improve this. Nursery attendance is good but work is being undertaken to improve the 9% that do not attend. Healthy weight remains stable, lower weight figures are decreasing but obese figures are increasing. A report on Healthy Weight is on the agenda to be discussed further.

The Sub Committee noted the report

12 FAMILY NURSE PARTNERSHIP (FNP)
GC talked to the report giving a background to the service and update on progress. NHS Lothian were a test site for the project commencing in Jan 2010 looking at early intervention approach to help the intergenerational cycles of poverty, deprivation and poor outcomes in people's lives. The project was rolled out in March 2013 to West Lothian. Eligible clients are identified through maternity TRAK and the total number of clients enrolled is 142. 109 completed the pregnancy phase, 5 have left the programme during pregnancy phase, 18 have completed the programme in infancy phase 6 left in infancy phase, no toddlers have left the programme in the toddler phase giving a total attrition rate of 7.6% the target is 40% or less. There are currently 3 FNP team with another team commencing in July 2015 and another in July 2016. FNP has successfully integrated in to the West Lothian area working closely with the Young Mothers' Service.

AK asked if this service was in addition to health visiting support. GC confirmed FNP was a supplementary service to health visiting up until 2 years old.

The Sub Committee noted the report

13. YOUNG MOTHERS'S SERICE (YMS) EVALUATION
PH talked to the report stating it was evidence based programme providing support to young mothers under 20 for as long as required. Studies have shown that outcomes for mothers under 20 and their children have shown to be poorer than those of older parents. The young mother service was set up at the same time as the FNP was rolled out and was extended to any young mother not meeting the FNP criteria, refusing or not engaging with the FNP and also includes young mothers up to the age of 25 with additional need of mental health problems, domestic abuse, substance misuse or former Looked After Children. Two major developments of the service include a more rigid screening of domestic abuse and the results have shown rates unexpectedly high of 75%. The second

development has shown rates of breastfeeding in this age group are traditionally low and difficult to raise. The young women in the YMS has devised a wristband for wearing whilst in labour showing their intention to breastfeed alerting this intention to maternity staff.

This service works well with the FNP with good communication and working relationships with regular management meetings and frequent collaboration.

The Sub Committee noted the positive report and the concern for the high numbers of domestic abuse and supports the continuation of the work being undertaken.

ACTION

14. PSYCHOLOGY OF PARENTING EVAULATION

PH talked to the report stating this is a government sponsored project and West Lothian was selected as a Phase 1 Implementer site by NHS Education Scotland. This first year of the project has now been completed. In West Lothian 450 interventions took place in partnership with nurseries, health visitors and social work using the strength and difficulties questionnaire. In year one 217 caregivers enrolled in the programme with 63% from high deprivation areas and a high level of female carers. Almost ¾ measured the highest score for challenging behaviour. A high proportion (83 %) had an improved score on completion of the programme, 37 children moved out of high risk. The majority of referrals were made from nursery schools and health visitors. Thirty seven staff are now trained across different agencies to deliver the programme providing capacity for a higher number of referrals.

The Sub Committee noted the report.

15. EARLY YEARS COLLABORATIVE (EYC)

JK talked to the report providing an update on the progress of West Lothian participation in the Early Year's Collaborative which has targeted smoking cessation in pregnant women, reducing child poverty, improving the transition experience of children moving from nursery to primary school, improving attachment through evidence based interventions and the implementation of systematic screening for domestic a sexual violence. Three workstream have been set up with leads across NHS and education services. Practitioners across NHS, council and voluntary sectors are linked together to test out innovative changes in practice and are now looking further at how these changes can be tested and implemented across a broader scale. The EYC, FNP POPP are working together providing a whole population approach.

The Sub Committee noted the report.

16. EARLY LEARNING AND CHILD CARE

PH talked to the report highlighting the progress of the development and uptake of the new provision of free education and childcare for Looked After two year old (LAC2s). This service has supported more children than expected with an initial estimate of 16 – 20 but supported 33 last year. In January 2014 extension of the service was announced to include 'vulnerable' two year olds with funding from August 2014. This has proved positive for families taking up the places but there have been challenges around providing evidence of eligibility for the support. By January 2015 a total of 146 people had contacted the Council regarding the service and 49 children have taken up places, 7 through child minding, 20 in council establishments and 22 placed in playgroup.

The Sub Committee noted the report

17. CONCURRENT PLANNING

SMc talked to the report advising the Sub Committee of the concurrent planning project being undertaken in partnership with West Lothian Council, The Centre for Excellence for Looked After Children in Scotland (CELCIS) and St Andrew's Children's Society.

ACTION

The purpose of the project is to achieve early permanent accommodation for young children who are looked after or accommodated away from home either by returning them home or settling to live with another family permanently. Referrals are received pre birth at 20 weeks pre birth assessment. Concurrent planning is a simple concept that requires to be supported by detailed, robust and complex processes. Babies from families identified as a very high risk will at birth be placed with a carer who is register as a foster carer and also as an adopter. These will be families who have previously had children permanently removed from home. The families will consent to the concurrent plan and agree to a programme of intensive work and support. If after this programme it is still deemed unsafe to return the child home the foster carer will become the adoptive parents. This will take place around 4 ½ months of age of the child.

The Sub Committee noted the report

18. HEALTHY WEIGHT REPORT

JK talked to the report providing statistics on the low birth weight of babies, underweight, overweight, obese and healthy weight of children in West Lothian. The statistics highlighted a higher number of low birth weight children than the Scottish average. There has been a rise in overweight children but a reduction of underweight children between the years of 08/09 to 12/13. Joint working is taking place within the Early Years Collaborative with a specific focus of work stream 1 being to reduce low birth weight.

MV provided an update on the Healthy Families Healthy Children programme funded by NHS. There have now been 19 schools in total taken part in the programme which focuses on the importance of a balanced diet and physical education to promote healthy weight children.

The Sub Committee noted the report.

19. COMMUNITY PLANNING PARTNERSHIP AUDIT

JF talked to the Community Planning Audit summary of finding and recommendations on behalf of Lorraine Gillies, asking members if they had any questions these would be noted and taken back to the CPP to answer.. No questions were raised at the meeting.

The Sub Committee noted the finding and recommendations

20 . ANY OTHER COMPETENT BUSINESS

The meeting closed at 3.30pm

DATE, TIME OF NEXT MEETINGS

CHCP Sub Committee meetings at 2pm – 4pm in Strathbrock Partnership Centre.

16th April 2015
11th June 2015 to be re-arranged

.

NHS LOTHIAN

2.1

Board Meeting
1 April 2015

Chief Officer

SUMMARY PAPER - WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

The key points of the paper are summarised here.

A total of 649 patients were beyond the treatment time guarantee at end of February with 564 treated in the month beyond the expected 12 weeks.	**3**
Outpatients over 12 weeks numbered 3621 at the end of February.	**4**
18 week performance from referral to treatment for February remained stable at 85.6%.	**5**
Both 31 and 62 day performance against Cancer were above 95% across the final quarter of 2014 as whole.	**6**
An improvement in the number waiting over 6 weeks for a diagnostic endoscopy at the end of February to 791. 42 radiology patients also exceeded this 6 week standard and predominately were waiting for an ultrasound scan.	**7**
42 patients were waiting beyond the standards in place in audiology at the end of February.	**9**
The forthcoming standard for IVF continues to be met.	10
Numbers waiting in Child and Adolescent Mental Health over 18 weeks are reducing (February actual: 446), aiming to meet the standard - as described previously to the Board - by May.	11
Psychological Therapy performance is covered separately on the agenda.	12

Andrew Jackson
Information Services
24 March 2015
andrew.c.jackson@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
1 April 2015

Chief Officer

WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

1 Purpose of the Report

1.1 The purpose of this report is to update the meeting on recent performance on waiting times.

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

2 Recommendations

2.1 It is recommended that the Board receives this update is received on performance and progress on inpatient, outpatient and other waiting times.

3 Inpatients and Daycases

3.1 Table 1 outlines the number of patients waiting beyond the waiting time standard at month end. At the end of February 649 patients who had waiting more than 12 weeks remained on the waiting list with 564 treated in month beyond the guarantee (Table 2).

Table 1 – Treatment Time Guarantee Patients waiting beyond standard at month end.

Specialty	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Plastic Surgery	137	120	142	128	122	150	191	188	162	181	195	255	212
Urology	142	108	111	127	134	138	140	134	122	109	68	63	108
Orthopaedic Surgery	32	13	28	28	32	20	42	34	51	64	49	89	107
ENT	46	26	28	42	19	11	20	34	33	34	48	74	81
Maxillofacial	35	35	28	30	22	28	34	37	39	35	30	41	52
Colorectal/General	61	39	46	56	57	70	76	55	35	39	18	14	27
Paediatric ENT	22	7	9	20	12	13	16	19	21	15	14	16	21
Ophthalmology	146	42	60	38	31	24	32	16	15	10	11	22	10
Others	64	24	64	106	63	46	17	15	8	11	14	18	31
TOTAL	**685**	**414**	**516**	**575**	**492**	**500**	**568**	**532**	**486**	**498**	**447**	**592**	**649**

Table 2 – Treatment Time Guarantee Patients seen beyond 12 weeks.

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
TTG Patients treated over 12 weeks	528	574	443	533	476	388	402	467	448	397	427	406	564

3.2 As will be known, there are some patients admitted as inpatients and daycases who are not included within the Treatment Time Guarantee. This numbers were not available at the time of writing and will be included in the next report.

3.3 Figures on list size and unavailability are shown in the following table. The use of unavailability and choice codes in Lothian remains low.

Table 3 – List Size and Unavailability

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Total List Size (TTG)	9884	9555	9445	9256	9252	9307	9534	9842	9841	9832	9961	9600	9481
Available	8842	8400	8260	8016	7891	8000	8322	8697	8810	8733	8784	8714	8576
Unavailable	1042	1155	1185	1240	1361	1307	1212	1145	1031	1099	1177	886	905
Percentage Unavailable	11%	12%	13%	13%	15%	14%	13%	12%	10%	11%	12%	9%	10%

4 Outpatients

4.1 Across NHS Lothian 3621 were over 12 weeks at the end of February, figures in key specialties are shown in the table below.

Table 4 – Trend in Outpatients over 12 weeks – Key Specialties

Specialty	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Orthopaedic Surgery	71	25	16	24	29	84	169	152	223	408	459	647	775
Colorectal/General Surgery	380	164	127	131	176	152	256	226	305	352	288	506	596
Ophthalmology	542	231	273	323	361	425	395	407	362	288	285	335	481
Urology	178	67	12	29	54	41	28	121	248	339	358	378	339
Gynaecology	60	4	12	53	75	110	123	74	71	98	112	341	284
ENT	185	59	66	174	314	305	551	447	446	292	295	272	269
Neurology	263	123	131	166	218	224	203	284	340	380	455	355	261
Gastroenterology	557	409	402	351	350	339	328	259	288	263	198	210	252
Community Child Health	35	2	3	11	12	9	8	22	36	24	66	115	144
Vascular Surgery	111	4	3	1	2	3	8	3	7	6	6	49	65
Dental Institute	219	16	43	96	253	n/a	n/a	114	7	32	17	39	20
Others	1247	899	969	1151	1038	888	676	426	383	220	133	144	135
TOTAL	3848	2003	2057	2510	2882	2580	2745	2535	2716	2702	2672	3391	3621

4.2 Figures on list size and unavailability are shown in the following table.

Table 5 – List Size and Unavailability[1]

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Total List Size	40691	40970	40808	42481	42480	43738	43091	42624	43955	43004	42639	41721	42861
Available	39786	40021	39837	41357	41169	42320	41854	41441	42808	42085	41527	41000	41987
Unavailable	905	949	971	1124	1311	1418	1237	1183	1147	919	1112	721	694
Percentage Unavailable	2%	2%	2%	3%	3%	3%	3%	3%	3%	2%	3%	2%	2%

5 18 Weeks Referral to Treatment Standard

5.1 The figure below shows the recent trend for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard up to the end of 2014. 90% compliance is expected. NHS Lothian remains below this expectation with 85.6% achievement during February.

Table 6 -Trend in 18 Week Performance and Measurement

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Patient journeys within 18 weeks (%)	84.7	85.2	86.0	86.4	85.9	86.1	86.0	86.1	87.3	85.9	86.3	85.1	85.6
Number of patient journeys within 18 weeks	11,861	12,797	12,552	12,742	13,178	12,947	12,573	13,415	13,877	13,042	11,811	12,044	11,838
Number of patient journeys over 18 weeks	2,135	2,217	2,044	2,003	2,164	2,098	2,044	2,163	2,014	2,137	1,873	2,103	1,996
Patient journeys that could be fully measured (%)	86.2	86.1	86.3	85.7	86.6	86.6	86.5	86.3	85.9	86.0	83.4	85.5	85.6

6 Cancer

6.1 Performance against cancer standards is shown in the following tables. Figures are January and February are currently being finalised.

6.2 Provisional information places both 31 and 62 day performance above the 95% across the final three months of 2014. Although the latter fell in 92.9% compliance in November, it was balanced out by the performance in the other two months.

[1] Figures may differ from those previously reported. These were drawn from national data warehouse to ensure compariability throughout.

Table 7 – Trend in Cancer Performance (31 days from diagnosis to treatment)

	Lothian Quarter Jul - Sep 14	Scotland Quarter Jul - Sep 14	Lothian October 2014	Lothian November 2014	Lothian December 2014
All cancer types	**97.9%**	**96.7%**	**98.2%**	**95.3%**	**97.4%**
Breast	100%	97%	100%	100%	100%
Cervical	97%	99%	100%	100%	100%
Colorectal	99%	98%	98%	97%	94%
Head & Neck	90%	97%	100%	92%	94%
Lung	100%	100%	100%	98%	100%
Lymphoma	100%	100%	100%	100%	100%
Melanoma	100%	98%	100%	100%	100%
Ovarian	100%	100%	100%	83%	100%
Upper GI	100%	99%	100%	100%	100%
Urology	94%	91%	90%	85%	91%
Eligible Cases	1017	5876	331	298	308
Excluded Cases	15	129	5	7	5
%age excluded Cases	1.5%	2.1%	1.5%	2.3%	1.6%

Table 8 – Trend in Cancer Performance (62 days from urgent referral to treatment)

	Lothian Quarter Jul - Sep 14	Scotland Quarter Jul - Sep 14	Lothian October 2014	Lothian November 2014	Lothian December 2014
All cancer types	**95.9%**	**93.5%**	**96.8%**	**92.9%**	**96.5%**
Breast	100%	97%	100%	100%	100%
Cervical	100%	95%	100%	100%	80%
Colorectal	95%	91%	88%	95%	86%
Head & Neck	84%	91%	100%	67%	100%
Lung	91%	94%	100%	100%	100%
Lymphoma	95%	93%	80%	71%	100%
Melanoma	93%	96%	100%	50%	100%
Ovarian	100%	99%	100%	50%	100%
Upper GI	96%	94%	100%	92%	100%
Urology	94%	87%	95%	88%	94%
Eligible Cases	466	3157	158	140	142
Excluded Cases	10	112	6	3	7
%age excluded Cases	2.1%	3.4%	3.7%	2.1%	4.7%

6.3 The tables also show the proportion of cases excluded from consideration. National guidance indicates that clinically complex patients, those declining treatment and those who die during treatment should not be incorporated into performance measures.

7 Diagnostics

7.1 The tables below show the breakdown on waits in both areas by diagnostic test reducing in February to 791 over 6 weeks.

7.2 In radiology, there was 42 patients were waiting over 6 weeks at the end of December, predominately for an ultrasound examination within the vascular lab.

Table 9 –Numbers over 6 week standard for Key Diagnostic Tests (Endoscopy)

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Colonoscopy	8	9	10	17	7	24	37	42	47	49	25	151	100
Upper Endo	13	9	21	24	14	20	13	29	41	72	36	261	288
Flexi Sig	13	8	4	4	14	36	21	39	19	17	13	99	115
Flexi Cysto	31	45	42	57	129	294	442	485	603	602	514	495	288
Total	**65**	**71**	**77**	**102**	**164**	**374**	**513**	**595**	**710**	**740**	**588**	**1006**	**791**

Table 10 – Numbers over 6 week standard for Key Diagnostic Tests (Radiology)

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
CT	1	0	0	0	0	1	0	0	0	0	0	0	2
MRI	5	2	1	0	1	4	2	0	1	0	1	1	0
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0
Ultrasound	0	0	0	0	0	0	0	1	7	21	67	90	40
Total	**6**	**2**	**1**	**0**	**1**	**5**	**2**	**1**	**8**	**21**	**68**	**91**	**42**

8 Surveillance Endoscopy

8.1 The number of patients waiting beyond their planned review date is outlined in the Table 14, with an increasing number waiting longer than their planned review date. Detailed DCAQ analysis has now been completed with improvement trajectories being finalised and implemented from April 1st.

Table 11 – Surveillance and Review Patients overdue appointment

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Colonoscopy	118	105	82	89	81	83	108	113	96	191	301	447	487
Upper Endo	54	58	52	53	42	57	55	51	71	99	125	206	279
Flexi Sig	16	15	23	22	16	18	20	19	17	18	35	58	80
Flexi Cysto	226	257	199	219	234	180	190	269	334	324	282	263	259
Other	48	32	34	56	49	33	37	39	59	34	62	105	93
Total	**462**	**467**	**390**	**439**	**422**	**371**	**410**	**491**	**577**	**666**	**805**	**1079**	**1198**

9 Audiology

9.1 An overall 18 week standard applies to audiology patients and such journeys are included with the 18 week figures covered earlier in the paper. In addition to this pathway standard, audiology services are expected to also meet stage of treatment targets for assessment and both treatment and hearing aid fitting.

9.2 These standards are set locally within an overall 18 week timeframe. Adult services elected to adopt 9 weeks for both elements, while paediatric services selected timeframes of 12 and 6 weeks.

9.3 Performance against these two standards for these services is shown in the tables below to the end of February and at the end of the year 42 were exceeding the standards set in these services.

Table 12 – Adult Audiology – Performance against Standard

		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Patients waiting for audiology assessment ***(first contact)***														
	Number waiting 9 weeks and over	**2**	**11**	**17**	**14**	**38**	**11**	**3**	**0**	**0**	**0**	**111**	**174**	**5**
	Total number waiting	1648	1730	1677	1619	1599	1735	1516	1608	1464	1662	1939	1710	1683
Patients waiting for fitting of hearing aid														
	Number waiting 9 weeks and over	**4**	**21**	**33**	**33**	**108**	**45**	**3**	**1**	**0**	**26**	**215**	**177**	**2**
	Total number waiting	842	901	944	1001	1051	931	983	995	1007	1024	978	886	789
Patients waiting for other treatment ***(excl. hearing aids)***														
	Number waiting 9 weeks and over	**1**	**0**	**2**	**0**	**2**	**4**	**4**	**4**	**0**	**8**	**15**	**27**	**6**
	Total number waiting	113	105	105	42	92	126	96	67	84	116	121	115	117

Table 13 – Paediatric Audiology – Performance against Standard

		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Patients waiting for audiology assessment ***(first contact)***														
	Number waiting 12 weeks and ove	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total number waiting	240	228	220	264	216	142	144	101	168	238	189	161	229
Patients waiting for other treatment ***(excl. hearing aids)***														
	Number waiting 6 weeks and over	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**17**	**29**
	Total number waiting	30	40	50	3	7	12	6	8	7	38	47	50	71

10 IVF

10.1 90% of those receiving IVF treatment are expected to be within 12 months by March 2015.

10.2 NHS Lothian is currently meeting this standard and using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland.

10.3 Publication of this provisional information has now commenced nationally. The numbers waiting at month end since July are outlined below and excludes those patients waiting to be seen on behalf of other centres.

Table 14 – IVF Waiting List

	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Numbers waiting	296	277	252	242	196	192	192	190
Numbers over 12 months	2	2	2	2	3	2	0	0

11 CAMHS

11.1 The waiting times and trajectory for CAMHS is detailed in Table 18.

Table 15 – CAMHS Performance Trend

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Percentage seen within 18 weeks	75%	67%	67%	67%	63%	69%	57%	52%	53%	51%	50%
Trajectory for seen within 18 weeks	85%	85%	85%	88%	88%	88%	90%	90%	90%	90%	90%
Total waiting at end of month	1,537	1,542	1,547	1,553	1,565	1724	1,680	1,678	1,784	1,651	1,699
Those waiting more than 18 weeks	462	503	508	514	601	623	526	492	494	428	446

11.2 Table 19 details the performance of the generic outpatient teams against the agreed monthly trajectory for patients waiting over 18 weeks, which was agreed in the June Board paper.

Table 16 – CAMHS Generic Team Performance – Over 18 weeks

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Predicted	519	526	465	405	345	285	225
Actual	601	559	535	435	390	344	362

11.3 At the end of February there were 137 more patients waiting over 18 weeks than predicted. It should be noted that there has been a 6.4% increase in referrals in 2014 compared to 2013 which was not assumed in the trajectory and in the last quarter of 2014. The performance against the trajectory will continue to be monitored via the agreed capacity planning cycle with action being taken as required.

12 Psychological Therapies

12.1 The position in psychological therapies is covered elsewhere on the Board's agenda.

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Information Services
24 March 2015
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NHS LOTHIAN

2.2

Board Meeting
1 April 2015

Medical Director/Nurse Director

SUMMARY PAPER - QUALITY REPORT

This paper summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

	Para
• The number of formal complaints remains fairly stable (excluding prisons Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. The response rate at 20 days and 3 days remains a challenge (graphs 1 & 2).	3.1.1 and Graphs 1-4
• HSMR – None of the three acute hospitals are a statistical outlier; all are below one and have seen reductions from the October-December 2007 baseline.	3.1.2 and Graphs 7-9
• Staff absence levels (Graph 6) are over 4% (5.5%) which appears to reflect seasonal variation, but appears to be increasing over a six-month period.	3.1.3 and Graph 6
• The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). Healthcare Associated Infection is a separate agenda item and paper.	3.1.4 and Graphs 11&12
• A number of reports on the Board agenda examine in more detail delayed discharges, A&E 4 hour waits, Cancer 62 day waits and compliance with stroke standards which remain a challenge.	3.1.5 and Graphs 5,17,18 & 19-21

Jo Bennett
Clinical Governance & Risk Manager
10 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Medical Director/Nurse Director

QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for February 2015, to provide assurance on the quality of care NHS Lothian provides.

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

2 Recommendations

2.1 Review the quality dashboard and exception reporting to inform assurance requirements, (context and technical appendix are set out in Appendix 1).

3 Discussion of Key Issues

3.1 Exception Reporting – Quality Dashboard

3.1.1 The number of formal complaints remains fairly stable (excluding prisons Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. The response rate at 20 days and 3 days remains a challenge (graphs 1 & 2).

3.1.2 Since December 2009, Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP). The aim of the Scottish Patient Safety Programme is to reduce hospital mortality by 15% by December 2012 compared to baseline of 2007. This has been extended to a national aim of a 20% reduction by December 2015. The publication in November 2014 is for the period April to June 2014.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties (medical and surgical). The calculation takes account of patients who died within 30 days from admission; that is, it includes deaths that occurred in the community (out of hospital deaths) as well as those occurring in-hospital. It excludes deaths that occur more than 30 days after admission whether in hospital or not.

Hospital Standardised Mortality Ratio (HSMR) = Observed Deaths / Predicted Deaths. The prediction is based on data from SMR01 returns. The purpose is to adjust observed mortality for the underlying risk of death at the time of admission (Graphs 7-9).

Key Points:

- The current values and change from baseline are in Table 1 below
- None of the three acute adult hospitals is a statistical outlier and all are below 1.

Table 1

	HSMR Oct-Dec 2007	**HSMR July-Sept 2014**	**Change from baseline**
Scotland	1.00	0.85	-16.3%
RIE	0.87	0.73	-17.7%
St John's	0.88	0.75	-8.9%
WGH	0.74	0.66	-11.6%

3.1.3 Staff absence levels (Graph 6) are over 4% (5.5%) which appears to reflect seasonal variation, but appears to be increasing over a six-month period.

3.1.4 The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). Healthcare Associated Infection is a separate agenda item and paper.

3.1.5 A number of reports on the Board agenda examine in more detail delayed discharges, A&E 4 hour waits and compliance with stroke standards which remain a challenge.

Quality Dashboard – February 2015 (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focussing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.
If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

QUALITY AMBITION

PERSON-CENTRED - Process Measures
20-day Complaints Response Rate *
3-day Complaints Response Rate *
Delayed Discharges and Average Length of Stay *

PERSON-CENTRED - Outcome Measures
Number of Complaints (excluding HMP Healthcare) *
Number of Complaints for HMP Healthcare *
Staff Absence Levels *
Patient Experience
Staff Experience

SAFE – Outcome Measures
Hospital Standardised Mortality Ratios for RIE, WGH & St. John's *
Incidents with harm *
C. Difficile Numbers *
Staph. Aureus Bacteraemia Numbers *
Number of Cardiac Arrests *
Rate of Cardiac Arrests *
Inpatient Falls with Harm *
Inpatient Pressure Ulcers Grade 2 or above *

EFFECTIVE – Process Measures
A&E 4 Hour Wait *
Cancer Waits 62 Days from Diagnosis to Treatment
Admission to stroke unit on day or day after admission *
Stroke Treatment Measure: CT Scan *
Stroke Treatment Measure: Swallow Screen *

Additional Quality Measures

Hospital Scorecard: January – March 2014

Indicator	Lothian Rate (Per 1000 admissions)	Scottish Rate
Standardised Surgical Readmission rate within 7 days	23.83	21.73
Standardised Surgical Readmission rate within 28 days	43.30	40.22
Standardised Medical Readmission rate within 7 days	48.36	51.88
Standardised Medical Readmission rate within 28 days	115.19	112.69
	Lothian	**Scotland**
Average Surgical Length of Stay – Adjusted	0.95	1.00
Average Medical Length of Stay – Adjusted	1.10	1.00

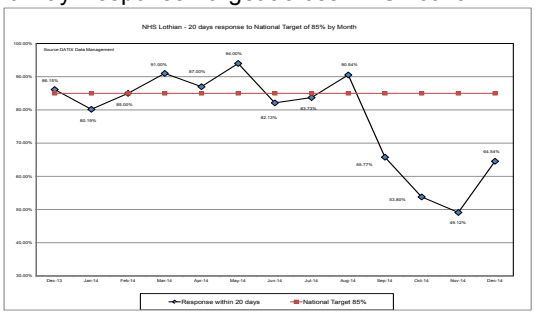
Person-Centred

"Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making."

Title:	20-day Complaints Response Rate (Graph 1)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	85% of complaints responded to within 20 days

Process Measure

20-Day Response Target across NHS Lothian

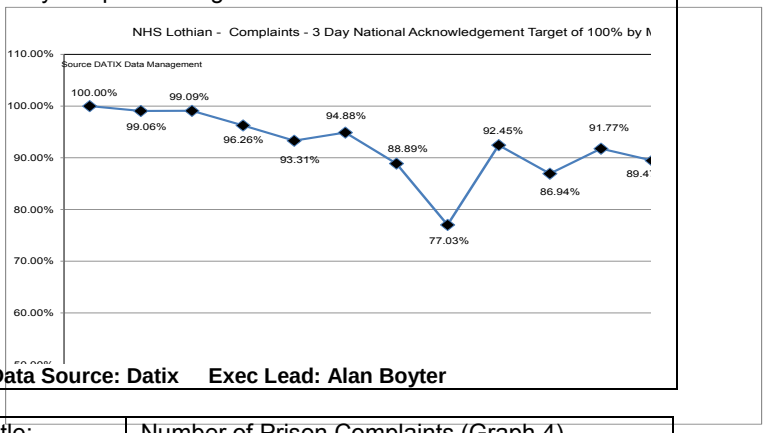


Data Source: Datix Exec Lead: Alan Boyter

Title:	3-day Complaints Response Rate (Graph 2)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	100% formal acknowledgement within 3 working days

Process Measure

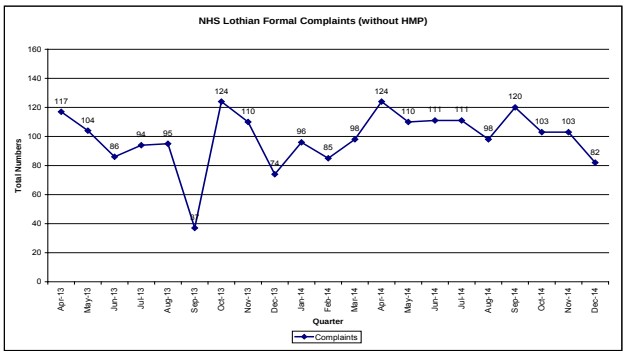
3-Day Response Target across NHS Lothian



Data Source: Datix Exec Lead: Alan Boyter

Title:	Number of Complaints (excluding Prison Complaints) (Graph 3)
Numerator:	Total number of complaints
Goal:	Reduction in number of formal complaints

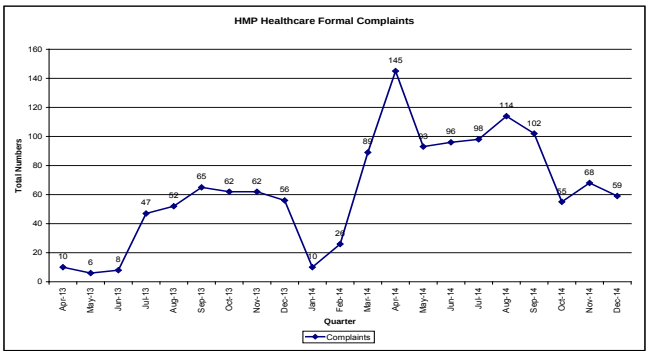
Outcome Measure



Data Source: Datix Exec Lead: Alan Boyter

Title:	Number of Prison Complaints (Graph 4)
Numerator:	Total number of prison complaints
Goal:	Reduction in number of formal complaints

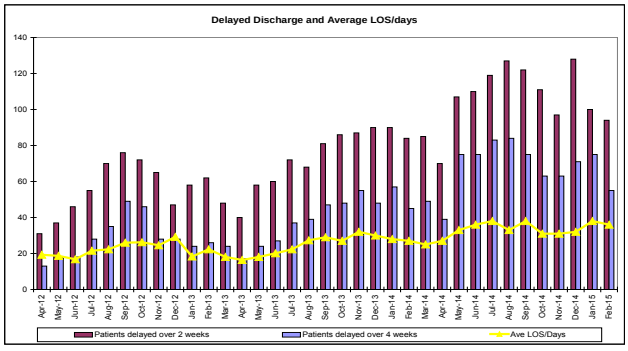
Outcome Measure



Data Source: Datix Exec Lead: Alan Boyter

Title:	Delayed Discharges & Average Length of Stay (Graph 5)
Goal:	No patient waiting longer than 2 weeks for discharge, by April 2015

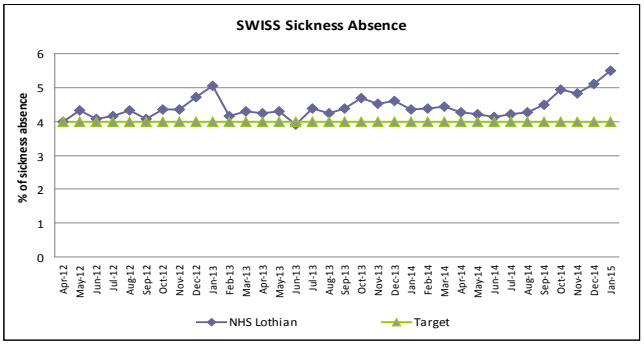
Process Measure



Data Source: Local data captured on EDISON shared data with Health & Social Care Exec Lead: Melanie Johnson

Title:	Staff Absence Levels (Graph 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

Outcome Measure



Data Source: Scottish Workforce Information Strategic Systems (SWISS) Exec Lead: Alan Boyter

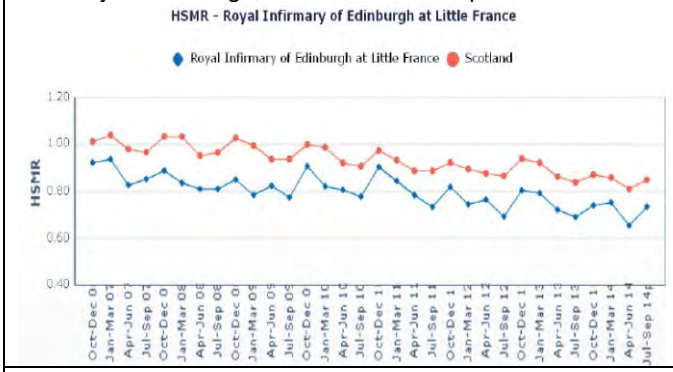
Safe

"There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times." Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, HAI indicators, arrest calls, falls with harm and pressure ulcers.

Title:	Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Graphs 7 – 9)
Numerator:	Total number of in-hospital deaths and deaths within 30 days of discharge from hospital
Denominator:	Predicted total number of deaths
Goal:	20% reduction against 2006/07 baseline by December 2015

Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – September 2014



Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – September 2014

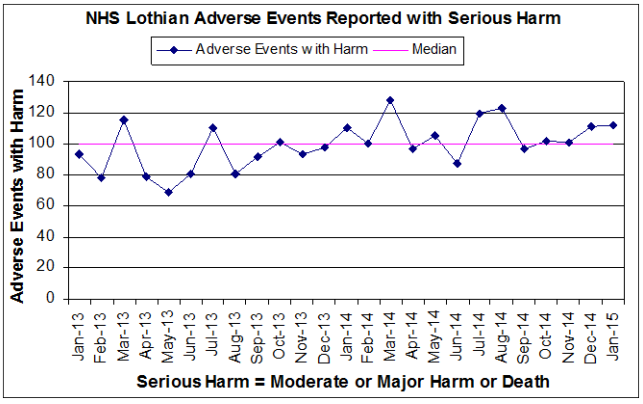
Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in St John's Hospital, October 2006 – September 2014

Data Source: ISD (Quarterly) Exec Lead: David Farquharson

Title:	Incidents with harm (Graph 10)
Numerator:	Number of incidents associated with serious harm reported per month in NHS Lothian (Dec 2011- Nov 2013)
Goal:	There are specific goals for reductions in Falls & Pressure Ulcers. See separate graphs for progress against these.

Outcome Measure

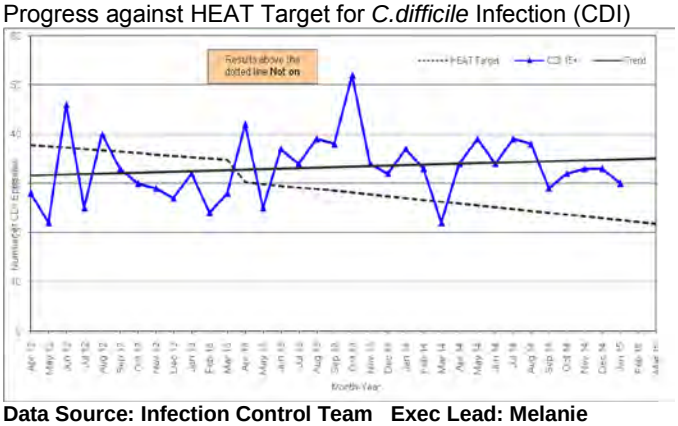


Data Source: Datix Exec Lead: David Farquharson

Title:	C. difficile associated disease against HEAT Target 2012-13 (Graph 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve 262 or fewer CDI by March 2015 as shown by trend line.

Outcome Measure

Progress against HEAT Target for *C.difficile* Infection (CDI)



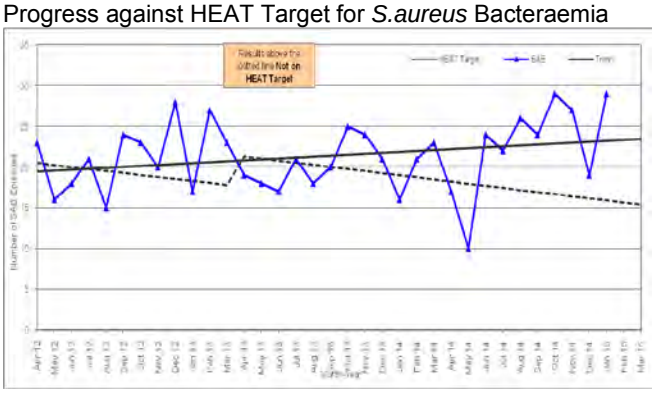
Data Source: Infection Control Team Exec Lead: Melanie Johnson

Safe (cont'd)

Title:	Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 12)
Numerator:	The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)
Goal:	NHS Lothian is to achieve 184 or fewer SABs by March 2015 as shown by trend line.

Outcome Measure

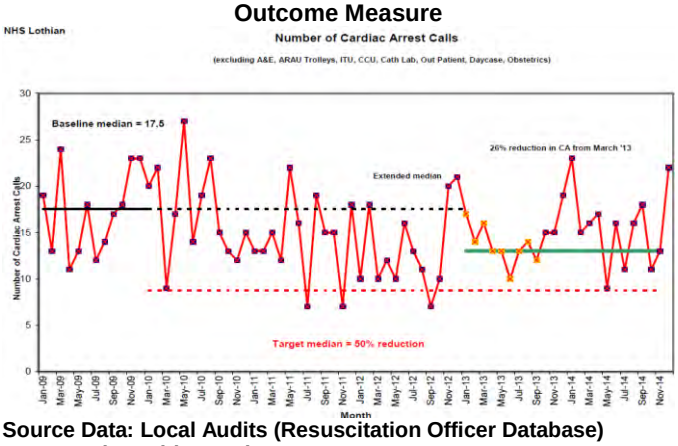
Progress against HEAT Target for *S.aureus* Bacteraemia



Data Source: Infection Control Team
Exec Lead: Melanie Johnson

Title:	Number of Cardiac Arrests (Acute Wards) (Graph 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

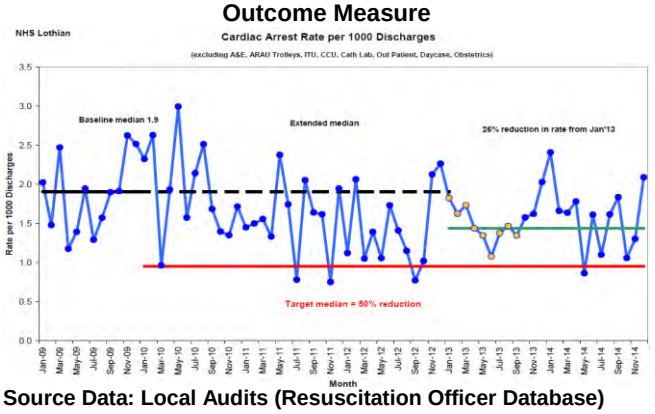
Outcome Measure



Source Data: Local Audits (Resuscitation Officer Database)
Exec Lead: David Farquharson

Title:	Rate of Cardiac Arrests (Acute Wards) (Graph 14)
Numerator:	Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

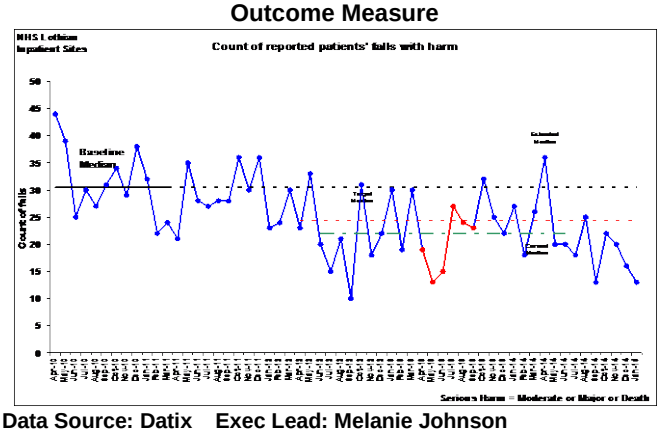
Outcome Measure



Source Data: Local Audits (Resuscitation Officer Database)
Exec Lead: David Farquharson

Title:	Patient Falls with Harm (Graph 15)
Numerator:	Number of falls reported resulting in moderate or major harm or death (define moderate/ major). Data for NHS Lothian inpatient sites
Goal:	20% reduction in inpatients falls and associated harm by December 2015

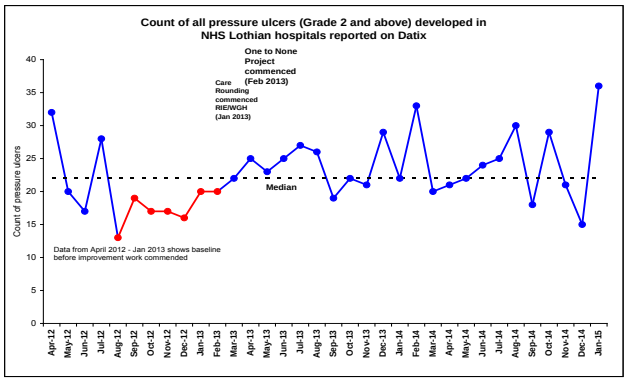
Outcome Measure



Data Source: Datix Exec Lead: Melanie Johnson

Title:	Number of Pressure Ulcers per month across NHS Lothian (Graph 16)
Numerator:	Number of Grade 2 or above pressure ulcers
Goal:	To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2015 (from one a day to none a day)

Outcome Measure



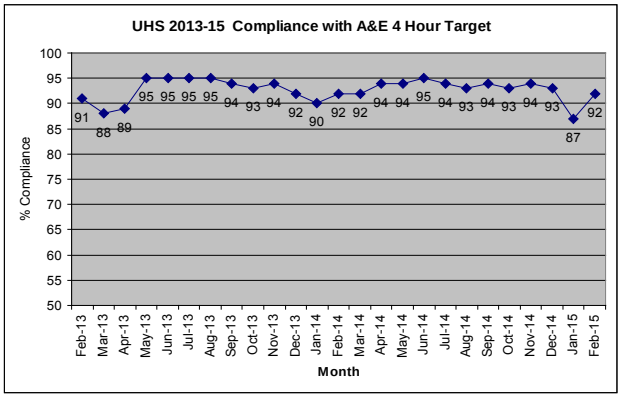
Data Source: Datix Exec Lead: Melanie Johnson

Effective

"The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated." Progress on this ambition is measured through clinical quality indicators and stroke care.

Title:	A&E 4 Hour Wait (Graph 17)
Numerator:	Number of patients waiting less than 4 hours from arrival to admission or discharge
Denominator:	Number of patients attending
Goal:	98% of patients waiting less than 4 hours from arrival to admission by March 2015

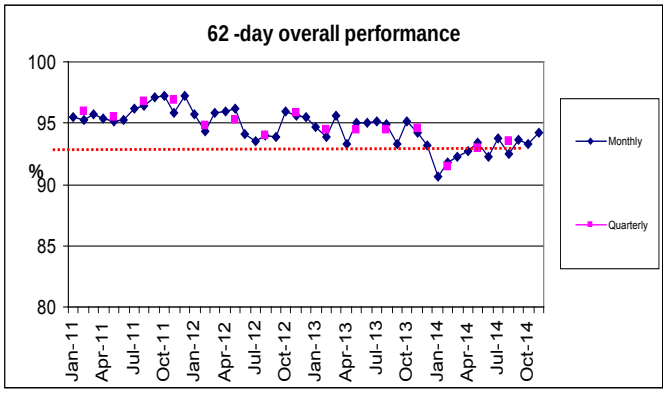
Process Measure



Data Source: Patient Administration System (TRAK)
Exec Lead: Melanie Johnson

Title:	Cancer Waits 62 Days from Diagnosis to Treatment (Graph 18)
Numerator:	Number of patients waiting 62 days to treatment Please note the scale
Denominator:	Number of cancer patients
Goal:	95% of patients from diagnosis to treatment wait no longer than 62 days

Process Measure

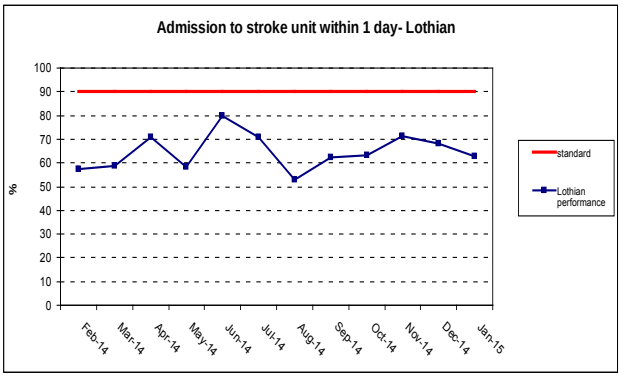


Data Source: SGHD Management Information
Exec Lead: Jim Crombie

Title:	Admission to Stroke Unit within 1 day of admission (Graph 19)
Numerator:	Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal:	90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional

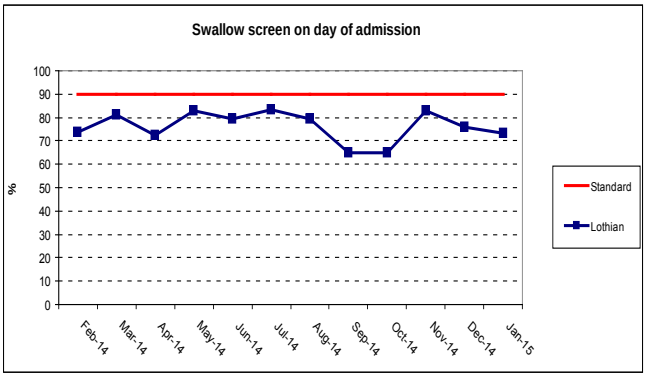


Lothian (57/91) = 62.6%
Data Source: ISD Exec Lead: Melanie Johnson

Title:	Stroke Treatment Measures (Graph 20)
Numerator:	Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional



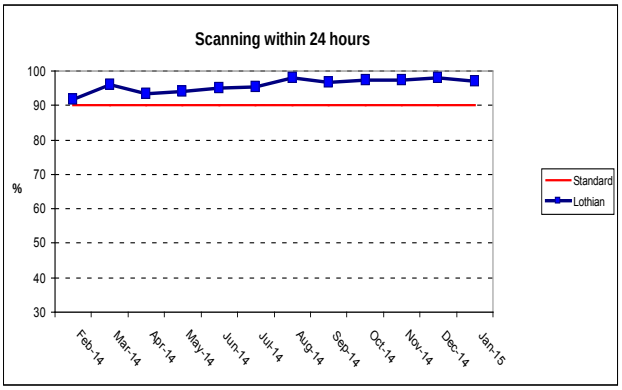
Lothian (77/105) = 73.3%
Data Source: ISD Exec Lead: Melanie Johnson

Effective (cont'd)

Title:	Stroke Treatment Measures (Graph 21)
Numerator:	Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional



Lothian (102/105) = 97.1%

Data Source: ISD Exec Lead: Melanie Johnson

4 Key Risks

4.1 Achieving the HAI HEAT target, complaints response times, stroke targets, delayed discharge target and cancer target.

4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.

4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

5 Risk Register

5.1 Achieving HAI targets is also on the Corporate Risk Register (Risk 1076) and its risk grading has been increased to reflect that NHS Lothian is outwith HAI trajectory. Access to Acute Stroke Unit is on the University Hospital Services Risk Register – Medicine and Associated Services (Risk 2444). Compliance with stroke standards is captured in Unscheduled Care on the Corporate Risk Register. Complaints Management is also captured on the Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.

6.2 This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).

6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

7 Involving People

7.1 No service change.

8 Resource Implications

8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.

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10 March 2015
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List of Appendices

Appendix 1: Supporting Context and Technical Appendix

APPENDIX 1

Context and Technical Appendix

Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland's quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian's Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

Hospital Standardised Mortality Ratio (HSMR)

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.

S.aureus Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.

***C.difficile* Infection (CDI) rate**
New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

Incidents associated with harm
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.

Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days
As for 7 day readmissions.

Medical Re-admissions Within 7 Days
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.
The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions Within 28 Days
As for 7 day readmissions.

Average Length of Surgical Stay (Adjusted)
Ratio of 'observed' length of stay over 'expected' length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty 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).

Average Length of Medical Stay (Adjusted)
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty 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).

* 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.

NHS LOTHIAN

2.3

Board Meeting
1 April 2015

Director of Finance

SUMMARY PAPER - FINANCIAL POSITION TO FEBRUARY 2015

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• The financial position for the year remains one of break-even, with further non-recurrent resources required to achieve this	2.1
• There has been a significant adverse movement in the month for prescribing, following the release of the December data. Consideration will require to be given to the potential impact once the local and national position is better understood	3.5
• In month delivery of LRP is improved with a small over delivery of £107k in February, bring the savings to date to £23835k against a target of £33589k	2.1

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24 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Director of Finance

FINANCIAL POSITION TO FEBRUARY 2015

1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the financial position for period 11 and the latest forecast outturn position for the financial year 2014/15.

1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 Members are asked to note the following:

- An in-month underspend of £168k is reported in February against the Revenue Resource Limit (RRL), bringing the year to date position to a £3,906k overspend, including unachieved LRP.
- This incorporates a significant adverse movement of £3m on the prescribing position in primary care, with further local and national work required to fully understand.
- LRP is reporting an in-month delivery of £3,738k against a target of £3,631k, leading to an over delivery of £107k in February. For the year to date, savings of £23,835k have been achieved against a target of £33,589k, bringing the year to date shortfall to £9,754k.
- A further £1.1m of reserves has been released in the month of February, (£12.1m year to date) in relation to the £13.2 non recurrent LRP requirement that was put in place to underpin the operational position.
- A review of all corporately held reserves and available flexibility at mid year resulted in a further £9,348k being identified to support the financial position, with £7,790k phased in for the year to date. In addition, based on advice from professional advisers, £5m of backdated rates rebate have been assumed in this year and is being phased in equally over the last three months of the year, with £1,666k released in month 11.
- The timing and implementation of some Financial Plan resources has allowed a further £1,388k of in year flexibility to be identified, with eleven months worth released in month to support the overall position.
- Based on a month 11 review, the forecast outturn estimate position remains breakeven at year end, with further non-recurrent resources required to achieve this.

3 Discussion of Key Issues

Overall Position

3.1 At period 11 of this financial year, NHS Lothian has overspent by £3,906k year to date against the Revenue Resource Limit. The RRL outturn position is summarised in Table 1 below with a detailed analysis by expenditure type attached in Appendix 1 and by operational unit in Appendix 2.

Table 1: RRL Financial Position to 28th February 2015

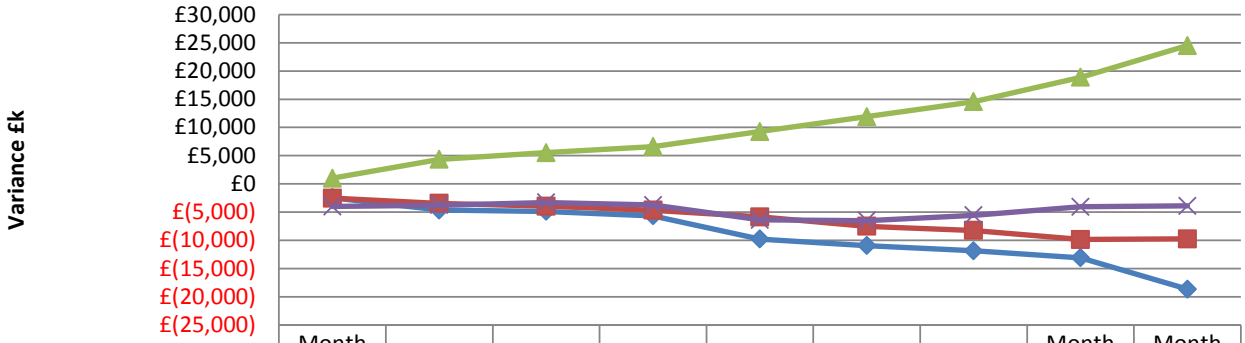
	Pay	Non Pay	Income	YTD	In Month
	£k	£k	£k	£k	£k
Baseline position	(871)	(25,497)	7,722	(18,647)	(5,534)
Outstanding efficiency savings		(9,754)		(9,754)	107
Non-Recurring Corporate LRP		12,100		12,100	1,100
General Reserves Flexibility per Mid Year Review		7,790		7,790	1,558
Release of Financial Plan Flexibility		1,272		1,272	1,272
Rates Rebates		3,333		3,333	1,666
Net operational position	**(871)**	**(10,757)**	**7,722**	**(3,906)**	**168**

3.2 In month, NHS Lothian underspent in total by £168k. A net overspend (before the inclusion of non-recurrent flexibility) of £5,427k is due to baseline overspend of £5,534k offset by a £107k benefit from LRP over-achievement. Offsetting this is a total of £5,596k of flexibility arising from non-recurrent LRP identified at the start of the year, additional flexibility identified at the Mid Year Review, and Rates Rebates assumed in-year. In addition, flexibility arising from financial plan and other resources identified in period 11 has allowed an additional £1,272k of support to be included in the position this month.

3.3 Despite the significant non-recurrent resources included this month, the year to date financial position has only shown a marginal improvement over the period 10 outturn, due to the deterioration in the baseline position in this month. This is largely driven by Prescribing, which has seen its overspend increase by £3,295k in the month, taking the cumulative position to £6,787k overspent. In addition, an in month overspend of £2.7m arising from Waiting Times activity for which no specific funding stream is available also contributed significantly to the baseline overspend. The Waiting Times expenditure had previously been anticipated in the year-end forecast.

3.4 Table 2 below shows the cumulative run rate of the core position, the variance against LRP Targets and the increasing level of reserves that have been released to support the operational position.

Table 2: Cumulative Run Rate



	Month 1-3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11
Core Variance	£(2,462)	£(4,653)	£(4,871)	£(5,667)	£(9,774)	£(10,932)	£(11,866)	£(13,113)	£(18,647)
LRP Variance	£(2,536)	£(3,458)	£(3,970)	£(4,674)	£(5,860)	£(7,506)	£(8,264)	£(9,861)	£(9,754)
Reserves Released	£1,000	£4,333	£5,533	£6,600	£9,258	£11,916	£14,574	£18,899	£24,495
Total	£(3,998)	£(3,778)	£(3,308)	£(3,742)	£(6,376)	£(6,522)	£(5,556)	£(4,075)	£(3,906)

Primary Care Prescribing

3.5 As noted above, Primary Care Prescribing is reporting an overspend of £6,787k to date which represents an adverse movement of £3,295k in the month. The increase arises from increases in December to both volume and prices. The volume growth for the year had been estimated at 2.5%, but after exceptionally high December volumes (reflected across Boards nationally) this has been revised to a 3.1% increase. Average prices remain higher than budgeted, principally due to short supply issues. Whilst this deterioration is significant, this is due to the delay in receiving data and the subsequent assumed impact projected into subsequent months. The year end forecast has been revised to a £7,600k overspend, an increase of £3,100k, and has a significant impact on the CHPs' forecast year end position. This is a material change to the prescribing position and consideration will need to be given to the potential impact on next year once the position is better understood both within Lothian, and nationally.

Waiting times

3.6 For the 11 months to date, £23.1m has been spent on waiting times against available resources of £20.4m, taking the year to date deficit to £2.7m. This impacts on the reported performance of the Scheduled Care business unit.

3.7 The waiting times overspend reflects the projected deficit identified at Mid Year Review. The updated year end forecast identified a potential £4m deficit on the basis of projected expenditure to the end of March and the current expenditure trend remains in line with this forecast.

3.8 Following discussions with SGHD a further £550k has been made available in support of TTG, contingent on delivery of a reduction in breaches against TTG performance at the end of March. Plans for this expenditure have not yet been finalised.

Income

3.9 Income is reporting an over recovery of £4.5m for February. This is generated from various sources of activity. The main drivers in month relate to the cumulative effect of an adjustment to the Road Traffic Accidents provision plus an adjustment in relation to the transfer of the Neonatal Transport Service. Further, some of the over-recovery against income is offset against an equal and opposite adjustment against admin costs relating to primary care adjustments. In year the main drivers relate to Transplant UNPACS which has experienced a high volume of non Lothian patients particularly around fulminant hepatic failure plus the over-recovery of income budgets within Corporate; Facilities Management and Non Lothian activity.

4 Update Forecast Outturn

4.1 A review of the forecast outturn position has been undertaken based on expenditure to February 2015. An outturn breakeven remains as the forecast for the year end, however there has been some movement against individual lines since the Quarter 3 Review.

4.2 Table 10 below provides a summary breakdown of the estimated outturn by business unit, including baseline variance and any shortfall against LRP. It shows the outturn forecast in comparison to the previous Quarter 3 forecast.

Table 3 - Forecast Outturn Movement

	Quarter 3 Position			Month 11 Forecast Position			Mvt Q3 to Mth 11		
	Baseline £000	LRP £000	Total £000	Baseline £000	LRP £000	Total £000	Baseline £000	LRP £000	Total £000
East Lothian CHP	36	(281)	(245)	(1,219)	(281)	(1,500)	(1,255)	0	(1,255)
Midlothian CHP	(69)	(104)	(173)	(496)	(104)	(600)	(427)	0	(427)
Edinburgh CHP	(5,373)	(1,426)	(6,799)	(7,097)	(1,426)	(8,523)	(1,724)	0	(1,724)
West Lothian CHCP	(78)	(187)	(265)	(209)	(187)	(396)	(131)	0	(131)
Scheduled Care	(7,567)	(5,564)	(13,131)	(6,493)	(5,564)	(12,057)	1,074	0	1,074
Unscheduled Care	(4,117)	(3,078)	(7,195)	(4,305)	(3,078)	(7,383)	(188)	0	(188)
Facilities & Consort	1,435	(46)	1,389	1,646	(46)	1,600	211	0	211
Corporate Services	1,166	(426)	740	1,764	(426)	1,338	598	0	598
Strategic Services	(322)	(147)	(469)	(2,098)	(147)	(2,245)	(1,776)	0	(1,776)
Operational Position	**(14,889)**	**(11,259)**	**(26,148)**	**(18,507)**	**(11,259)**	**(29,766)**	**(3,618)**	**0**	**(3,618)**
Additional Pressures:-									
Unscheduled Care	(3,000)	0	(3,000)	(1,515)	0	(1,515)	1,485	0	1,485
Waiting Times	(2,000)	0	(2,000)	(4,000)	0	(4,000)	(2,000)	0	(2,000)
SMC Drugs	(3,400)	0	(3,400)	(1,400)	0	(1,400)	2,000	0	2,000
Total Additional Pressures	(8,400)	0	(8,400)	(6,915)	0	(6,915)	1,485	0	1,485
Reserves & N/R Flexibility	26,903	0	26,903	36,681	0	36,681	9,778	0	9,778
NHS Lothian Forecast	**3,614**	**(11,259)**	**(7,645)**	**11,259**	**(11,259)**	**0**	**7,645**	**0**	**7,645**

4.3 The main areas of adverse movements since the Quarter 3 review are:

- An increased spend of £2m in achieving Waiting Times targets;
- Prescribing – an increase of £3.3m in prescribing has impacted on all the CHPs positions.
- East Lothian – assumed reductions in sickness absence levels have not occurred as expected along with higher than planned expenditure on step down beds resulting in a significant pressure within Roodlands Hospital. An emerging pressure within LUCS was also not anticipated.
- Strategic Services - finalising both the outward and inward service level agreements and agreeing contract exclusions with other health boards has identified a cost pressure of £1m.

4.4 This increased level of expenditure is offset by a reduction on the estimated unscheduled care level of investment of £1.5m, Scottish Government funding for drugs of £2m, review of provisions and allocations of £4.8m and the rates benefits previously mentioned of £5m.

4.5 NHS Lothian has a statutory requirement to deliver a breakeven outturn by the year end, therefore the necessary improvement in the operational position in month 12 will be required from a review of flexibility options including the requests for deferring of funding into next financial year.

4.6 Two key additional non-recurrent adjustments are required to be made to support the delivery of financial balance at the year-end. It should be noted that these costs are estimates at this stage. Firstly, NHS Lothian will undertake a review of provisions currently held within the Balance Sheet to identify flexibility – this is standard procedure as part of year-end processes. In addition, estimated flexibility for Invest to Save of approximately £1.6m which had initially been set aside to provide a resource for this programme in 2015/16 will now be used to support breakeven this year. This will have a financial implication for the Invest to Save programme next year.

4.7 Additional non-recurrent support will also be sought from requests for deferrals into the new financial year in order to make up the balance of resources required to achieve breakeven. These requests will be prioritised for carry forward based on commitment.

4.8 Within this revised forecast position there are a number of risks and assumptions that have been made to achieve a balanced outturn. These have been reviewed regularly to ensure there is no detriment to the forecast.

5 Property and Asset Management

5.1 Expenditure of £35.1m has been incurred to the end of February and the detailed programme for the year is shown in Appendix 3. Detail on the programme is routinely considered by the Finance and Resources Committee as is a review of all Business Cases.

6 Risk Register

6.1 There is nothing further to add to the Risk Register at this stage.

7 Health and Other Inequalities

7.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

8 Involving People

8.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

9 Resource Implications

9.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

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20 March 2015
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List of Appendices

Appendix 1: NHS Lothian Income & Expenditure Summary 28 February 2015
Appendix 2: NHS Lothian Summary by Operational Unit to 28 February 2015
Appendix 3: NHS Lothian Property & Asset Management Investment Programme

APPENDIX 1

NHS Lothian Income & Expenditure Summary to February 2015

Description	Annual Budget £k	YTD Budget £k	YTD Actuals £k	YTD Variance £k	Period Variance £k
Medical & Dental	225,598	205,461	204,385	1,077	248
Nursing	367,923	334,042	338,818	(4,776)	(22)
Administrative Services	79,723	72,471	71,763	708	369
Allied Health Professionals	60,823	55,680	54,311	1,369	348
Health Science Services	37,637	33,557	32,703	854	82
Management	10,468	9,611	8,993	618	26
Support Services	49,796	45,299	46,885	(1,586)	(144)
Medical & Dental Support	7,217	6,605	6,482	123	20
Other Therapeutic	24,461	22,559	21,477	1,082	123
Personal & Social Care	2,929	2,685	2,462	223	26
Other Pay	(7,213)	(6,466)	(5,922)	(544)	(42)
Emergency Services	9	8	27	(19)	(2)
Pay	**859,370**	**781,512**	**782,383**	**(871)**	**1,033**
Drugs	107,996	99,133	100,173	(1,040)	(352)
Medical Supplies	81,946	75,205	80,342	(5,137)	(361)
Maintenance Costs	5,830	5,293	6,572	(1,280)	(129)
Property Costs	38,525	34,642	32,103	2,540	632
Equipment Costs	27,036	24,053	26,606	(2,554)	(149)
Transport Costs	9,312	8,777	10,215	(1,439)	(103)
Administration Costs	100,968	65,137	66,832	(1,695)	(3,115)
Ancillary Costs	15,187	14,157	14,223	(66)	17
Other	(15,766)	(15,198)	(10,014)	(5,184)	(3,618)
Service Agreement Patient Serv	99,133	94,888	98,069	(3,180)	(1,052)
Non-Pay	**470,167**	**406,086**	**425,120**	**(19,034)**	**(8,231)**
Other Payments/Reimbursements	18	18	18	0	0
Gms2 Expenditure	115,936	98,546	98,090	456	447
Ncl Expenditure	3	2	(6)	8	0
Other Primary Care Expenditure	0	0	86	(86)	(10)
Pharmaceuticals	130,564	117,043	123,831	(6,787)	(3,295)
Primary Care	**246,521**	**215,610**	**222,019**	**(6,409)**	**(2,858)**
Bad Debts	4	4	59	(55)	1
Fhs Non Discret Allocation	(1,986)	(1,778)	(1,778)	1	(1)
Other	**(1,982)**	**(1,774)**	**(1,719)**	**(55)**	**(0)**
Total Non-Pay	**714,706**	**619,922**	**645,420**	**(25,497)**	**(11,090)**
Income	**(1,654,790)**	**(234,742)**	**(242,463)**	**7,722**	**4,523**
Sub Total Core Basline Position	**(80,714)**	**1,166,693**	**1,185,340**	**(18,647)**	**(5,534)**
Savings Target Non-Pay	(11,641)	(9,754)	0	(9,754)	107
N/R Corp Savings LRP	12,100	12,100	0	12,100	1,100
Additional Reserve Flexibility	7,790	7,790	0	7,790	1,558
Release of Financial Plan Flexibility	1,272	1,272	0	1,272	1,272
Rates Rebate	3,333	3,333	0	3,333	1,666
TOTAL	**(67,860)**	**1,181,433**	**1,185,340**	**(3,906)**	**168**

APPENDIX 2

NHS Lothian Summary by Operational Unit to February 2015

Description	Unscheduled Care £k	Scheduled Care £k	East Lothian CHP £k	Edinburgh CHP £k	Midlothian CHP £k	West Lothian CHP £k	Facilities And Consort £k	Corporate Services £k	Strategic Services £k	Total £k
Annual Budget	**222,578**	**391,467**	**79,264**	**305,021**	**53,587**	**119,577**	**135,877**	**88,101**	**(1,463,333)**	**(67,860)**
Medical & Dental	865	(400)	48	300	(41)	140	0	319	(155)	**1,077**
Nursing	(1,712)	(1,813)	67	(1,323)	128	(109)	(36)	23	(1)	**(4,776)**
Administrative Services	97	690	(33)	(45)	(80)	(102)	109	59	13	**708**
Allied Health Professionals	62	(525)	49	94	267	169	(4)	(23)	1,280	**1,369**
Health Science Services	219	372	13	219	3	130	0	(102)	0	**854**
Management	63	82	(35)	115	(8)	14	41	350	(4)	**618**
Support Services	(34)	(413)	(50)	(9)	0	15	(1,113)	20	(1)	**(1,586)**
Medical & Dental Support	(23)	(285)	0	0	0	392	0	39	0	**123**
Other Therapeutic	28	95	110	51	(27)	345	0	480	0	**1,082**
Personal & Social Care	2	(52)	(14)	55	3	0	25	204	0	**223**
Other Pay	(385)	(193)	(0)	(3)	0	0	46	(9)	0	**(544)**
Emergency Services	0	0	0	0	0	(13)	(5)	0	0	**(19)**
PAY	**(820)**	**(2,442)**	**155**	**(545)**	**246**	**979**	**(938)**	**1,360**	**1,133**	**(871)**
Drugs	(337)	(84)	20	(152)	(15)	(96)	(2)	(103)	(271)	**(1,040)**
Medical Supplies	(1,089)	(2,896)	(107)	(816)	46	(59)	(40)	(174)	(2)	**(5,137)**
Maintenance Costs	(174)	(364)	(51)	(128)	(24)	(33)	(447)	(49)	(9)	**(1,280)**
Property Costs	(14)	(22)	87	153	19	(81)	2,413	(3)	(12)	**2,540**
Equipment Costs	(1,228)	(787)	(91)	(349)	(16)	(109)	68	15	(57)	**(2,554)**
Transport Costs	(130)	(492)	(138)	(224)	(81)	12	(242)	(139)	(5)	**(1,439)**
Administration Costs	(401)	6	(3,198)	246	118	313	(46)	855	412	**(1,694)**
Ancillary Costs	23	115	(7)	35	(8)	41	(237)	(26)	(2)	**(66)**
Other	(542)	(3,254)	(1,325)	(543)	(206)	(111)	43	756	0	**(5,184)**
Service Agreement Patient Serv	(45)	(0)	(127)	(13)	10	(115)	(0)	(93)	(2,795)	**(3,180)**
NON PAY	**(3,939)**	**(7,777)**	**(4,937)**	**(1,792)**	**(156)**	**(240)**	**1,508**	**1,039**	**(2,740)**	**(19,033)**
Gms2 Expenditure	0	(12)	(30)	291	114	96	(0)	(2)	0	**456**
Ncl Expenditure	6	0	2	0	0	0	0	(0)	0	**8**
Other Primary Care Expenditure	0	(86)	0	0	0	0	0	0	0	**(86)**
Pharmaceuticals	0	(0)	(956)	(3,535)	(744)	(1,554)	(0)	2	0	**(6,787)**
Primary Care	**6**	**(99)**	**(983)**	**(3,245)**	**(630)**	**(1,458)**	**(0)**	**0**	**0**	**(6,409)**
Fhs Non Discret Allocation	2	0	7	(17)	0	(2)	0	11	0	**1**
Bad Debts	(4)	(51)	(4)	0	0	(1)	(2)	3	4	**(55)**
Other	**(2)**	**(51)**	**3**	**(17)**	**0**	**(3)**	**(2)**	**13**	**4**	**(55)**
SUB TOTAL NON PAY	**(3,935)**	**(7,926)**	**(5,918)**	**(5,054)**	**(786)**	**(1,701)**	**1,506**	**1,052**	**(2,735)**	**(25,497)**
INCOME	**137**	**2,513**	**4,376**	**(223)**	**(28)**	**(138)**	**366**	**736**	**(17)**	**7,722**
CORE POSITION	**(4,618)**	**(7,855)**	**(1,386)**	**(5,822)**	**(568)**	**(860)**	**934**	**3,149**	**(1,620)**	**(18,646)**
Savings Target Non-Pay	(2,508)	(5,349)	(395)	(1,320)	(43)	(127)	358	(359)	(12)	**(9,754)**
N/R Corp Savings LRP	0	0	0	0	0	0	0	0	12,100	**12,100**
Additional Reserves Felixibility	0	0	0	0	0	0	0	0	7,790	**7,790**
Release of Financial Plan Flexibility	0	0	0	0	0	0	0	0	1,272	**1,272**
Rates Rebate	0	0	0	0	0	0	0	0	3,333	**3,333**
TOTAL	**(7,126)**	**(13,204)**	**(1,782)**	**(7,142)**	**(612)**	**(986)**	**1,292**	**2,790**	**22,864**	**(3,906)**

APPENDIX 3

NHS Lothian Property & Asset Management Investment Programme – February 2015

	Agreed Programme £k	Expenditure to M11 £k	Remaining Anticipated Expenditure £k
INCOME			
SGHSCD Specific Funding	20,746		
SGHSCD Formula Funding	30,435		
SGHSCD Funding	**51,181**		
EXPENDITURE			
Rolling Programmes			
Projects Under £250k	1,780	715	1,065
Medical Equipment	4,965	2,374	2,591
Strategic Priorities (Ehealth)	2,013	1,086	927
Backlog Maintenance	5,032	2,696	2,337
Digital Radiology	85	85	0
Donated Schemes	677	315	363
NSD Schemes	352	81	271
SGHSCD Cancer Schemes	228	0	228
	15,133	**7,351**	**7,782**
Primary Care Sites			
Tranent Health Centre Extension	632	632	0
Blackburn Partnership Centre	285	38	247
Firhill Partnership Centre	817	44	774
North West Edinburgh Partnership Centre	876	500	376
Bundle Sub Debt Investment	0	0	0
Ratho GP Reprovision	3	7	(4)
Modernisation of GP Premises	187	130	57
	2,801	**1,350**	**1,451**
Integration			
Astley Ainslie Hospital Improvements	52	48	4
East Lothian Community Hospital	174	34	140
Liberton Quality Improvements	132	88	44
RVH Continuing Care	310	316	(6)
Rvh Integrated Care Facility	400	329	71
	1,069	**816**	**253**
Royal Edinburgh Campus			
REH Master Planning	545	527	18
REH Infrastructure Investment	1,188	1,189	(1)
REH Sub Debt Investment	1,232	1,232	0
Orchard Clinic Redwood Upg Reh	380	0	380
	3,345	**2,948**	**397**

	Agreed Programme £k	Expenditure to M11 £k	Remaining Anticipated Expenditure £k
Edinburgh Bioquarter Campus			
Consort Life Cycle Costs Rie	4,718	4,301	417
Rhsc Reprovision	13,419	9,660	3,759
LEPP RIE	427	431	(3)
RIE Additional Assessment Beds	212	157	55
Endoscopy Decontamination Unit RIE	150	73	77
RIE Additional Beds Wards 120/220	15	21	(6)
	18,941	**14,644**	**4,297**
Western General Campus			
Endoscopy Decontamination Unit WGH	70	(4)	74
WGH Expansion Of Ward 58	99	0	99
Aseptic Pharmacy Modernisation	711	190	521
WGH Front Door	3,245	2,986	259
WGH Masterplanning	196	104	92
Traffic Management (WGH)	100	0	100
CT Scanner WGH	8	2	6
Radiotherapy Phase 9	2,467	2,049	418
Rvh Ward 7 Recommission	5	5	0
	6,901	**5,331**	**1,569**
St Johns Campus			
MRI Scanner St Johns	2,229	2,169	60
Labour Ward St Johns	145	148	(3)
Burns Unit St Johns	39	0	39
Special Care Baby Unit St Johns	1,238	1,015	223
St Johns Hospital Masterplanning	30	20	9
Dental Decontamination St Johns	624	357	267
	4,305	**3,710**	**595**
Lauriston Campus			
Lauriston Masterplanning	27	17	10
	27	**17**	**10**
Other Schemes			
Erostering	444	0	444
Opthalmic Service	0	0	0
Woodburn House	1,166	1,160	6
Other Schemes	(900)	(1,312)	412
West End Medical Practice	(224)	(400)	175
Westerhailes Healthly Living Centre	(364)	(528)	165
	122	**(1,080)**	**1,202**
Total Gross Capital Expenditure	**52,644**	**35,087**	**17,556**
Donated Asset Capital Income	677		
Net Book Value of Receipts	873		
Total Net Capital Expenditure	**51,093**		
Total (Over) / Under Commitment	**88**		

NHS LOTHIAN

2.4

Board Meeting
1 April 2015

Director of Finance

SUMMARY PAPER - FINANCIAL PLAN 2015/16-2019/20

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• The paper presents the Financial Plan 2015/16-2019/20 to the Board following progress reports over the last few months, and scrutiny by the Finance & Resources Committee	3.1 & 3.2
• The Plan sets out how financial balance can be achieved for 15/16 utilising a combination of recurring, and non-recurring sources, reserves and LRP delivery	3.3
• Board members should note that in-year balance is only achieved by offsetting a recurring shortfall of £14m by non-recurring in-year support of £14m	3.3
• A number of risks are highlighted, including the current risk profile of the LRP programme, the impact of delayed discharges and capacity to deliver targets	4.4
• The Finance & Resources Committee approved the Financial Plan subject to further work underway to make assumptions on capacity explicit. The Committee will also be reviewing LRP plans and delivery in detail over the coming months, recognising the current risk profile of our LRP programme	3.2

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25 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Director of Finance

FINANCIAL PLAN 2015/16 - 2019/20

1 Purpose of the Report

1.1 The purpose of this report is to seek the Board's approval to the Financial Plan 2015/16 – 2019/20.

1.2 NHS Lothian's approach is to develop the Financial Plan for 2015/16 as an integral part of finalising the Local Delivery Plan (LDP) for the coming year. The Board has, through its meetings and development sessions, been provided with routine updates on the financial plan. This paper provides an update on the achievement of a balanced financial plan for 2015/16 and the outstanding issues which remain.

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

2 Recommendations

2.1 Approve the 2015/16 Financial Plan, recognising the inherent risks.

2.2 Note the indicative Financial Plan for 2016/17 to 2019/20.

3 Discussion of Key Issues

3.1 The Financial Plan for 2015/16 has been developed over a period of months with an initial view of the extent of the financial challenge, being a gap of £70m, considered by the Board in December 2014. Since then work has focussed on three areas: agreeing additional resource with Scottish Government colleagues in relation to the Barnett consequentials and Pharmaceutical Price Regulation Scheme (PPRS) benefits, identifying internal reserves, and non recurring sources of funds, and developing Local Reinvestment Programme (LRP) plans. Updates on progress have been provided to the Board and Finance & Resources Committee over the last four months.

3.2 The Finance & Resources Committee considered the final draft of the financial plan at its meeting on the 11 March 2015 (attached as Appendix 1) and agreed to recommend it for approval to the Board. This approval was subject to further work taking place to make assumptions in the plan on capacity explicit. This work is underway and will be considered by the Committee at the next meeting in May. The Finance & Resources Committee also will be reviewing LRP plans and delivery in detail over the coming months, recognising the current risk profile of our LRP programme.

3.3 The attached Financial Plan sets out how financial balance can be achieved in year: In summary:

- In year balanced plan with a recurring shortfall of £14m offset by non recurrent in year support of £14m to bridge this gap.

- Additional recurring commitments of £72.2m and non recurring commitments of £15.1m, plus a carry forward gap of just over £30m relating to cost pressures and undelivered LRP in 2014/15.

- Available recurring resources to support the plan of £73.5m, and non recurring sources of £19.3m, with the gap between resources and known commitments assessed at £30m. The Financial Plan assumes this level of cash efficiency savings will be delivered in year to offset this gap.

- Efficiency savings identified of around £31.5m against a total target of £48m across acute services, partnerships and corporate services.

- Work continuing to deliver additional savings and to reduce the level of risk associated with delivery of schemes.

- A five year plan based on available information which is not in financial balance again until 2018/19. Further work is required on this aspect of the plan.

3.4 In developing the financial plan for 15/16 there has been a parallel process to ensure that the impact of the financial plans is understood at Business Unit level in anticipation of the move to Integration. This shows that despite a strategic intention to shift the balance of care investment is weighted towards the Acute sector to support delivery of targets and access to medicines.

4 Key Risks and Issues

4.1 There are a number of risks and issues highlighted in the LDP in which the Financial Plan is incorporated. However given the extent of the challenge in delivering the Financial Plan it is important to emphasis the specific risks in relation to the Financial Plan.

4.2 The Financial Plan makes a number of assumptions around the achievement of breakeven in relation to income. Key assumptions around the plan are noted below:

Assumed allocations for which confirmation is yet to be received includes:

- PPRS Support - £12.5m. NHS Lothian has assumed this sum as its share of the £90m PPRS benefit. However, NHS Lothian has yet to receive confirmation of this resource. A further risk is its application, which is set against drug growth as well as a relatively low amount of SMC additional costs for next year. Communication from the Scottish Government (SG) has stated that this resource should be prioritised against orphan, ultra orphan, end of life medicines and Individual Patient Treatment Requests (IPTRs). We have received feedback from the SG that the assumptions made around the use of this resource are “reasonable”, however this remains a material risk.

- Waiting Times Funding - £5m. This is still to be confirmed by the SG. Until such time that this is received, this remains an assumed allocation and a risk.

- Additional Capital to Revenue - £2.689m. This benefit is assumed on the basis of asset sales in 2015/16.

- Technology Enabled Care - £807k.

- The five year Financial Plan assumes full National Resource Allocation Committee (NRAC) parity is achieved in 2016/17 with an additional recurring allocation of £12m. Although this is indicative at present it would support the Board's plans to mitigate the £14m recurring gap brought forward from 2015/16.

4.3 As well as the above assumed allocations, further internally generated resources have been included to get to a balanced position. This includes a number of high risk assumptions including:

- Profit on Asset sales - £1.744m
- Rates Rebates (over and above 14/15 recovery) - £6m

4.4 A number of further expenditure and LRP risks have been highlighted in the paper to the Finance & Resources Committee. These include:

- LRP - At this stage the LRP programme has identified savings of £32m against a total target of £48m. However, only £5.7m is defined as low risk. The financial plan assumption of delivery of £30m savings next year is a significant risk

- Month on Month balance - It is important to note that in completing the financial plan, there are a number of potential cost pressures which have been assumed as being 'manageable' at an operational budget level. As pressures on the delivery of LRP continue, the sustainability of this approach presents a risk to the organisation;

- Delayed Discharges - The plan requires a major reduction in the current level of delayed discharges, to enable the acute sector to achieve planned bed reductions included in the savings plan and improve unscheduled care. These bed closures are a mix of delayed discharge beds, with no recurring funding source, and those where redesign is underway to improve patient flow, avoid unnecessary delay, and move care closer to home. The current approved budget for the City of Edinburgh's Adult Social Care budget has been reduced for 2015/16 and this clearly presents a major risk in relation to delayed discharges and the bed closures required. The financial plan assumes no adverse impact from bed capacity and delayed discharges.

- Targets and standards: Given the financial and capacity pressures across the system, there will be significant challenges to deliver all of the required targets in 2015/16.

- Service change proposals: the plan includes a number of service change proposals which need to be delivered during 2015/16 to achieve in year balance and also proposals to be delivered from the start of 2016/17 to ensure that

recurring balance is restored. If any of these changes are not able to be delivered then balance in 2015/16 is at risk and the financial challenge in future year's increases.

Integration Joint Boards

4.5 In considering finalising the Financial Plan it is important to note that the Integration Joint Boards (IJBs) may be in place from early in the new financial year with their new responsibilities for strategic planning of local services and substantial elements of unscheduled care. This has a range of implications for this financial planning process.

4.6 The Board is responsible for allocations to the new Partnerships. In approving Integration Schemes the Board agreed in principle to allocations which reflected Partnerships financial and savings plans for 2015/16 with the likelihood of enabling financial balance to be achieved in 2015/16 and the IJBs to be established on a financially viable basis. A number of the savings plans are non recurrent posing real challenges for the IJBs to deliver recurrent balance in 2016/17. It is also important to underline the substantial pressures on social care budgets which will flow through from Council allocations to IJBs from 2015/16 onwards.

5 Risk Register

5.1 At this time, there is nothing to add to the Risk Register.

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 Involving People

7.1 Discussions on key financial issues are being progressed through Core group meetings with service leads.

8 Resource Implications

8.1 The resource implications are set out above.

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24 March 2015
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List of Appendices

Appendix 1: Financial Plan 2015/16 - 2019/20

APPENDIX 1

NHS LOTHIAN

Finance & Resources Committee
11 March 2015

Director of Finance

FINANCIAL PLAN 2015/16 - 2019/20

1 Purpose of the Report

1.1 This paper provides an update on the Financial Plan for the period 2015/16 to 2019/20, setting out the movements in values since the last iteration reported to Committee and the risks identified which will impact on the achievement of a balanced position next year.

1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 The Committee is asked to:

- **Note** the presentation of a balanced financial plan in 2015/16;
- **Note** the forecast gap between additional income and expenditure of £30m, expected to be recovered via efficiency savings from the Local Reinvestment Programme (LRP);
- **Note** the changes impacting on the financial gap since the previous iteration;
- **Review** progress against the LRP target for the new financial year, and consider the current assumptions for anticipated savings delivery;
- **Review** and note the key risks identified and the imbalance between recurring and non-recurring balance;
- **Recommend** for approval the draft Financial Plan for 2015/16 – 2019/20, noting the key risks and the associated performance management arrangements, to NHS Lothian Board at its meeting on 1st April 2015.

3 Discussion of Key Issues

Draft Financial Plan

3.1 Development of the financial plan is an iterative process, taking cognisance of:

- Planning assumptions in relation to pay, prices and drugs uplifts. Uplifts to budget are shown in Appendix 1;
- Known or anticipated cost increases which are deemed “unavoidable”;
- Planned investments which have already been approved through the Board’s governance processes; and
- Any recurring impact of issues emerging in the current financial year, including under-delivery of savings targets.

3.2 The previous version of the Financial Plan presented to the F&R committee in January highlighted a plan out of balance by circa £18m. Since this time further follow up work has been undertaken to review all anticipated future costs and income streams within the plan, in order that a financially balanced plan can be presented.

3.3 Table 1 below sets out the updated financial plan estimates for incremental expenditure in the new financial year. In total, a financial gap of £30m is now shown before delivery of LRP savings, comprising a recurrent shortfall of circa £34m offset by £4m of non-recurrent flexibility. Further detail on the elements comprising this are provided in Appendix 2 of this report. Anticipated savings of £30m are also shown, based on information to date, split between recurrent (£20m) and non-recurrent (£10m) savings.

Table 1 – Revised Draft Financial Plan

	Recurring £k	Non-Recurring £k	Total £k
Funding Streams	**73,578**	**19,340**	**92,918**
Recurring Deficit			
Recurring Baseline Pressures	(14,268)	0	(14,268)
Recurring LRP gap per Q3	(16,240)	0	(16,240)
Total recurring deficit	**(30,508)**	**0**	**(30,508)**
Unavoidable Commitments			
Pay	(21,042)		(21,042)
Medicines	(18,387)		(18,387)
Supplies, Developments and Infrastructure	(10,673)	(84)	(10,757)
Capacity & Unscheduled Care	(12,548)	(11,729)	(24,277)
Proposed Strategic Investments	(7,551)	(1,067)	(8,618)
Integration	(4,493)		(4,493)
Other	(2,523)	(2,313)	(4,836)
Total Unavoidable Commitments	**(77,217)**	**(15,193)**	**(92,410)**
Net Position before LRP	**(34,147)**	**4,147**	**(30,000)**
LRP- estimated in year delivery	**20,000**	**10,000**	**30,000**
Net Position	**(14,147)**	**14,147**	**0**

3.4 Table 2 below provides a breakdown of the £93m of assumed funding streams to support the financial plan.

Table 2 – Assumed Funding streams in financial plan

NHS Lothian Draft Financial Plan 2015/16			
Funding Stream	**Recurring £k**	**Non-Recurring £k**	**Total £k**
Uplift - Confirmed			
Base Uplift	21,384		21,384
NRAC	7,000		7,000
Integration Fund	4,493		4,493
	32,877	-	32,877
Confirmed Allocations			
SG - Additional Drugs Funding	4,863		4,863
Delayed Discharge	4,272		4,272
	9,135	-	9,135
Anticipated Allocations			
PPRS - Support SMC/IPTR	12,500		12,500
Waiting Times Funding	5,000		5,000
Additional Capital to Revenue		2,689	2,689
Technology Enabled Care Proposals		807	807
	17,500	3,496	20,996
Internally Generated Resources			
Junior Doctor Reserve Flexibility		900	900
Non Lothian Income / Other	1,935	4,200	6,135
Review of Financial Plan/General Reserves	12,131		12,131
Profit on Asset Sales		1,744	1,744
Phase 2 of Rates Rebates		6,000	6,000
Slippage on Allocations & In Year Flexibility		3,000	3,000
	14,066	15,844	29,910
	73,578	**19,340**	**92,918**

4 Reconciliation to previous Financial Plan

4.1 The updated plan presented in this paper shows a balanced position. To achieve this a number of cost pressures have been reviewed and additional funding assumed since the last plan. A comparison of the current plan against the previous iteration is provided in Table 3.

Table 3 – Movement in Draft Financial Plans

	£k	£k
Gap in Previous Financial Plan		**(17,966)**
Additional Resources now included in Plan		
PPRS Allocation	9,900	
Waiting Times Funding	5,000	
Delayed Discharge Allocation	4,272	
Review of Reserves	4,000	
Technology Enabled Care	807	
Phase 2 of Rates Rebates	1,000	
		24,979
Additional Commitments in Plan		
CNORIS - increase in estimate	(1,540)	
Reduction in Energy increase	720	
Delayed Discharge	(4,272)	
Reduction in Depreciation	1,000	
Other	(470)	
Technology Enabled Care	(807)	
Radiotherapy Staffing	(227)	
Reduction in RVH costs	1,106	
Investment in Primary Care	(1,000)	
Pay & Supplies Uplift	(359)	
		(5,849)
Increase in LRP c/fwd estimate		(1,164)
Gap in Revised Financial Plan		**0**

The key movements are:

- Additional Resources – An additional £24m of resources has been assumed. This increase includes an additional £9.9m PPRS funding (total assumed of £12.5m) to support the costs of new SMC approved drugs including Hep C. Scottish Government funding has also been assumed for Waiting Times of £5m and Delayed Discharges of £4.3m, although the latter is offset by additional assumed expenditure. A further review of reserves has released a further £4m of

recurrent flexibility, giving a total reduction in recurring reserves of £12m to support the plan. The second phase of the rates revaluation project is now expected to deliver £6m, giving a further £1m benefit;

- CNORIS – Updated information has been received and this would indicate that NHS Lothian's contributions for 15/16 will increase by £1.5m;
- Energy – This cost pressure has reduced reflecting the recent price reductions in the supply of gas and energy;
- Depreciation – Further refinement of the depreciation costs for 15/16 have released £1m on a non recurring basis;
- Radiotherapy Staffing – This is Lothian's share of the increased costs of radiotherapy staffing - this is a regional SCAN development;
- RVH Costs – the long term usage of the beds on the RVH site is still being discussed, however initial plans would indicate that this will not be a long term solution. It is proposed that for 2015/16 the Edinburgh CHP share of the central delayed discharge allocation (£4.272m for Lothian) will be utilised to fund the 55 delayed discharge beds currently at RVH. Funding will be released to the CHP on a recurring basis as these beds are closed;
- Investment in Primary Care – An estimate of £1m for additional primary care planned investments is included in the plan, with discussions ongoing in relation to the specific application of this resource;
- Pay and Supplies Uplift – this has been recalculated using an updated pay base and the latest forecast GDP and RPI indices. The additional cost is £359k, principally supplies uplift;
- Other – The change in values reflect movements of cost to other lines on the schedule. The main element is a £506k investment in instruments to comply with national guidelines around the management of surgical risk relating to vCJD.
- Carry forward unachieved LRP – The Quarter 3 Review forecasted an increase of £1.164m in the carry forward shortfall. This brings the total carry forward to £16.240m against the 14/15 LRP target of £39m. This is presented as a gap to be recovered in 2015/16. The carry forward gap on delivery will remain with the originating business unit.

4.2 Attached in Appendix 3 is the current proposed financial plan split at Business Unit level. The Appendix highlights the differential investment in the acute sector compared with the CHPs. This approach is inconsistent with the Board's strategic plan priorities, however it reflects the need to invest in acute driven targets.

4.3 The total level of additional budget into business units is shown as 5.25% of baseline. This increase assumes LRP delivery of £48m to be removed from budgets, which includes a carry forward requirement of £16m as well as a new 3% target of £32m. However the plan achieves a balanced position through an anticipated LRP delivery of £30m, including £20m recurrent and £10m non-recurrent.

5 Beyond 2015/16 – The 5-year Plan

5.1 The current draft Financial Plan incorporates assumptions on additional funding and planned investment for the 4 years beyond 2015/16. This has been based on

Scottish Government guidance on indicative uplifts to baseline allocations for 2016/17 to 2019/20, including 1.8% uplift to baseline resources from 2016/17 to 2019/20. This will be clarified during the Spending Review process in 2015/16.

5.2 In addition to the baseline uplift, the Scottish Government has funding set aside to support the ongoing alignment of health board baselines to NRAC. The revised NRAC values recently published show Lothian's share has increased from 14.36% to 14.5%. Whilst this is only a 0.14% increase, this equates to additional funding of £11.9m which has been built into the 2016/17 financial plan.

5.3 The detail of the 5 Year Financial Plan will continue to be refined and is presented in Appendix 4 in its current unbalanced form. In relation to planned investments beyond 2015/16, these largely reflect assumptions for pay and supplies uplifts (including medicines) and the revenue implications of approved capital developments.

5.4 In 2016/17 changes to employers national insurance contributions will mean an additional £13.7m of pay costs on top of the normal 1% pay rise which will need to be met by the health board. This change combined with a projected under delivery of LRP each year will result in minimal or no flexibility to fund further developments/pressures over the coming years.

5.5 The constraints on available resources in the future will mean that the implementation of the recently agreed Strategic Plan will be challenging, and on the whole will be required to be self financing through additional LRP delivery beyond that already assumed.

5.6 The indications are that the service needs to plan to continue to deliver annual efficiencies of 3%-5% and this will be a key issue for the Board moving forward. Work is ongoing to refine the plan including the implications of the Strategic Plan and revenue consequences of the 5 year capital plan.

6 Efficiency & Productivity 2015

6.1 Efficiency savings are a key component in delivering a balanced financial plan. At this stage, cash releasing plans have been submitted to deliver £31.6m of LRP savings in the new financial year, however based on previous experience and the level of high risk plans submitted a total of £30m delivery has been anticipated in the plan. Appendix 5 of this paper sets out the total target identified of approximately £48m (which includes approximately £32m of new LRP as well as the carry forward shortfall previously noted) at Business Unit level, the value of schemes identified, and the risk currently applied to the schemes. Whilst the risk rating is weighted towards high risk, this is expected to reduce as schemes evolve.

6.2 Ensuring robust oversight of all existing and emerging plans as well as identifying all further actions which will be required to deliver a balanced budget is essential and therefore a small 'Delivering Financial Balance' Core Steering Group has been set up to provide that oversight and ensure that, across the system, sufficient momentum and focus is being given. This is being led by the Chief Executive and includes the Director of Finance, Director of Strategic Planning and the Director of HR.

6.3 The Core Group is working with each Executive Director to consider existing and emerging plans and to discuss and determine all options to deliver a balanced budget over the next three years.

6.4 In support of these discussions, a key aspect of the group's initial work has been to determine an overarching framework which sets out clear organisational targets to deliver savings against each element of our cost base including workforce, property, supplies & services and prescribing. The framework sets out the specific goals and objectives expected to be pursued to drive down cost and improve efficiency. This will provide Executive Directors and their teams with a policy framework against which plans and options can be developed.

6.5 It is proposed that the F+R committee is provided with greater assurance of the deliverability of the LRP programme for 2015/16 at its meeting on the 1st of May. Directors from Edinburgh CHP and the Acute sector will be invited to present on their respective plans, risk profiles and strategy to reduce their remaining LRP gap. Their combined LRP targets equate to 66% of the Board's £48m target.

7 Key Risks

7.1 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. For 15/16 a number of these are material and recognising this it is planned to continue with the "Delivering Financial Balance" Core Steering Group to oversee financial performance.

LRP

7.2 At this stage the LRP programme has identified savings of £33m against a total target of £48m. However, only £5.7m is defined as low risk. The financial plan assumes delivery of £30m next year and at this stage this is a significant risk.

7.3 Across the business units a review of LRP plans has concluded that £13.1m of savings plans are classified as high risk, with many linked to capital investment and invest to save proposals. The availability of resources to pump prime these initiatives has still to be earmarked and is a risk to the delivery of the required level of savings.

Month on Month financial balance

7.4 It is important to note that in completing the financial plan, there are a number of potential cost pressures which have been assumed as being 'manageable' at an operational budget level. As pressures on the delivery of LRP continue, the sustainability of this approach presents a risk to the organisation.

Bed Reductions

7.5 The LRP programme within acute services includes a reduction of 114 beds. At the same time, the City of Edinburgh Council, as part of its budget setting in the new financial year, has reduced its total budget for Social Care in the new financial year by £3m, despite an overspend projection of £5m this year. These actions are incompatible as the organisation strives to reduce delays in discharges.

7.6 In the ten months of this financial year, NHS Lothian has lost a total of 161,015 days to delayed discharge, compared to 115,621 days over the same period last year. This is an increase of 39%, and with fewer beds and a reduction to the social care budget in Edinburgh, this is a key risk for the health board, and may impact on surgical capacity, acute flow, A+E targets and overall patient care.

Funding Assumptions

7.7 In their letter to the health board of the 12th January, The SGHSCD set out the key uplift values in the new financial year. In order to present a balance plan for next year, there are a number of assumptions for the receipt of additional funding which have yet to be confirmed, including anticipated allocations for PPRS (£12.5m, relating to drugs), Waiting Times (£5m), and Capital to Revenue adjustments (£2.689m)

Medicines

7.8 Whilst there is significant additional resource being invested into medicines next year, both within acute and in Primary Care, there remain a number of significant risks associated with potential expenditure, particularly around new Hep C drug arrangements.

7.9 A Risk Schedule is attached in Appendix 6.

8 Conclusions

8.1 A balanced financial plan has been presented for 2015/16 however there requires to be a continued effort to ensure the delivery of a breakeven position in year. This will include minimising any unavoidable commitments and maximising recurring LRP delivery.

8.2 The challenging financial environment for 2015/16 is being addressed with a cohesive approach, however further focus will require to be given to the medium and long term strategy.

9 Risk Register

9.1 At this time, there is nothing to add to the Risk Register.

10 Impact on Inequality, Including Health Inequalities

10.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

11 Involving People

11.1 Discussions on key financial issues are being progressed through Core group meetings with service leads.

12 Resource Implications

12.1 The resource implications are set out above.

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List of Appendices

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APPENDIX 1

Planning Assumptions for Uplift

	2015/16	2016/17	2017/18	2018/19	2019/20
Base Uplift	1.80%	1.80%	1.80%	1.80%	1.80%
Pay	1.00%	1.00%	1.00%	1.00%	1.00%
Supplies	2.50%	2.50%	2.50%	2.50%	2.50%
GP Prescribing	6.06%	3.41%	3.41%	3.41%	3.41%
Hospital Drugs	15.22%	6.98%	6.98%	6.98%	6.98%

APPENDIX 2

NHS Lothian Draft Financial Plan 2015/16

	Recurring £k	Non-Recurring £k	Total £k
Funding Stream	**73,578**	**19,340**	**92,918**
Recurring Deficit			
Recurring Baseline Pressures	(14,268)	0	(14,268)
Recurring LRP gap per Q3	(16,240)	0	(16,240)
Total recurring deficit	**(30,508)**	**0**	**(30,508)**
Unavoidable Commitments			
Pay			
Pay uplift	(9,183)		(9,183)
Consultant Seniority/Discretionary Points	(1,763)		(1,763)
Workforce Plans	(1,016)		(1,016)
Other Pay Issues	(382)		(382)
Employers Pension Contribution	(8,698)		(8,698)
Medicines			
GP Prescribing	(5,000)		(5,000)
Secondary Care Prescribing	(13,100)		(13,100)
Other Medicines Investment	(287)		(287)
Supplies Uplift	(8,004)		(8,004)
Delayed Discharge	(4,272)		(4,272)
Unscheduled Care Investments 14-15 stepup	(1,322)		(1,322)
Non Recurring Support for RVH	0	(2,482)	(2,482)
Step Down Beds in East Lothian	(1,000)		(1,000)
Delivering for Patients	0	(9,000)	(9,000)
Sustainable Delivery of TTG/WT Standards	(5,297)		(5,297)
Psychology/CAMHs Capacity	(657)	(247)	(904)
Investment in Primary Care	0	(1,000)	(1,000)
Service Developments	(2,262)	(84)	(2,346)
Infrastructure	(407)		(407)
Strategic Investments			
Royal Edinburgh Hospital	(270)	(414)	(684)
RHSC & Neurosciences	(3,406)	(470)	(3,876)
WGH Front Door	(3,460)		(3,460)
East Lothian Community Hospital	0	(163)	(163)
Other Small Projects	(415)	(20)	(435)
Integration	(4,493)		(4,493)
Other	(2,523)	(1,313)	(3,836)
Total Unavoidable Commitments	**(77,217)**	**(15,193)**	**(92,410)**
Net Position before LRP	**(34,147)**	**4,147**	**(30,000)**
LRP- estimated in year delivery	**20,000**	**10,000**	**30,000**
Net Position	**(14,147)**	**14,147**	**0**

APPENDIX 3

NHS Lothian - Financial Plan by Business Unit

SUMMARY	NHSL				Scheduled Care				Unscheduled Care				Edinburgh CHP				East Lothian CHP				Mid Lothian CHP				West Lothian CHCP				Corporate Depts				Facilities & Consort				Strategic			
	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget	R	NR	Total	% of Budget
	£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k		£k	£k	£k	
Recurring Annual Budget	**1,426,243**		**1,426,243**		**368,644**		**368,644**		**208,393**		**208,393**		**286,615**		**286,615**		**73,804**		**73,804**		**50,556**		**50,556**		**107,875**		**107,875**		**76,439**		**76,439**		**135,319**		**135,319**		**118,598**		**118,598**	
Increase on Budget																																								
Pay	21,042	0	21,042	1.48%	8,051	0	8,051	2.18%	4,971	0	4,971	2.39%	2,866	0	2,866	1.00%	586	0	586	0.79%	366	0	366	0.72%	1,096	0	1,096	1.02%	1,741	0	1,741	2.28%	1,196	0	1,196	1.56%	170	0	170	0.14%
Medicines	18,387	0	18,387	1.29%	6,280	0	6,280	1.70%	6,821	0	6,821	3.27%	2,600	0	2,600	0.91%	670	0	670	0.91%	565	0	565	1.12%	1,165	0	1,165	1.08%	0	0	0	0.00%	0	0	0	0.00%	287	0	287	0.24%
Supplies, Developments and Infrastructure	10,673	84	10,757	0.75%	2,692	0	2,692	0.73%	468	0	468	0.22%	1,397	27	1,424	0.50%	277	0	277	0.38%	272	0	272	0.54%	395	0	395	0.37%	365	57	422	0.55%	2,589	0	2,589	3.39%	2,218	0	2,218	1.87%
Capacity & Unscheduled Care	12,548	11,729	24,277	1.70%	5,297	9,000	14,297	3.88%	1,322	0	1,322	0.63%	2,851	130	2,981	1.04%	1,528	0	1,528	2.07%	432	21	453	0.90%	1,118	96	1,214	1.13%	0	0	0	0.00%	0	588	588	0.77%	0	1,894	1,894	1.60%
Proposed Strategic Investments	7,551	1,067	8,618	0.60%	3,737	490	4,227	1.15%	3,460	0	3,460	1.66%	270	414	684	0.24%	69	163	232	0.31%	0	0	0	0.00%	0	0	0	0.00%	15	0	15	0.02%	0	0	0	0.00%	0	0	0	0.00%
Integration	4,493		4,493	0.32%	0	0	0	0.00%	0	0	0	0.00%	2,176	0	2,176	0.76%	504	0	504	0.68%	464	0	464	0.92%	1,349	0	1,349	1.25%	0	0	0	0.00%	0	0	0	0.00%	0	0	0	0.00%
Recurring Baseline Pressures	14,268	0	14,268	1.00%	3,522		3,522	0.96%	3,471		3,471	1.67%	4,520		4,520	1.58%	469		469	0.64%	396		396	0.78%	1,231		1,231	1.14%	95		95	0.12%	564		564	0.74%	0		0	0.00%
Other	2,523	2,313	4,836	0.34%	0	506	506	0.14%	0	0	0	0.00%	0	750	750	0.26%	0	100	100	0.14%	0	167	167	0.33%	0	407	407	0.38%	0	0	0	0.00%	0	0	0	0.00%	2,523	383	2,906	2.45%
	91,485	**15,193**	**106,678**	**7.48%**	**29,578**	**9,996**	**39,574**	**10.74%**	**20,512**	**0**	**20,512**	**9.84%**	**16,680**	**1,321**	**18,001**	**6.28%**	**4,103**	**263**	**4,366**	**5.92%**	**2,495**	**188**	**2,683**	**5.31%**	**6,354**	**503**	**6,857**	**6.36%**	**2,216**	**57**	**2,273**	**2.97%**	**4,349**	**588**	**4,937**	**3.65%**	**5,198**	**2,277**	**7,475**	**6.30%**
LRP Target 15/16	31,786	0	31,786	2.23%	9,629	0	9,629	2.61%	5,454	0	5,454	2.62%	5,624	0	5,624	1.96%	1,556	0	1,556	2.11%	941	0	941	1.86%	2,236	0	2,236	2.07%	3,211	0	3,211	4.20%	2,652	0	2,652	1.96%	483	0	483	0.41%
Net increase in budget	**59,699**	**15,193**	**74,892**	**5.25%**	**19,949**	**9,996**	**29,945**	**8.12%**	**15,058**	**0**	**15,058**	**7.23%**	**11,056**	**1,321**	**12,377**	**4.32%**	**2,547**	**263**	**2,810**	**3.81%**	**1,554**	**188**	**1,742**	**3.44%**	**4,118**	**503**	**4,621**	**4.28%**	**(995)**	**57**	**(938)**	**-1.23%**	**1,697**	**588**	**2,285**	**1.69%**	**4,715**	**2,277**	**6,992**	**5.90%**
Revised Budget	**1,485,942**	**15,193**	**1,501,135**		**388,593**	**9,996**	**398,589**		**223,451**	**0**	**223,451**		**297,671**	**1,321**	**298,992**		**76,351**	**263**	**76,615**		**52,109**	**188**	**52,297**		**111,993**	**503**	**112,496**		**75,444**	**57**	**75,501**		**137,015**	**588**	**137,603**		**123,313**	**2,277**	**125,590**	

APPENDIX 4

NHS Lothian – Summary of LRP Plans 2015/16

	2015/16			2016/17			2017/18			2018/19			2019/20		
	Recurring £k	Non-Recurring £k	Total £k	Recurring £k	Non-Recurring £k	Total £k	Recurring £k	Non-Recurring £k	Total £k	Recurring £k	Non-Recurring £k	Total £k	Recurring £k	Non-Recurring £k	Total £k
Income	**73,578**	**18,533**	**92,111**	**40,112**	**0**	**40,112**	**28,606**	**0**	**28,606**	**24,023**	**0**	**24,023**	**24,432**	**0**	**24,432**
Recurring Deficit															
Recurring Baseline Pressures	(14,268)	0	(14,268)	0	0	0	0	0	0	0	0	0	0	0	0
Recurring LRP gap	(16,240)	0	(16,240)	(14,147)	0	(14,147)	(11,260)	0	(11,260)	(9,679)	0	(9,679)	(2,423)	0	(2,423)
Total recurring deficit	**(30,508)**	**0**	**(30,508)**	**(14,147)**	**0**	**(14,147)**	**(11,260)**	**0**	**(11,260)**	**(9,679)**	**0**	**(9,679)**	**(2,423)**	**0**	**(2,423)**
Unavoidable Commitments															
Pay	(21,042)		(21,042)	(24,600)		(24,600)	(10,794)		(10,794)	(10,646)		(10,646)	(10,438)		(10,438)
Medicines	(18,387)		(18,387)	(12,287)		(12,287)	(12,287)		(12,287)	(12,287)		(12,287)	(12,287)		(12,287)
Supplies Uplift	(8,004)		(8,004)	(8,494)		(8,494)	(8,501)		(8,501)	(8,501)		(8,501)	(8,501)		(8,501)
Capacity and TTG Investments	(12,548)	(11,729)	(24,277)	(6,308)	(5,000)	(11,308)	(6,308)	(5,000)	(11,308)	(1,324)	(5,000)	(6,324)	(1,324)	(5,000)	(6,324)
Service Developments	(2,262)	(84)	(2,346)	(2,339)		(2,339)	(1,937)		(1,937)	(1,689)		(1,689)	(1,689)		(1,689)
Strategic Investments	(7,551)	(1,067)	(8,618)	(2,877)	(1,736)	(4,613)	(6,878)	(1,379)	(8,257)	(2,000)	(1,082)	(3,082)	(2,000)	(1,088)	(3,088)
Integration	(4,493)		(4,493)	0		0	0		0	0		0	0		0
Other	(2,930)	(1,506)	(4,436)	(320)		(320)	(320)		(320)	(320)		(320)	(320)		(320)
Total Unavoidable Commitments	**(77,217)**	**(14,386)**	**(91,603)**	**(57,225)**	**(6,736)**	**(63,961)**	**(47,025)**	**(6,379)**	**(53,404)**	**(36,767)**	**(6,082)**	**(42,849)**	**(36,559)**	**(6,088)**	**(42,647)**
Net Position before LRP	**(34,147)**	**4,147**	**(30,000)**	**(31,260)**	**(6,736)**	**(37,996)**	**(29,679)**	**(6,379)**	**(36,058)**	**(22,423)**	**(6,082)**	**(28,505)**	**(14,550)**	**(6,088)**	**(20,638)**
LRP Assumed Delivery	**20,000**	**10,000**	**30,000**	**20,000**	**10,000**	**30,000**	**20,000**	**10,000**	**30,000**	**20,000**	**10,000**	**30,000**	**20,000**	**10,000**	**30,000**
Net Position	**(14,147)**	**14,147**	**(0)**	**(11,260)**	**3,264**	**(7,996)**	**(9,679)**	**3,621**	**(6,058)**	**(2,423)**	**3,918**	**1,495**	**5,450**	**3,912**	**9,362**

APPENDIX 5

NHS Lothian Draft 5 Year Financial Plan 2015/16 to 2016/2020

	2015/16 Target	Estimated Carry Forward	Adjust to Carry Forward	Total Indicative Target	Total Plans	Work-force	Cost Avoid	Cash Release	H	M	L	Gap		FYE
	£k	£k	£k	£k	£k	WTE	£k	£k	£k	£k	£k	£k		£k
Scheduled Care	9,629	7,707		17,336	7,387	2.11	120	7,267	4,346	2,421	500	10,069		8,108
Unscheduled Care	5,454	2,938		8,392	6,189	43.26	685	5,504	2,537	1,482	1,485	2,888		5,735
East Lothian CHP	1,041	41		1,082	1,203	3.50	0	1,203	594	499	110	(121)		1,402
Edinburgh CHP	3,628	2,322		5,950	3,790	48.60	0	3,790		2,536	1,254	2,161		4,535
Midlothian CHP	507	296		803	716	3.92	0	716	200	371	145	86		985
West Lothian CHCP	1,341	0	(18)	1,323	1,323	6.34	0	1,323	197	481	644	0		1,331
Prescribing	3,840	800		4,640	3,325	0.00	0	3,325	3,325	0	0	1,315		3,325
Facilities	2,652	556	(31)	3,177	3,126	0.00	0	3,126	243	2,795	89	51		4,089
Corporate Services	3,211	1,354		4,565	3,918	70.25	0	3,918	368	2,022	1,527	646		2,967
Strategic Services	483	226		709	124	0.00	0	124	0	124	0	585		124
Pan Lothian	0	0		0	1,275	2.40	0	1,275	1,275	0	0	(1,275)		984
Total	**31,785**	**16,240**	**(49)**	**47,976**	**32,375**	**180.38**	**805**	**31,570**	**13,085**	**12,731**	**5,754**	**16,406**		**33,585**
									41%	**40%**	**18%**			

APPENDIX 6

NHS Lothian Risk Schedule – 2015/16

Key Assumptions / Risks	Risk rating	Impact
Local Reinvestment Programme	High	Delivery of recurring savings to the value required to meet the known gap between anticipated income and planned activities.
Scheduled Care	High	There requires to be continued management of the financial exposure on elective capacity pressures. The risk that additional investment in capacity will not deliver the required volume and to meet the DFP Strategy.
Unscheduled Care	High	Continued management of the financial exposure on unscheduled care capacity pressures
Delayed Discharge	High	Need to manage the volume of delayed discharges and the cost of new initiatives to deliver the required reductions will not succeed
Parental and Adoption Leave	High	The implementation of paid parental leave until the child is 14 years has been modelled with various scenarios; the initial take up will be high. An implementation date of April 2014 has been agreed. No additional funding has been assumed in the Financial Plan.
Rates Rebates and Property Sales	Medium / High	The ongoing rateable value appeal of the GMS properties could generate substantial backdated rebates. At present £6m has been assumed as part of the non recurring support available for 2015/16.
Prescribing	Medium	A sustained level of short supply has been included in the financial plan along with growth and price increases, however there is the potential for increases to be greater than projected.
Changes to the IPTR process	High	It has been assumed that these costs will be offset by national savings in the drug tariff along with any further costs incurred in year.

Hep C Drugs	High	The use age of the new range of Hep C Drugs is greater than the costed projection.
Changes to pay terms & conditions, specifically the review of the implementation of transitional points under Agenda for Change and the ongoing discussions with Consort on the full implication of the Two Tier Agreement	Medium	Neither of these issues can at the moment be fully quantified. The financial consequence has not be included in the financial plan and will need to be monitored as the year progresses.
SGHD Allocations	High	Availability of SGHD funding for previously separately funded programmes and initiatives.
Capital Programme	High	NHSiL has an ambitious capital programme which requires significant resources in addition to those available. The revenue consequences of the programme are a significant pressure to the organisation
Equal Pay	High	Discussions are continuing with CLO and Audit Scotland with regards to the treatment of this potential financial exposure.

NHS LOTHIAN

Board Meeting
1 April 2015

2.5

Nurse Director/Director of Human Resources & Organisational Development

SUMMARY PAPER - PERSON CENTRED CULTURE FEEDBACK AND COMPLAINTS REPORT

This paper summarises the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

	Para
• The Board is asked to accept the Armstrong report Listening and Learning from Feedback and Complaints	2.5 and Appendix
• The Board is asked to task the Nurse Director to implement an action plan on Feedback and Complaints	2.7
• The Board is asked to agree to transfer the Executive responsibility for Feedback and Complaints from the Director of Human Resources and Organisational Development to the Nurse Director with effect from 1st April 2015	2.8
• NHS Lothian is developing a comprehensive person centred measurement framework, including in-depth surveys for wards in the collaborative plus testing a revised TTT aligned with the 5 Must Do's of the national programme on the Royal Infirmary site.	3.1.1
• NHS Lothian has had its first Person Centred Collaborative on 6th February 2015. 8 test teams were brought together to share best practice, examine results from the in-depth survey results and agreed improvement plans. The next collaborative is planned for November 2015.	3.1.2
• The aggregate results from the in-depth surveys and the first TTT report are set out in paras 3.2 and 3.3, including qualitative comments which the wards find particularly valuable. The testing of an agreed A&E adapted TTT questionnaire is to take place at the RIE and the Inpatient Ward TTT is to be rolled out to St. Johns.	3.2 & 3.3
• In line with the next steps set out in the independent report on complaints management, consultation workshops have been taking place on the new model which has been supported by those who participated. An implementation plan will now be developed and the delivery of actions in the plan will depend on all staff working together to share the future direction and create a culture where feedback and complaints are valued and acted upon.	3.6.3

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18 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Nurse Director/Director of Human Resources & Organisational Development

PERSON-CENTRED CULTURE, FEEDBACK AND COMPLAINTS

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on the quality improvement plan that was approved at the January 2015 Healthcare Governance Committee (HCG).

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

2 Recommendations

2.1 Acknowledge the NHS Lothian's Person-Centred Collaborative, that took take place on Friday 6 February 2015 at Heriot Watt University

2.2 Note the continuing development and reporting of the measurement framework that was discussed at the HCG committee on the 27 January 2015

2.3 Note the first reporting of Tell us Ten Things (TTT) at the Royal Infirmary of Edinburgh (RIE).

2.4 Note the outcome of the consultation workshops on the proposed complaints management model for NHS Lothian.

2.5 Accept the content of Dr Dorothy Armstrong's report dated January 2015 entitled Listening and Learning from Feedback and Complaints as the blueprint for the future management of feedback and complaints (Appendix 4).

2.6 Accept the content of Dr Dorothy Armstrong's report dated March 2015 entitled Listening and Learning from Feedback and Complaints: Consultation Workshops (Appendix 5).

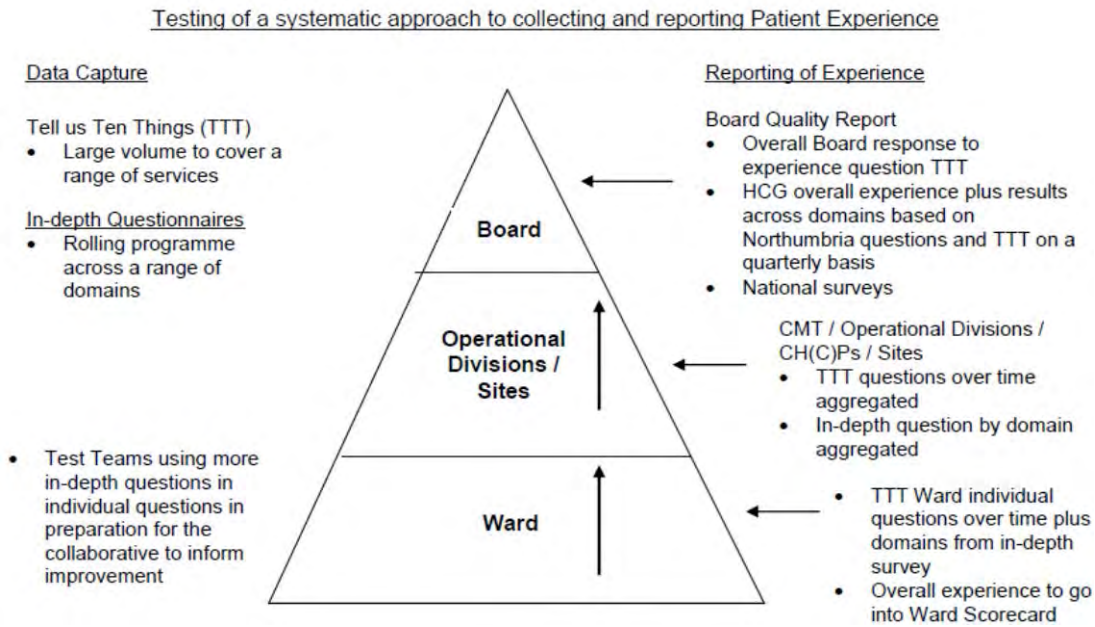
2.7 Agree to implement an action plan using project management methodology led by the Nurse Director, with non-executive Board member involvement under the auspices of the Healthcare Governance Committee.

2.8 Agree that the corporate responsibility for Feedback and Complaints transfers from the Director of Human Resources and Organisational Development to the Nurse Director with effect from 1st May 2015.

3 Discussion of Key Issues

3.1.1 The measurement framework (Diagram 1) below was agreed at the January HCG committee will be used to systematically demonstrate our approach to patient experience reporting. This paper will provide an update on our activities.

Diagram 1



3.1.2 **NHS Lothian's Person-Centred Collaborative** - The Person Centred Health and Care Collaborative was launched by the Scottish Government in November 2012. It is central to the 2020 Vision for Health and Social Care that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting.

3.1.3 NHS Lothian is using a Breakthrough Series Collaborative Methodology to establish a person-centred collaborative and its first learning session took place on Friday 6 February 2015 at Heriot Watt University. The day was planned so that staff heard best practice from colleagues across the United Kingdom; including patient experience work taking place in Northumbria Healthcare NHS Trust and a programme of patient shadowing at Alder Hey Children's Hospital.

3.1.4 The afternoon session gave the 8 clinical areas the opportunity to work as a multi-disciplinary team using their baseline data from the in-depth surveys set out below and best practice examples they heard from the morning presentations to generate improvement plans and local actions for testing at service level. For further information on these improvement plans please contact the Quality Improvement Dept. Examples of actions being tested by the clinical teams include:-

- Introducing What Matters to Me templates
- Look at noise levels at night
- Test patients' understanding of what is communicated during a visit
- To continue with plans for staff to shadow a patient's journey in medicine.

3.1.5 Feedback from the day was very positive and 75% of the delegates, who completed the Evaluation Forms answered "Strongly Agree / Agree" to the question "Participating in this event has improved my understanding of Person-centred health & care" and 95% of the delegates reported that the event had the "right amount" of mix of presentations, discussions and exercises. Written feedback from the delegates:

- *"Session from Alder Hey was informative and inspiring"*

- *"Session from Geraldine Marsh & Shaun Maher's presentation on knowing your patients – good idea how to use the information from Getting to know me"*
- *Enjoyed the afternoon session – very informative."*

3.1.6 The second Person-Centred Collaborative will take place on Tuesday 17th November 2015 and further details on this will follow.

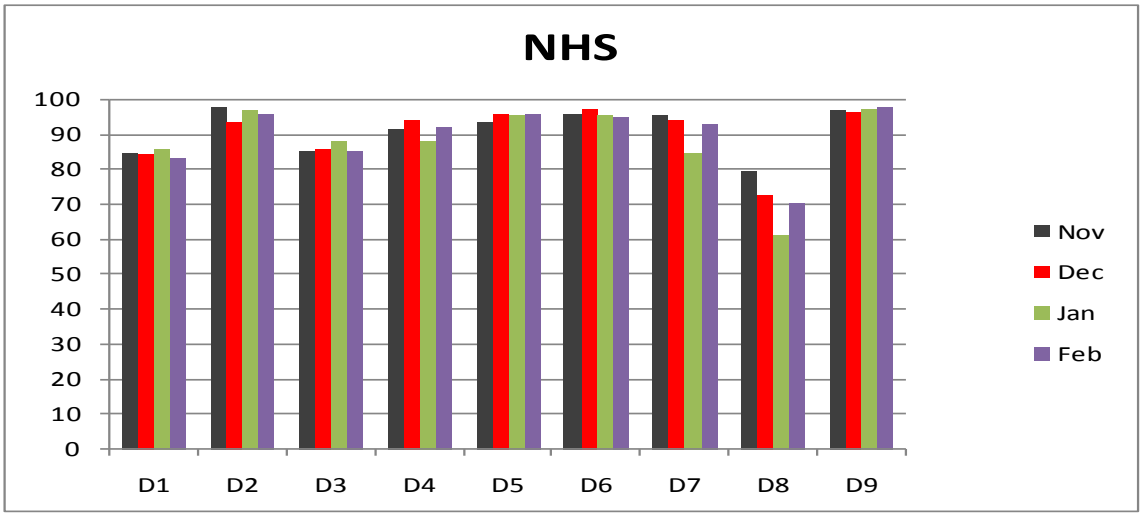
3.2 NHS Lothian's In-depth Patient Survey

3.2.1 NHS Lothian is testing a validated in-depth experience questionnaire in conjunction with TTT. The in-depth question questionnaire includes the following domains based on extensive review of what matters to patients plus two appreciative enquiry questions (Appendix 1):

- Care & Co-ordination
- Respect & Dignity
- Involvement
- Medical Staff
- Nursing Staff
- Cleanliness
- Pain Control
- Medication
- Kindness & Compassion
- 2 appreciative enquiry questions:
  - What have we got right for you?
  - What comments or suggestions do you have for improvement?

3.2.2 From 10th November until 28th February 2015, 515 patients across the 8 clinical areas undertook the questionnaires. Not all the patients answered every question. The aggregated baseline results are set out in Chart 1 below. The eight clinical teams were provided with individual ward reports to inform improvement plans. An aggregate report is included as Appendix 2.

Chart 1



Number of respondents 515
Data established on patients surveyed Nov 2014, Dec 2014, Jan 2015 and Feb 2015

3.2.3 Of the 515 patients that we spoke to during the 4 month period, we received 383 responses to question 23 (What have we got right for you?) and 382 responses

question 24 (What comments or suggestions do you have for improvement?). The feedback has been themed using the "6 C's" from the NHS Scotland Healthcare Quality Strategy and also whether the comments were positive or negative. The results are detailed below in Table 1. An additional theme of "Corporate" was also included as a number of patients provided feedback on food, car-parking, WiFi, estates and staffing. Patients also provided feedback that included multiple themes. A small number of patients quotes are also included below:

Table 1

Q23 – What have we got right for you? (n=383)
Q24 – What comments or suggestions do you have for improvement? (n=382)

	Caring & Compassion	Communication	Collaboration	Clean	Continuity of Care	Clinical Excellence	Corporate	Positive	Negative
Q 23	154	44	15	4	7	7	35	369	4
Q 24	30	53	10	27	11	13	80	36	182

Example of corporate, positive feedback

- *"Excellent care. I am enjoying the regular meals and food is good. Open visiting is great. Access to the AHP's has been great for relatives. The meetings we have had with them have been good and they speak and do things at a level I can understand. Good integration of social services."*
- *"Everyone is really good, even the porters. It's lovely in here. I couldn't praise it enough."*

Example of corporate, negative feedback

- *"The lighting has been dreadful they are like huge headlights and give you snow blindness and lacks windows and daylight."*

Example of continuity of care negative feedback

- *"They get side tracked a lot. Someone will interrupt them for something and it is half and hour before they come back. The night staff change a lot. It is different nurses every night. The night shift are responsible for brushing my teeth and I didn't know that to begin with and it wasn't getting done but now they do it for me."*
- *"To see the medical staff more regularly."*

Example of care and compassion positive feedback

- *"Their attitude is amazing. They are interested in you as a person. They are always willing to help you. It is almost faultless and they are marvellous. The quality of staff is excellent."*
- *"They have not got anything wrong. They take me as a person into account. Every one of them has been kindly and respectful."*

Example of negative clean feedback

- *"Sometimes toilets don't flush and there are not enough of them. They are not clean and smell all the time. I have no other complaints at all."*

Example of positive communication feedback

- *"The experience has been smooth. Everything has been good. They have taken the time to tell you everything. All relevant information has been great. Everyone gets treated the same. I have nothing to fault."*
- *"Good Communication with surgeons."*

3.2.4 Moving forward there is a need to test efficient and effective mechanisms for theming qualitative feedback, one of which could be theming against the Lothian values of:-

- Quality

- Dignity & respect
- Care & compassion
- Openness, honesty & responsibility
- Teamwork

This could allow the organisation to see how the values are embedded into practice. We would welcome feedback from the HCG as to their views on this as we move forward with the qualitative feedback.

3.3 **Tell us Ten Things**

3.3.1 Tell us Ten Things" (TTT) is a local patient survey programme which runs within the Universities Hospital Services. In November 2014 the questions were reviewed against best practice and aligned with the "5 must do elements" of the national Person Centred Health and Care Collaborative:-

- What matters to you?
- Who matters to you?
- What information do you need?
- Nothing about me without me
- Personalised contact

3.3.2 The revised questions for Tell us Ten Things are currently being tested in all general inpatient wards at the Royal Infirmary of Edinburgh (RIE) and copies have been delivered to all wards, as well as a staff poster. All pilot wards have received their first TTT monthly report and Appendix 2 details the first aggregated RIE site Report.

3.3.3 <u>RIE Combined TTT Results</u>

As this is the first report from the pilot, these results simply provide a snapshot of current position during the timeframe. It is hoped that as the survey continues to be used, we will be able to present the results in a way which will show results over time, which will help staff to easily identify and focus their improvement activities.

<u>How the results are calculated and presented</u>

- The results are presented as an average score out of a possible max score of 10.

  A score is given to each possible answer so that the most positive response scores 10. For example, Q9 asks about patients being happy with the food and scores 10 for patients who strongly <u>agree</u> that they were happy. In contrast, Q7 asks about patients being bothered by noise at night and scores 10 for patients who strongly <u>disagree</u> that they were bothered.

  If a patient did not answer a question or said that it was not relevant, this has been excluded from the results summary.

- More detailed results for each question are provided in bar charts showing percentage response rates for each question.

- The last section of the report lists any comments made.

The weighted average responses to the questions are as follows:	Overall Weighted Average	Number of Valid Responses
Question 1: Do you feel that the staff took account the things that matter to you?	8.92	236
Question 2: Were the people that matter to you (family and friends) involved in decisions about your care and treatment	8.21	182
Question 3: How much information about your care & treatment was given to you?	8.53	232
Question 4: Were you involved, as much as you wanted to be, in decisions about your care & treatment?	8.30	232
Question 5: Were you treated with kindness & compassion by the staff looking after you?	9.50	238
Question 6: In your opinion, how clean was the hospital room or ward you were in?	9.04	239
Question 7: I was bothered by noise at night from the hospital staff:	7.62	221
Question 8: Do you think the staff did everything they could to help control your pain?	9.04	225
Question 9: I was happy with the food/meals I received:	6.79	233
Question 10: Overall: I had a very poor/good experience:	8.02	240

3.3.4 As part of TTT there is a question at the end that asks 'Is there anything else we could have done to improve your experience of our care?'. The ward staff particularly value these comments which are included in the monthly reports. These comments inform improvement plans and also highlight the positive experience of many patients. Appendix 3, TTT Survey Results also include comments at the back of the report.

3.3.5 The team have also been working with colleagues from the Emergency Dept at the RIE to develop a TTT question set relevant to their patients and this will be tested within the next few months before extending this to the other sites.

3.3.6 Moving forward TTT will be rolled out next to St. John's Hospital, however, further consideration and resource to find an effective method of data collection for the potential volume of returns is required.

3.4 Hello my name is....

3.4.1 NHS Lothian is in the process of applying for a small amount of funding to adopt the "Hello my name is" campaign. This was established by Dr Kate Grainger who as a doctor in training was diagnosed with terminal cancer and noticed that many of the staff who cared for her did not introduce themselves. Her work has now evolved into a national UK campaign and the majority of Health Boards in Scotland have adopted this. Further discussions are required with the Site Directors and 8 test teams as to where we will test this approach.

3.5 Programme Governance

3.5.1 The Executive Lead for this work is Melanie Johnson, Executive Nurse Director. The Person Centred programme will report through the Quality Management Group on a monthly basis and to the Healthcare Governance Committee on a quarterly basis along with patient experience data being reported through the Quality Report.

3.6 Feedback and Complaints

3.6.1 In February 2015 an independent Report (Appendix 4) was submitted to NHS Lothian, which outlined the key findings about feedback and complaints across the Board. A number of areas of good practice were identified. However, a number of recommendations were made to improve the service. Overall there was a lack of clarity and consistency about ownership of complaints. The Report noted a strong disengagement between the *Customer Relations and Feedback Team* (CRaFT) in the centre and the clinical management teams in the hospital sites and partnerships. Complaints management was protracted, inefficient and process driven approach rather than person centred, streamlined and positive.

3.6.2 The report proposed a new model for complaints management with a central point of contact for information/feedback and complaints. Concerns and complaints from there would then be devolved to accountable directors at site/integrated boards. In addition, all staff require information and skills to be empowered to manage concerns and complaints at early resolution stage requiring investment in learning and development.

3.6.3 In line with the next steps set out in the independent report on Page 19, consultation workshops have been taking place on the new model which has been supported by those who participated. An implementation plan will now be developed and the delivery of actions in the plan will depend on all staff working together to share the future direction and create a culture where feedback and complaints are valued and acted upon.

Consultation workshops Feb/March 2015	Share findings Engage and involve staff and users
Implementation Plan March 2015	Agree priorities Set parameters, actions & outcomes
Phase 1 April 2015	Adopt new model Test learning in early resolution skills
Phase 2 April 2016	Review new model Sustain and embed

Immediate actions

- Set up an **implementation group** to provide the visible **leadership** needed to make this successful. This should include people from the Board, partnership and users and be chaired by the Executive Lead, the Nurse Director
- Review **data** presented to the Board about feedback and complaints to include thematic reports and patient stories
- Test team learning in **early resolution** skills and techniques
- Review the **NHS Lothian website** to make it easier to give feedback or complain
- Provide **training and support** to the triage team to enable more signposting and accurate activity/data collection in early resolution
- Provide key staff with **training** based on the *Patient Association Charter* (Annexe A) and the *NHS Education for Scotland e-learning resources* (Annexe B)
- Embrace ***Patient Opinion*** as a feedback mechanism and train a small team to respond to patient opinion posts

4 Key Risks

4.1 This is an ambitious cultural programme and as such to achieve a person centred culture it needs to be woven into all aspects of NHS Lothian activity and measurement frameworks

4.2 Complaints Management is on the Corporate Risk Register.

5 Risk Register

5.1 Enabling a person centred approach within all work streams including complaints management which is on the revised Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 The principles of this agenda will see the person at the centre and therefore all aspects of inequalities will be embedded in the core values of the work programmes agreed.

7 Involving People

7.1 The agenda for person-centredness has at its core involving people and as this work progresses patients, carers and staff are central.

7.2 The staff in the complaints function have been kept informed of the direction of travel and are broadly supportive of it.

8 Resource Implications

8.1 This work is being undertaken within current resources and 2.8 WTE have been identified to support this national improvement programme. It uses short-term funding that has been provided by Scottish Government and there has been no confirmation as to any future funding for this work post 2015/16, which may be as a

result of a national review of the programme which is summarised below. The patient experience activity and associated staff have now been transitioned into the Quality Improvement Department.

8.2 Healthcare Improvement Scotland wrote to all NHS Board Chief Executives in January informing the boards that now may be the right time to transition to a different model of quality improvement support nationally which may affect funding. Proposing that HIS refocuses the national quality improvement support around:

- Supporting NHS Boards to further develop real-time feedback systems and methods to capture care experience, and then using that information to drive ongoing improvements in care
- Ensuring person-centred approaches are integral into all existing and new national improvement programmes, and therefore integral to the work taken forward locally. As an example, this will include ensuring that person-centred approaches are embedded into all the current Scottish Patient Safety Programmes.
- Supporting the sharing and spread of innovation and best practice in person-centred care by health and care staff through 'social movement' methods including networking, social media and a variety of communication media.

8.3 The budget for the Complaints Department will transfer to the Nurse Director with effect from 1 May 2015.

8.4 The detailed action plan for implementing change to how Feedback and Complaints are handled will consider resource implications in line with normal organisational change procedures.

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List of Appendices

Appendix 1: NHS Lothian In-depth Patient Experience Domain Questions
Appendix 2: NHS Lothian In-depth Patient Experience Aggregate Report (Nov – Feb)
Appendix 3: Tell us Ten Things - RIE Site Report, December 2014/January 2015 All Wards
Appendix 4: Report: Listening and Learning from Feedback and Complaints - available at http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx
Appendix 5 Listening and Learning from Feedback and Complaints: Consultation Workshops - available at http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx

APPENDIX 1

NHS Lothian In-depth Patient Experience Domain Questions

Questions

Consistency & coordination
1 Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?
2 How would you rate how well the doctors and nurses worked together?

Respect & dignity
3 Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Involvement
4 Were you involved as much as you wanted to be in decisions about your care and treatment?
5 How much information about your condition or treatment was given to you?
6 Did you receive timely information about your care and treatment?
7 Did you find someone on the hospital staff to talk to about your worries and fears?

Doctors
8 When you had important questions to ask a doctor, did you get answers that you could understand?
9 Did you have confidence and trust in the doctors treating you?
10 Did the doctors talk in front of you as if you weren't there?

Nurses
11 When you had important questions to ask a nurse, did you get answers that you could understand?
12 Did you have confidence and trust in the nurses treating you?
13 Did nurses talk in front of you as if you weren't there?

Cleanliness
14 In your opinion, how clean was the hospital room or ward that you were in?
15 How clean were the toilets and bathroom that you used while in hospital?
16 As far as you know, did doctors wash or clean their hands between touching patients?
17 As far as you know, did nurses wash or clean their hands between touching patients?

Pain control
18 Do you think the hospital staff did everything they could to help control your pain?

Medicines
19 Were you given sufficient explanation about the purpose of any new medications?
20 Did any member of staff tell you about medication side effects to watch for?
21 Were you told how to take your medication in a way you could understand?

Kindness & Compassion
22 Were you treated with kindness and compassion by the staff looking after you?

Appreciative Enquiry Questions
23 What have we got right for you?
24 What comments or suggestions do you have for improvement?

APPENDIX 2

People at the Centre of Health and Care

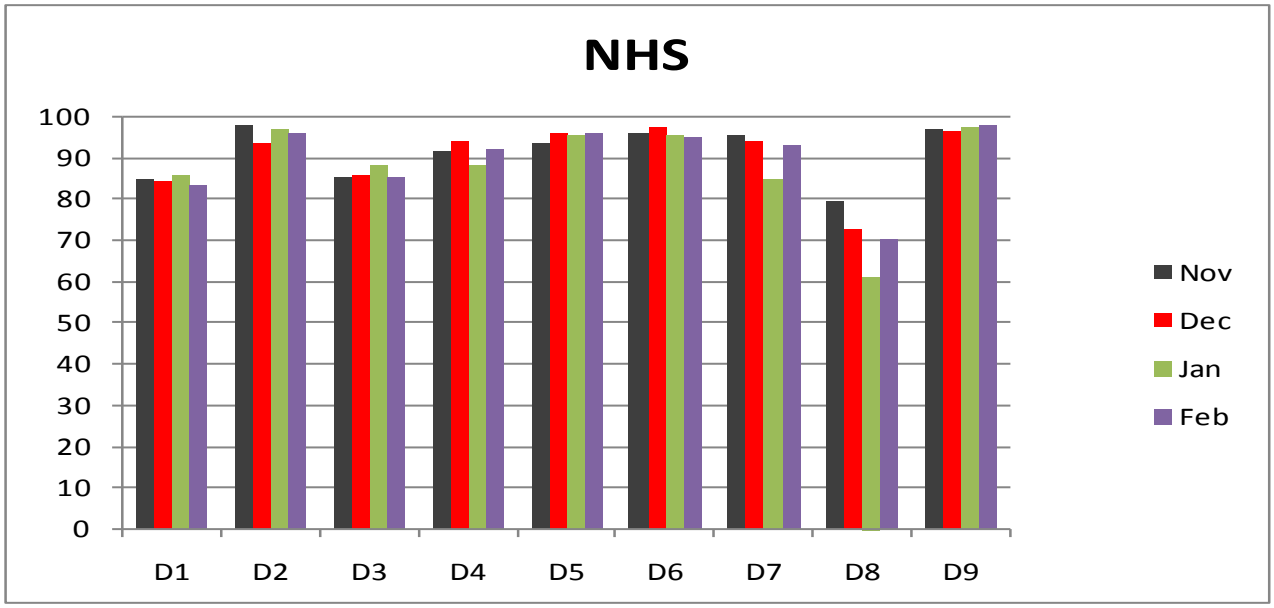
National Person-Centred Health and Care Programme

NHS Lothian Patient Experience Questionnaire Results

Information

- The chart displays the aggregated results from the nine test teams in NHS Lothian.
- We have been collecting data on a weekly basis and have condensed this data into monthly figures.
- We have grouped the 22 questions into 9 Domains:
    - Care & Co-ordination
    - Respect & Dignity
    - Involvement
    - Medical Staff
    - Nursing Staff
    - Cleanliness
    - Pain Control
    - Medication
    - Kindness & Compassion
- The tables show the number of valid responses and the number of total responses. All responses have been scored and Questions 7, 8, 11, 15, 16, 17, 18, 19, 20 & 21 all have responses which are invalid and not required to be counted.
- Each of the 9 test teams have their own local report which includes their own ward results and a comparison against an aggregate of the 8 test teams.
- The ward reports include the direct patient quotes given in response to:
    - Question 22 – What have we got right for you?
    - Question 23 – What comments or suggestions do you have for improvement?

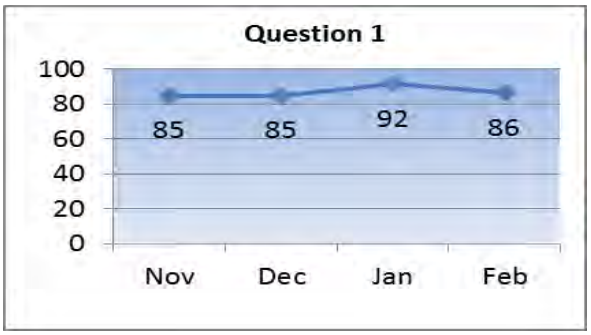
Graph showing Domain Average Totals by month for NHS Lothian:



Domains	Nov	Dec	Jan	Feb	Average
D1 Care & Co-ordination (Questions 1 & 2)	85	84	86	83	85
D2 Respect & Dignity (Question 3)	98	94	97	96	96
D3 Involvement (Questions 4- 7)	85	86	88	85	86
D4 Medical Staff (Questions 8-10)	92	94	88	92	91
D5 Nursing Staff (Questions 11-13)	93	96	95	96	95
D6 Cleanliness (Questions 14-17)	96	97	95	95	96
D7 Pain Control (Question 18)	95	94	85	93	92
D8 Medication (Question 19-22)	79	73	61	70	71
D9 Kindness & Compassion (Question 22)	97	96	97	98	97

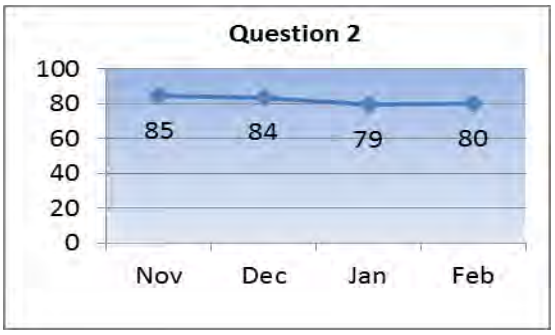
Question 1: I want to know how consistent your care feels. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you on ward?

Graph showing % of valid responses:



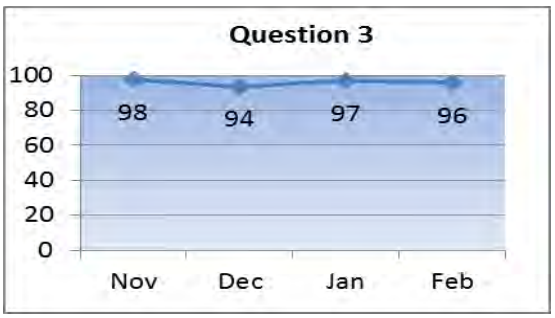
NHS Lothian Question 1	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	118	114	149	131	512
Total Responses	118	117	149	131	512

Question 2: In your opinion how well do the doctors and nurses work together on this ward?
Graph showing % of valid responses:



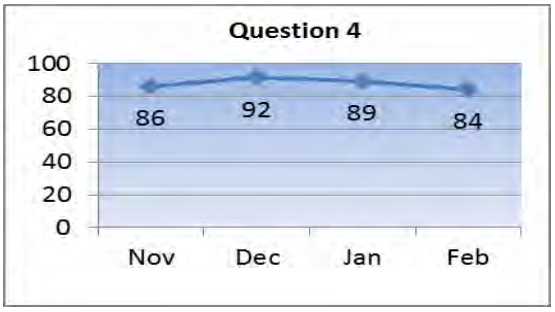
NHS Lothian Question 2	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	114	106	139	124	483
Total Responses	114	106	139	124	483

Question 3: Overall on this ward, did you feel you are treated with dignity and respect?
Graph showing % of valid responses:



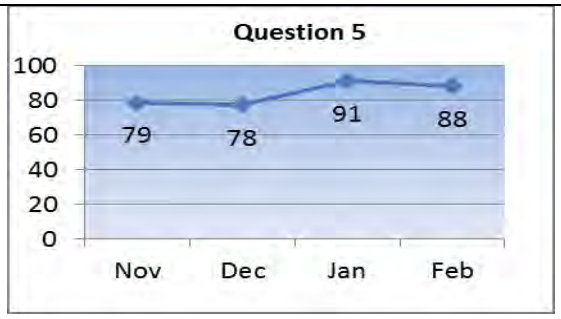
NHS Lothian Question 3	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	116	116	154	129	515
Total Responses	116	116	154	129	515

Question 4: Were you involved as much as you wanted to be in decisions about your care and treatment?
Graph showing % of valid responses:



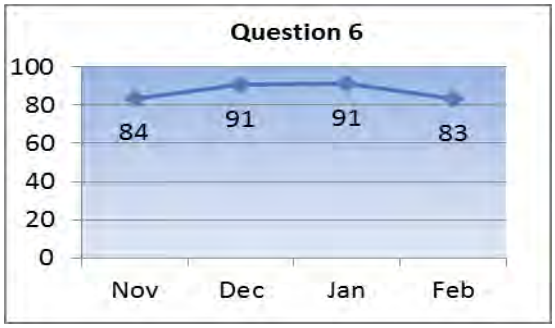
NHS Lothian Question 4	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	114	107	142	127	490
Total Responses	114	107	142	127	490

Question 5: How much information about your condition or treatment were you given?
Graph showing % of valid responses:



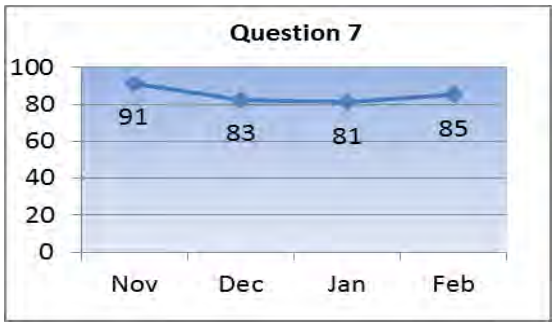
NHS Lothian Question 5	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	125	115	146	129	515
Total Responses	125	115	146	129	515

Question 6: Did you receive timely information about your care and treatment**?**
Graph showing % of valid responses:



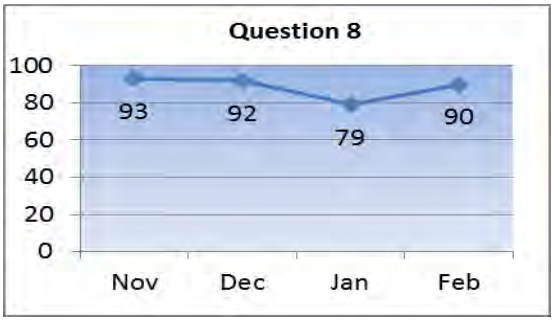
NHS Lothian Question 6	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	116	112	140	129	497
Total Responses	116	112	140	129	497

Question 7: If you have had any worries or fears, did you find someone on ward staff to talk to?
Graph showing % of valid responses:



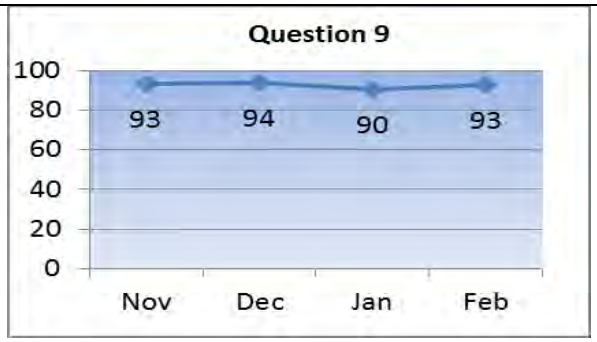
NHS Lothian Question 7	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	75	65	42	76	258
Total Responses	119	115	140	126	500

Question 8: When you had important questions to ask a doctor, did you get answers that you could understand?
Graph showing % of valid responses:



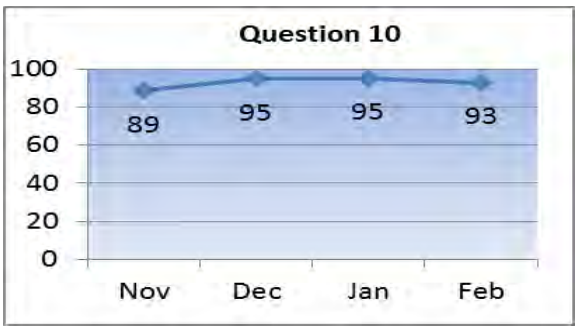
NHS Lothian Question 8	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	105	104	99	110	418
Total Responses	120	115	119	126	480

Question 9: Did you have confidence and trust in the doctors treating you?
Graph showing % of valid responses:



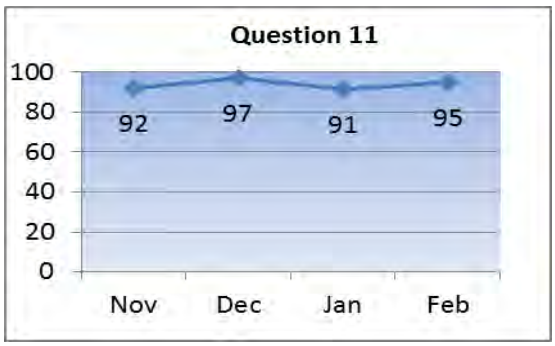
NHS Lothian Question 9	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	119	114	118	128	479
Total Responses	119	114	118	128	479

Question 10: Did the Doctors ever talk over you as if you weren't there?
Graph showing % of valid responses:



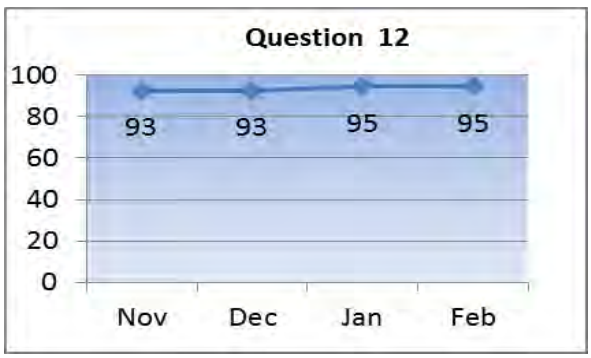
NHS Lothian Question 10	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	119	116	117	128	480
Total Responses	119	116	117	128	480

Question 11: When you had important questions to ask a nurse, did you get the answers you could understand?
Graphs showing % of valid responses:



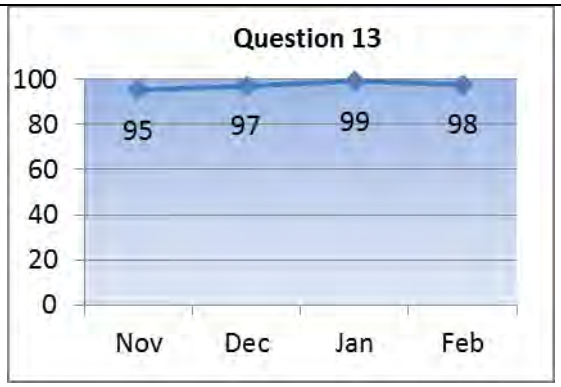
NHS Lothian Question 11	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	106	104	104	119	433
Total Responses	124	116	118	129	487

Question 12: Did you have confidence and trust in the nurses treating you?
Graph showing % of valid responses:



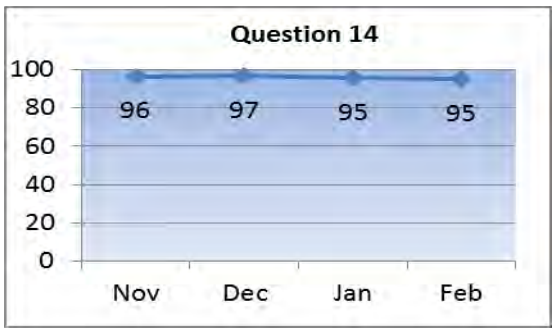
NHS Lothian Question 12	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	122	115	119	130	486
Total Responses	122	115	119	130	486

Question 13: Did the nurses ever talk over you as if you weren't there?
Graph showing % of valid responses:



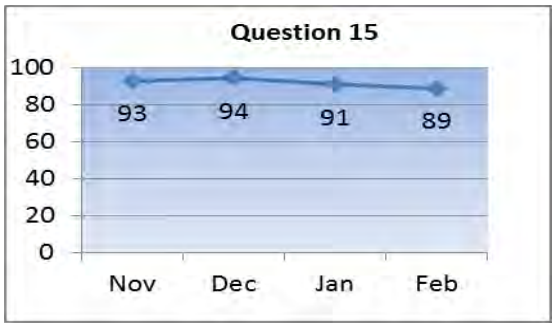
NHS Lothian Question 13	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	120	116	118	129	483
Total Responses	120	116	118	129	483

Question 14: In your opinion, how clean was the hospital room or ward that you were in?
Graph showing % of valid responses:



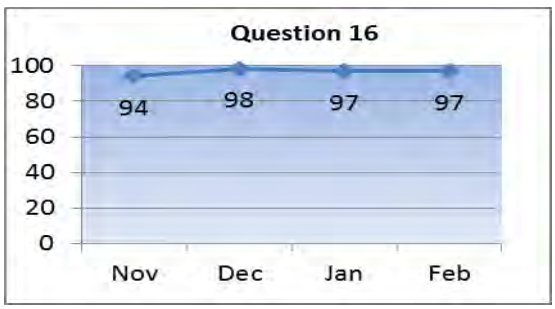
NHS Lothian Question 14	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	119	113	149	129	510
Total Responses	119	113	149	129	510

Question 15: How clean were the toilets and bathroom that you used while on this ward?
Graph showing % of valid responses:



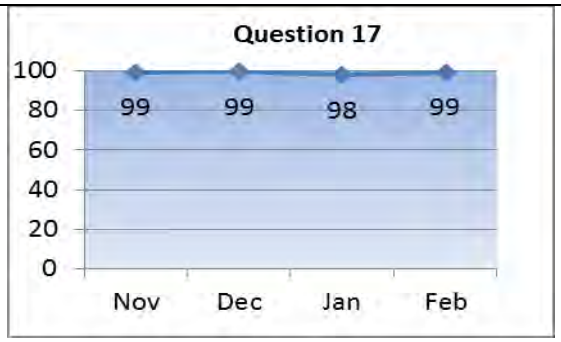
NHS Lothian Question 15	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	116	108	141	116	481
Total Responses	118	115	148	129	510

Question 16: As far as you know, did doctors wash or clean their hands between touching patients?
Graph showing % of valid responses:



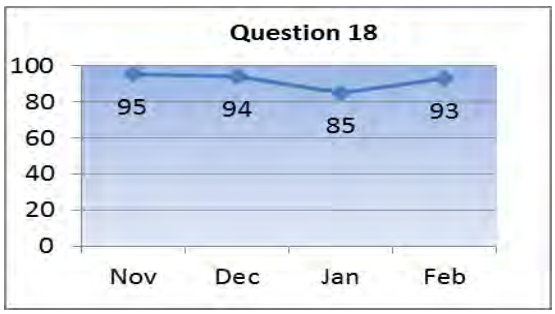
NHS Lothian Question 16	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	95	91	128	108	422
Total Responses	118	114	150	129	511

Question 17: As far as you know, did nurses wash or clean their hands between touching patients?
Graph showing % of valid responses:



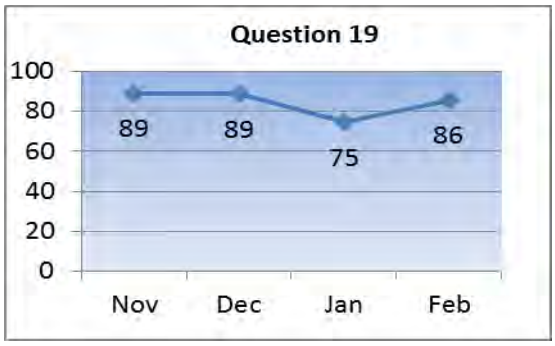
NHS Lothian Question 17	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	102	101	133	117	453
Total Responses	120	116	144	128	508

Question 18: Do you think the staff on this ward did everything they could to help control your pain?
Graph showing % of valid responses:



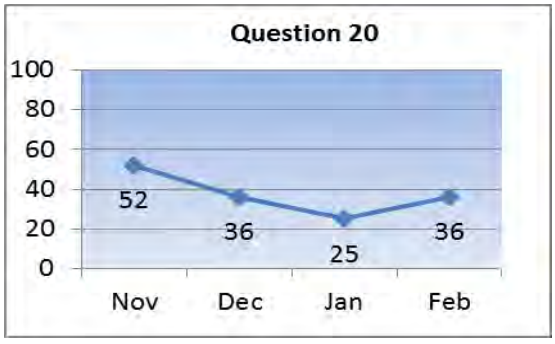
NHS Lothian Question 18	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	89	85	110	88	372
Total Responses	120	116	152	127	515

Question 19: Have you started any new medication or tablets on this ward? Were you given enough explanation about what these were for?
Graph showing % of valid responses:



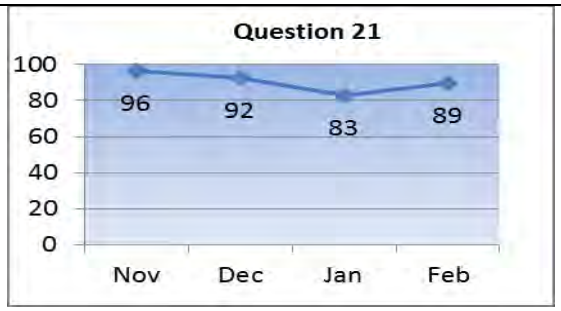
NHS Lothian Question 19	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	67	52	74	79	272
Total Responses	119	115	147	129	510

Question 20: Did any member of staff tell you about the side effects to watch for?
Graph showing % of valid responses:



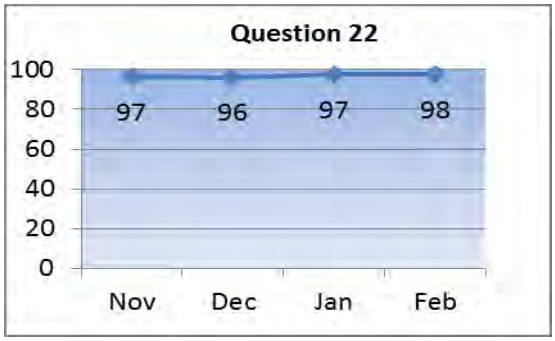
NHS Lothian Question 20	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	62	46	73	77	258
Total Responses	119	112	152	131	514

Question 21: Were you told how to take your medication in a way you could understand?
Graph showing % of valid responses:



NHS Lothian Question 21	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	68	44	78	82	272
Total Responses	120	109	151	130	510

Question 22: Were you treated with kindness and compassion by the staff looking after you?
Graph showing % of valid responses:



NHS Lothian Question 22	Nov 14	Dec 14	Jan 15	Feb 15	Total
No. of Valid responses	117	114	149	129	509
Total Responses	117	114	149	129	509

Tell Us Ten Things
Survey Results for December / January
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	Total
Discharges for the period were:	**7727**
The total number of survey returns this period is:	**240**

The weighted average responses to the questions are as follows:	**Overall Weighted Average**	**Number of Valid Responses**
Question 1: Do you feel that the staff took account the things that matter to you?	8.92	236
Question 2: Were the people that matter to you (family and friends) involved in decisions about your care and treatment	8.21	182
Question 3: How much information about your care & treatment was given to you?	8.53	232
Question 4: Were you involved, as much as you wanted to be, in decisions about your care & treatment?	8.30	232
Question 5: Were you treated with kindness & compassion by the staff looking after you?	9.50	238
Question 6: In your opinion, how clean was the hospital room or ward you were in?	9.04	239
Question 7: I was bothered by noise at night from the hospital staff:	7.62	221
Question 8: Do you think the staff did everything they could to help control your pain?	9.04	225
Question 9: I was happy with the food/meals I received:	6.79	233
Question 10: Overall: I had a very poor/good experience:	**8.02**	240

Tell Us Ten Things
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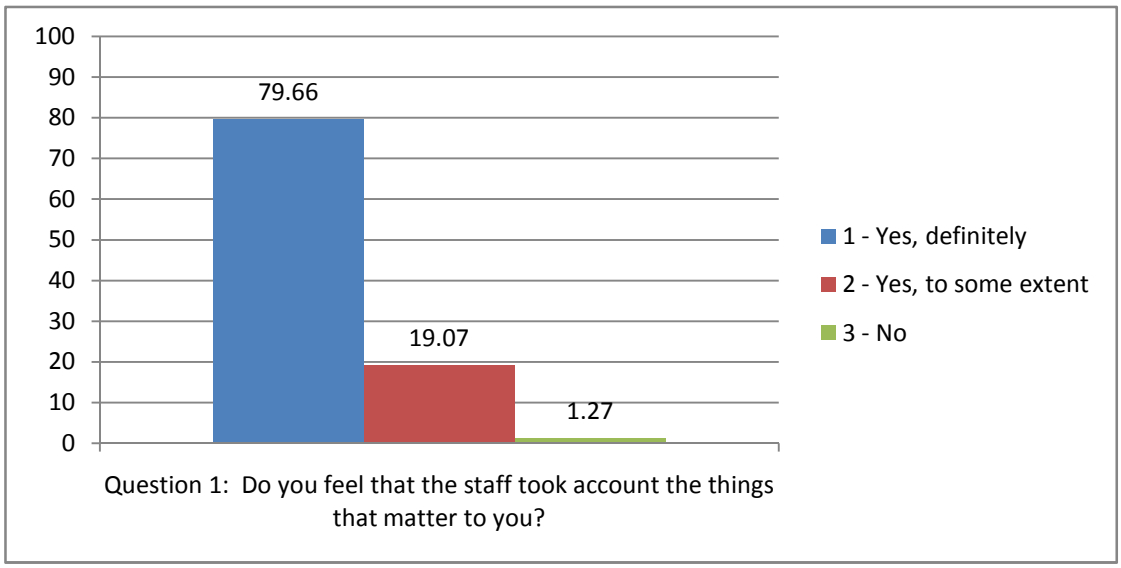

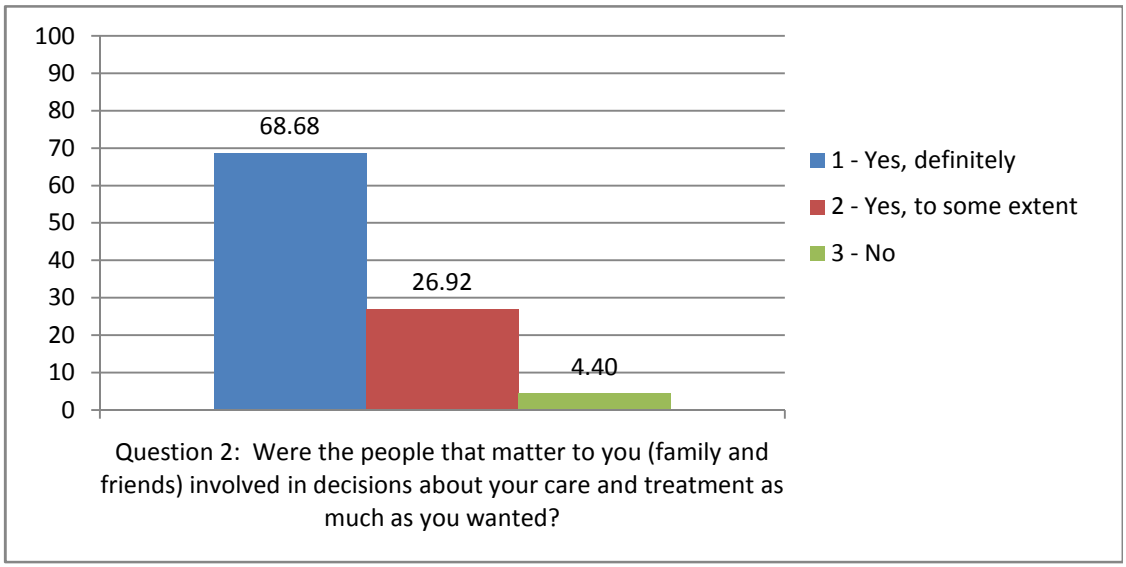

Tell Us Ten Things
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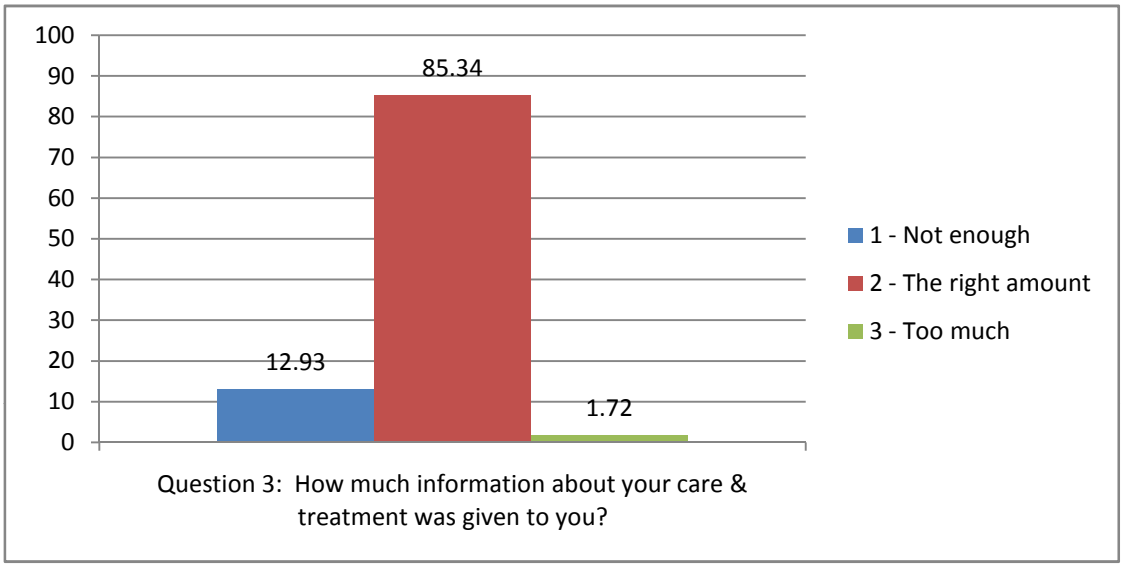
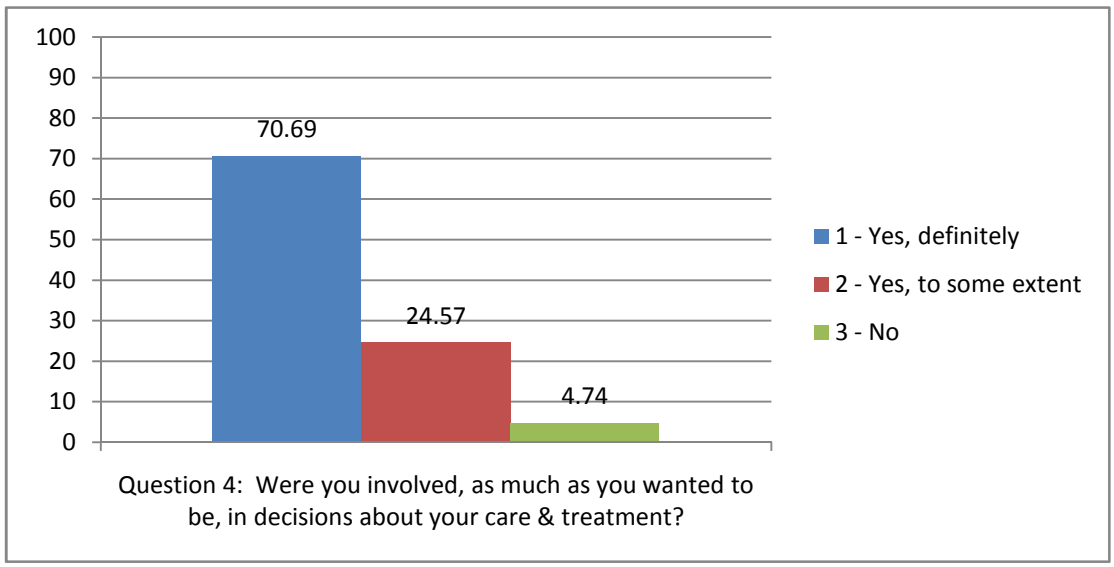
RIE - All Wards



Question 3: How much information about your care & treatment was given to you?



Question 4: Were you involved, as much as you wanted to be, in decisions about your care & treatment?

Tell Us Ten Things
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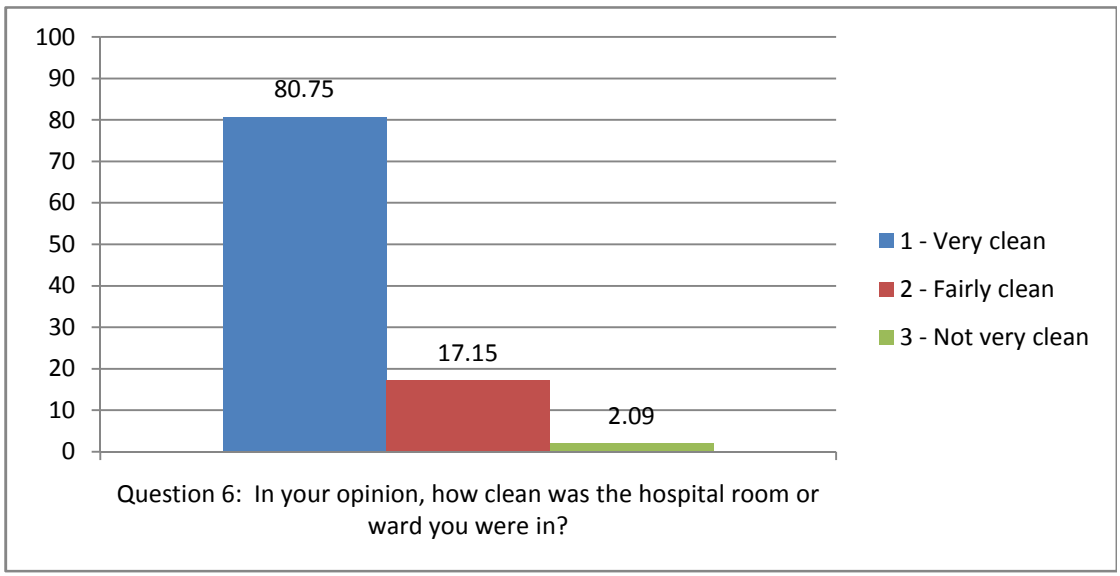
Question 5: Were you treated with kindness & compassion by the staff looking after you?



Question 6: In your opinion, how clean was the hospital room or ward you were in?

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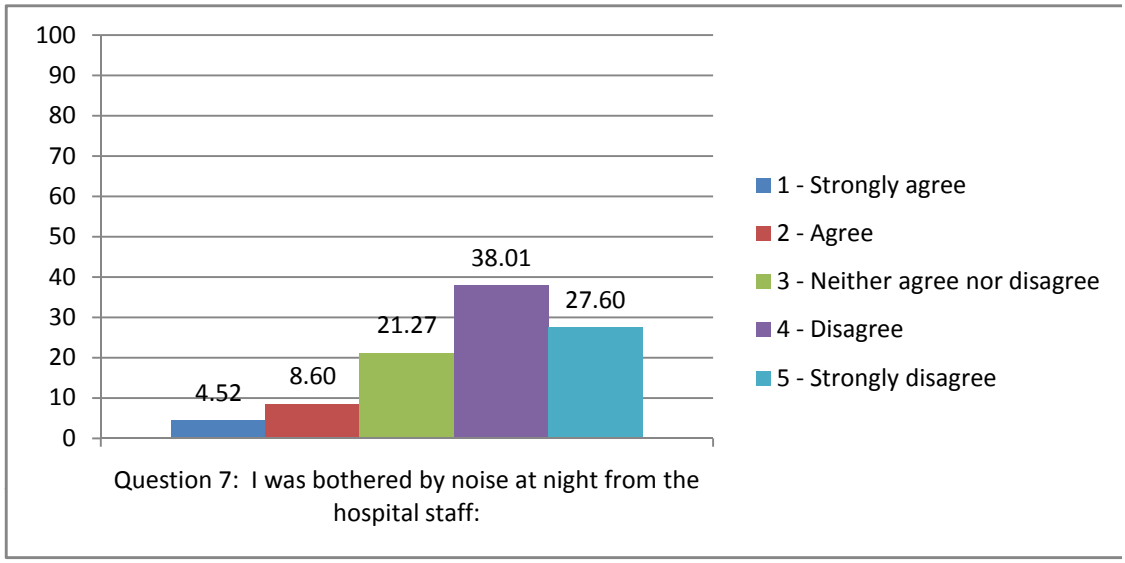
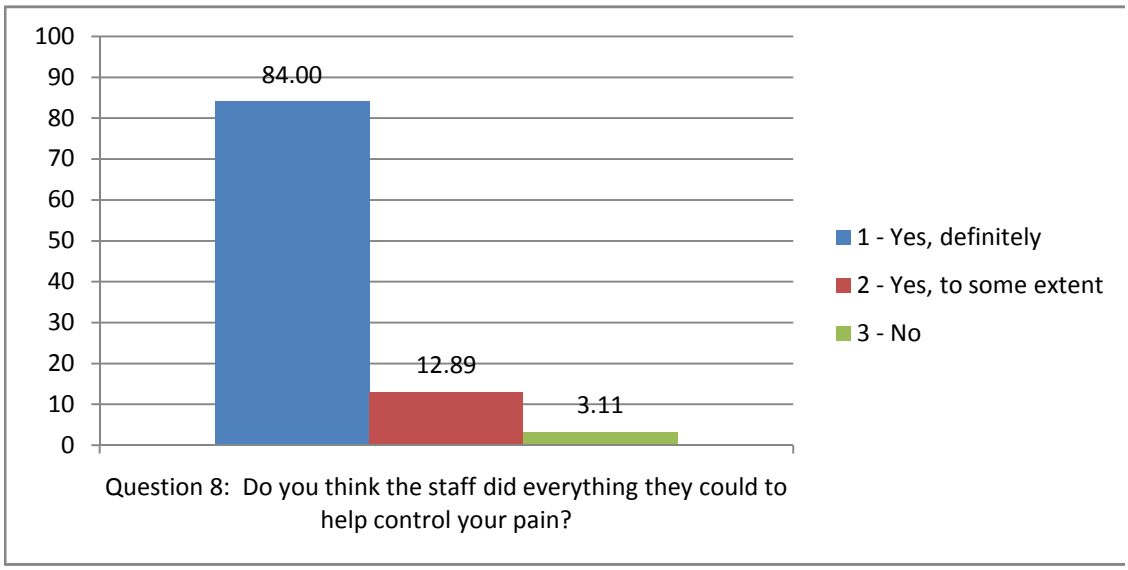


Question 7: I was bothered by noise at night from the hospital staff:



Question 8: Do you think the staff did everything they could to help control your pain?

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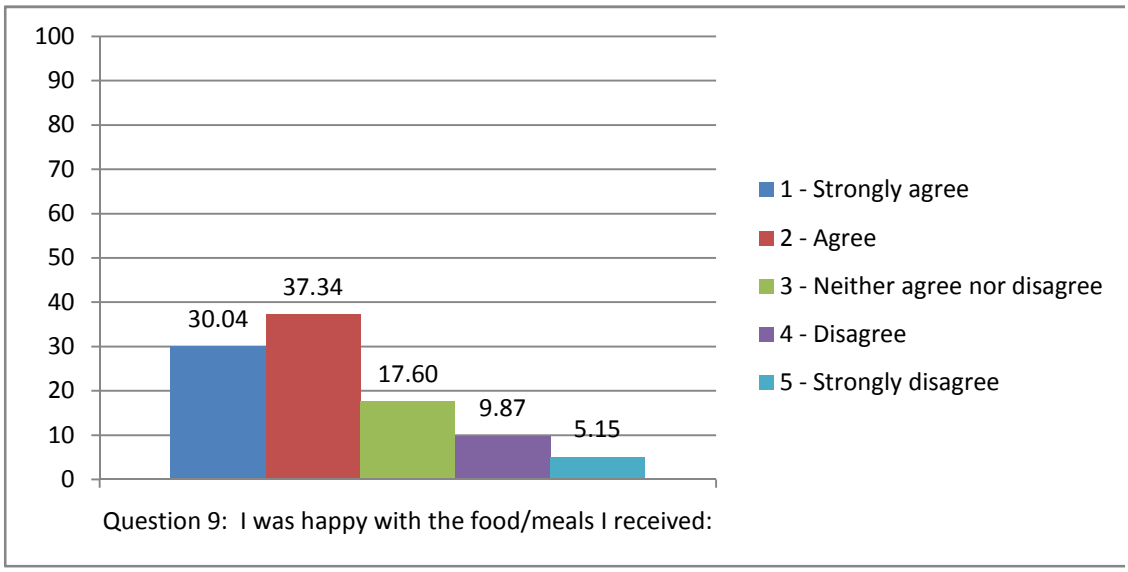
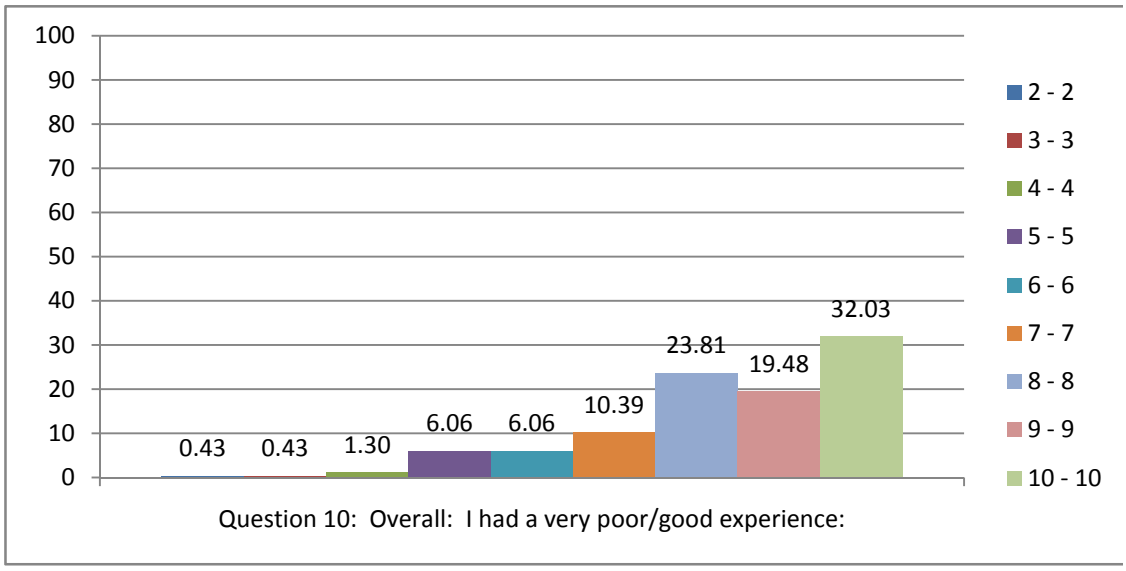


Question 9: I was happy with the food/meals I received:



Question 10: Overall: I had a very poor/good experience:

Tell Us Ten Things
Survey Results for December / January

TTT Q11 - Is there anything else we could have done to improve your experience of our care?

Date Completed	Comments
26/01/2015	Meals not great.
23/01/2015	I thought the overall standard of care was very good indeed. I would add that it's unpleasant to have the ward cleaned during meals.
23/01/2015	Staff were excellent, very caring & professional. Provide free TV & free WiFi. Menu was poor & needs over hauled. The shower requires a curtain to stop water going everywhere.
23/01/2015	No
23/01/2015	Not at all. All the nurses were so kind and caring to me - Doctors as well!
15/12/2014	The entrance to the hospital is still off putting with patients and relatives smoking and the area full of litter from people disposing of their tickets at the machine. Domestic staff standing around in the foyer area consuming their take away meals is also off putting if one is ill. Overall the staff were kind and courteous.
15/12/2014	Every little thing is perfect so not another thing can be added. Perfection.
15/12/2014	Probably would need individual private rooms.
16/12/2014	Staff can try to tell patients more about when they can go home. There seems not to be a strategy when patients can go home.
15/12/2014	I think it very important that family are kept well informed. Staffing levels at weekend could be improved. I think catering/café facilities are not very clean and do not think it is great that staff and visitors share them
16/12/2014	Patients shouldn't be left for long after been seen by Physio then waiting for Consultant to see you before getting released!
16/12/2014	Communication between shifts didn't always work. I know it should all be documented but some information not covered by pro-forma is lost.
16/12/2014	No

16/12/2014	Food - Soups & puddings were ok, main courses very poor - Imo As far as I understand, according to studies, patients that are given healthy, nutritious meals recover quicker and are able to be discharged sooner. Making the service more economical overall! Thank you.
17/12/2014	No. All care was first class.
18/12/2014	Not a thing! I had excessive care & attention both visits, care excellent.
17/12/2014	I thought my experience in this hospital was first class all staff were helpful and always had a smile [Name supplied]
17/12/2014	Majority of staff were pleasant, however as a Diabetic I felt annoyed at having food placed in front of me and no Insulin either given or prescribed till over an hour later. This made the majority of meals cold and unappetising.
24/12/2014	NHS staff are amazing.
24/12/2014	No
15/12/2014	In my ward, there are elderly people that feel the cold (I don't) Also my ward is the only ward that you have to pay for your TV which is disgraceful, while everyone else watching theirs free.
27/12/2014	No
24/12/2014	It was as good as it could be. Nb; Bin lids clattering!
15/12/2014	When being discharged the length of time it takes to get doctors letter and medication was a disgrace. I waited from 9am until almost 5pm and they had been told I was being picked up at 3pm. We have a 2 hour drive so we ended up hitting the works traffic which made our journey even longer.
24/12/2014	No not at all.
29/12/2014	Nothing. In my opinion I was very impressed with my treatment & care. From consultant to domestic everyone were wonderful to me.
25/12/2014	Ward could have been warmer.
17/12/2014	Just wished bathrooms were cleaned a bit more often, but that depends on how patients use it and it is different in every bedroom.
29/12/2014	Nothing. In my opinion I was very impressed with my treatment & care. From consultant to domestic everyone were wonderful to me.
17/12/2014	Some members of staff very helpful and considerate.
17/12/2014	No - I've been very well looked after
17/12/2014	No. Staff always very good. Very good experience.
18/12/2014	Staff need to remember that the patients they are looking after are ill and some staff are very rude.
18/12/2014	More staff? Night duty only one nurse on her own with one carer. Different staff every day no continuity, no trust built up one day very different somedays tea not given meals at different times, food uneatable.
18/12/2014	Build kitchens in the grounds and employ people in the pantry.
18/12/2014	The food was good but not to my liking,
18/12/2014	All I can say is the NHS is the jewel in the crown. Most countries would relish this service we receive in the United Kingdom. PS Keep the good work going.

18/12/2014	I am satisfied and pleased with everything.
18/12/2014	None
18/12/2014	More freedom to move about the hospital. More information about care/mental health. More info about why/how I got here.
18/12/2014	Frequent noise from the beeping machines. It would be good if the noise was less frequent. Thank you. Great team.
17/12/2014	More staff needed. Presently phone rings & rings as staff are so busy & rightly, put patients first.
19/12/2014	It was great for me to come to ward because in previous ward - elective rather than trauma - people didn't understand my condition. Some staff told me I wasn't doing well, needed to get up more and asked why I didn't have clothes in - said I should. I needed explanation of my situation & so did staff.
22/12/2014	Staff don't seem to listen, may be too busy.
24/12/2014	Improve the food.
19/12/2014	None.
19/12/2014	The patient next door was badly upsetting the other 3 patients, if a single room had been available he should have been moved.
19/12/2014	No. Totally happy considering it was an emergency hip replacement after having been pushed down accidentally . Very high standard throughout.
20/12/2014	No, except staff are brilliant.
16/12/2014	Food!!! Waiting time. Staff to patient ratio. Parking fees.
18/12/2014	No.
19/12/2014	I was impressed how well the support specialists were coordinated to make their involvement effective. Plenty of encouragement during the whole process. Excellent attention from [Name supplied].
16/12/2014	Bit more explanation and understanding of my pain - particularly in A&E. I still had severe pain even though no fracture showed in first instance - it later did show fracture.
16/12/2014	Need more staff!!
20/12/2014	Nothing to improve experience. Very few or no wheelchairs for disabled visitors - Why not use wheelchairs with chain & coin system to make people take chairs back (this is common in other EU countries)
19/12/2014	Excellent care.
19/12/2014	Very obliging - phoning family etc.
18/12/2014	Nothing at all, keep up the good work.
18/12/2014	The curtain situation! This is definitly a source for infection. Staff are meticulous about hand washing & rubber gloves but with the gloves on pull the curtains back when they finish with one patient. Only then are the gloves put in the bin. I observed just one doctor doing it correctly but perhaps she had more time!!
18/12/2014	All the staff were excellent. The nurses never stopped working and get impression didn't have enough time to take their breaks as possibly not enough staff sometimes. Minor point: had to wait quite a long time on a few occasions for assistance that would have been helpful e.g. walk with a drip stand & zimmer

22/12/2014	No
13/01/2015	More correspondence between doctor & patient. Having had x-rays & scans I still await results.
13/01/2015	Make sure I was washed before breakfast so that my porridge wasn't cold.
13/01/2015	No.
16/01/2015	I can't fault anything.
16/01/2015	Not really no.
16/01/2015	None
15/01/2015	Not really.
15/01/2015	Everybody was very good. Could not do enough for me.
16/01/2015	Lack of physio Sat & Sun after op. Leg stiffened & caused more pain. 2 auxilliary staff could have better manners & consideration. Very rude. 4/5 hrs in recovery ward before bed available. Most upsetting. Can't believe what goes on at night. Nurses & patients need more security. [Name supplied]
16/01/2015	Not from what I have encountered.
16/01/2015	The food was very bad, 3rd rate and I would not give to a animal, a disgrace. Regards to staff cannot fault anyone.
16/01/2015	No.
06/01/2015	No
31/12/2014	Better food.
31/12/2014	Nothing but tell the doubters the food/service is superb and makes nonsense of anyone criticising the NHS.
01/01/2015	Nothing - I had a great time. Would have preferred more beer on hogmanay.
31/12/2014	Not really.
05/01/2015	Only issue is food amount. Large - small portions (Same). Everything else 10/10
09/01/2015	Ward was the best ward that I have been in the care and attention was second to none.
11/01/2015	Food is always cold & tasteless. Feel a bit too much light at night but then the nurses trying to work.
11/01/2015	The food is disgusting.
13/01/2015	Better food.
12/01/2015	Nice manner to help patients.
15/01/2015	Toilets need cleaned more regularly. Invest in some oust or febreeze. Food is fantastically bland, hire a new chef.
15/01/2015	I was cancelled from previous month & turned up wondering if I would be turned away again, to be told that hardly ever happens. It would have been nice to know. My only criticism was the roaring TV in the wating room, that was terrible. And some patient had a roaring TV in a neighbouring single room & when I asked a member of staff if it could be sorted, she was pretty grumpy, but it was sorted.
15/01/2015	Waiting time for operation
15/01/2015	I think everyone works very hard. I admire all workers and carers.

14/01/2015	The doctors listened to what we had to tell them and kept us informed. The treatment was excellent for patient and family.
20/01/2015	Was better food at WGH.
21/01/2015	No
01/01/2015	After being an inpatient for 6 days, I found someone else's blood on my bed and side rails. This was disgusting! Pain relief was delayed by up to an hour because all staff were on breaks or doing handover so there wasn't enough staff to double check controlled drugs.
21/01/2015	A bit more communication between staff, was informed I would get meds over night but didn't due to transfer from ward to ward.
21/01/2015	Nothing
21/01/2015	No
21/01/2015	The meals were the least admirable part of the experience.
21/01/2015	No

NHS LOTHIAN

2.6

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - LOCAL DELIVERY PLAN 2015-16

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• The Board is recommended to approve the final version of the Local Delivery Plan (LDP) 2015-16	2.1
• The Scottish Government have provided a revised set of LDP standards (previously known as HEAT standards and targets)	3.3
• The 2015-16 LDP is aligned to the NHS Lothian Strategic Plan 2014 - 2024 progress report which was approved by the Board in February 2015	3.4
• A draft version of the LDP has been submitted to the Scottish Government for comment. Feedback has been incorporated in the final version of the LDP.	3.5
• Key risks associated with delivery of the LDP have been identified.	4.1
• The LDP financial plan assumes delivery of £30m efficiency savings via the Local Reinvestment Programme (LRP)	8.1

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20 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

LOCAL DELIVERY PLAN 2015-16

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the Local Delivery Plan (LDP) 2015-16 outlined in Appendix 1. The final LDP was due to be submitted to the Scottish Government on 20 March 2015, therefore a draft plan has been submitted until endorsement of the LDP by the Board. The final LDP will be submitted to the Scottish Government following the Board meeting.

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

2 Recommendations

2.1 The Board is recommended to approve the LPD 2015-16 for submission to the Scottish Government on or around 2 April 2015.

2.2 Note the LDP will continue to be the contract between the Scottish Government and NHS Lothian. Separate guidance has been produced for Integrated Joint Boards to support development of their Strategic Commissioning Plans which will need to be aligned to the LDP.

3 Discussion of Key Issues

3.1 The Scottish Government has reaffirmed its commitment to the 2020 Vision with a key target to increase healthy life expectancy. The 2015-16 LDP guidance sets out 6 improvement priorities (detailed below) and asks that NHS Board LDPs outline how plans and services will support delivery of these priorities.

- Health inequalities and prevention
- Antenatal and early years
- Person centred care
- Safe care
- Primary care
- Integration

3.2 In addition to the 6 improvement priorities, the LDP also outlines how NHS Lothian will support:

- LDP Standards (previously HEAT standards and targets)
- Financial Planning
- Workforce
- Community Planning

3.3 As many of the Hospital Efficiency and Access Targets (HEAT) targets and standards have been delivered in previous years, the Scottish Government have reviewed the priorities and provided a revised set of LDP standards for delivery which are outlined in Section 3 of the LDP. Further national guidance is awaited for standards relating to Alcohol Brief Interventions and Staphylococcus aureus Bacteraemia (SABs).

3.4 The 2015-16 LDP is aligned to the progress report associated with Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014-24 which was approved by the Board in February 2015.

3.5 An early draft of the LDP has been submitted to the Scottish Government seeking review and comment on the contents of the draft plan. The plan presented to the Board has been updated to reflect feedback received.

4 Key Risks

4.1 The LDP highlights 2015-16 will be a challenging year for NHS Lothian. The LDP is predicated on NHS Lothian's ability to deliver local investment plan assumptions, reliance on Scottish Government allocations particularly relating to primary care and mental health, delivering bed reductions, maintaining 'acute flow' and reduction in the number of people boarding and delayed across our system.

4.2 A risk schedule highlighting the key assumptions and risks associated with the LDP is outlined below.

Very High Risk	Bed Reductions, Income Assumptions, Social Care Investment
High Risk	Local Reinvestment Programme, Scheduled Care, Unscheduled Care, Delayed Discharge, Changes to IPTR Process, Parental and Adoption Leave, Hepatitis C Drugs, SGHD Allocations, Capital Programme, Equal Pay
Medium Risk	Pay (Terms and Conditions), Prescribing, Rebates and Property Sales

5 Risk Register

5.1 Responsible Directors are asked to ensure risks associated with targets and plans are clearly identified on the Risk Register and risks are escalated to the Corporate Risk Register as appropriate.

6 Impact on Inequality, Including Health Inequalities

6.1 The approved strategies and plans referred to in the LDP will have been subject to an Equality and Diversity Impact Assessment.

7 Involving People

7.1 The LDP is aligned to the NHS Lothian Strategic Plan 2014-2024 which was issued for public consultation from August to October 2014.

7.2 The other strategies referred to in the LDP will also have undergone a period of public consultation.

8 Resource Implications

8.1 The current assessment of the LDP financial plan for 2015-16 shows a recurring gap of £14m offset by non-recurring resources to achieve a balanced financial position. The financial plan assumes an in year delivery from efficiency savings via the Local Reinvestment Programme (LRP) of £30m.

8.2 At the time of writing this paper, confirmation is awaited for allocations expected from the Scottish Government to support delivery of plans relating to mental health and primary care services.

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List of Appendices

Appendix 1: Local Delivery Plan and LDP Appendices

APPENDIX 1

NHS LOTHIAN

LOCAL DELIVERY PLAN 2015 - 2016

Unique ID: NHS Lothian Local Delivery Plan 2015 /16	Author (s) Alex McMahon, Libby Tait, Alyson Cumming
Category/Level/Type: Local Delivery Plan 2015 -16	Authorised By: Director of NHS Lothian: Strategic Planning, Performance Reporting and Information
Status: Final Draft	Version 9: 20 03 15
Date Authorised:	Review Date: Ongoing

CONTENTS **PAGE**

Executive Summary

This years Local Delivery Plan outlines work which has progressed over the past year in the development of Our Health, Our Care, Our Future: NHS Lothian's Strategic Plan 2014-24. The Strategy outlines our commitment to improve the health of the population, support delivery of the Scottish Government 2020 Vision for health and social care and support for the integration of health and social care though the establishment of Integration Boards.

A strategic plan progress report was signed off by NHS Lothian Board in February 2015. This report outlines the key priorities and propositions relating to policy choices, re-profiling of our workforce to support new models of care, development of a person-centred care delivered through the Lothian House of Care approach, prioritising actions and projects in primary care to support a shift in the balance of care and development of Integrated Care Facilities in the North and South Edinburgh and further potential development of this type of facility in East and Mid Lothian. The plan also outlines the direction of travel and future development of our acute hospital sites and the re-provision and re-design of hospital and outpatient services.

NHS Lothian launched Improving 'The Health and Wellbeing of Lothian's Children and Young People', a Strategy for Children and Young People 2014-2020 which is supported by an implementation plan that includes actions to take forward the requirements of the Children and Young People (Scotland) Act 2014. At the same time the Board also signed off a new cancer and primary care strategy and a strategy for addressing health inequalities.

Work is on going to finalise the Integration Schemes to support the establishment of four Integration Joint Boards in Lothian during 2015-16. These schemes of establishment will be submitted to the Scottish Government at the end of March 2015 for approval. NHS Lothian is supporting development of the Integration Board Strategic Plans to ensure priority propositions outlined in Our Health, Our Care, Our Future are reflected in local plans. In progressing this work, we will look to achieve balanced financial plans for the new partnerships but this ambition remains challenging in the current climate.

2015-16 will be a challenging year for NHS Lothian and delivery of our Local Delivery Plan will be predicated on our ability to deliver our local reinvestment plan (LRP) assumptions. A significant proportion are in the high risk category i.e. delivering the redesign of bed based models of care; maintaining flow to ensure our elective programme delivers the Treatment Time Guarantee, which is dependent on maintaining a lower or reduced reduction in the number of people boarding and delayed across our system. Other factors are changes to the Individual Treatment Patient Requests and drug prescribing, particularly in acute care settings. As well as a reliance on allocations for primary care and mental health development from the Scottish Government. . The latter would assist in our ability to deliver an improved performance against the psychological therapies waiting times target. We look forward to the continuing dialogue and support in delivering the aspirations outlined in our strategy and in this plan.

1. INTRODUCTION

1.1 Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014-24

In April 2014, NHS Lothian Board approved a draft Strategic Plan, which was subsequently issued for public consultation and reported back to the NHS Lothian Board in October 2014. A final progress report setting out current context and the key work streams and propositions was taken to and signed off at the NHS Lothian Board meeting on 4th February 2015.

The Plan reflects considerable activity across a wide range of work streams, leading towards a clearer articulation of the 2020 Vision. What has become clear, in the interim, is the scale of the challenge in seeking to deliver our strategic ambitions in the absence of a balanced financial position.

Our work has concentrated on:-

- Finding innovative ways of delivering our strategic ambitions within a constrained financial position;
- Refining service models and identifying how current provision will need to be fundamentally reshaped to deliver the future;
- Prioritising the role of primary care and the immediate steps to address capacity challenges to support the shift in the balance of care;
- Agreeing the right 'footprint' for acute services, recognising the conflict of short-term expectations and longer term need in terms of meeting treatment time guarantees, the 4 hour waiting targets in A&E departments, delayed discharges and other performance targets;
- Reviewing and reorganising the workforce profile so that it is fit and sustainable to deliver the future.

A number of enabling strategies include:-

- The centrality of the Partnerships' Strategic Commissioning Plans, which will both inform and be informed by this plan but which also will progressively develop comprehensive local plans for each partnership that will replace some elements of this plan in the future;
- A robust and publically-defensible approach to improving efficiency and productivity, including the benchmarking of performance;
- A re-focused and energised system of clinical leadership to help identify solutions as well as to deliver change;
- A more rapid and systematic adoption of proven technologies together with encouragement of innovation;

Development of processes designed to achieve financial sustainability.

1.2 Policy Choices

Successful delivery of the strategic ambitions in our Strategic Plan is promulgated on the Board's adoption of a number of fundamental policy choices which it agreed in February this year, these include:-

- A renewed emphasis on providing services in the community, to support people to remain at home, regardless of the time of day or night, with hospital admission being the exception and only when it is clinically required;
- Discharging patients as soon as possible to assess their ongoing needs at home, instead of retaining them in hospital beyond their acute clinical need;
- Rehabilitating patients in their home, rather than retaining them in hospital beyond their acute clinical need;
- Phasing out the provision of delayed discharge beds in hospitals, in favour of appropriate levels of social care;
- The closure and disposal of outmoded institutions and their replacement with integrated care facilities and other such models of care;
- Reprofiling of the workforce to support more appropriate and contemporary models of care.
- Ring fence elective beds

1.3 Pathway Redesign – Lothian House of Care

Within our Strategic Plan, we developed four patient pathways, Sophie, Callum, Hannah and Scott. Aligned to the development of these pathways the 'House of Care' was identified as a useful model of care during the initial work on the Hannah patient pathway. In addition, the Scottish Government offered Lothian funding to support early adoption of the House of Care.

Initial £70,000 funding offered by the Scottish Government to support early adoption in Lothian has been confirmed. NHS Lothian and the Thistle Foundation have entered into a partnership to take this forward. A further £70,000 per annum for 2 years has recently been secured from the British Heart Foundation through the Scottish Government to establish early adopter sites targeted at people living with or at risk of heart disease.

Nationally the approach has been endorsed by the Action Plan "Many conditions, One life" to improve care and support for people living with multiple conditions in Scotland.

Pathway redesign utilising the House of Care approach is now considered to be a major driver of service change and improvement. Planning for service change in a number of services is now actively incorporating consideration of the needs of our four "typical" patients represented by Hannah, Callum, Scott and Sophie.

2. IMPROVEMENT PRIORITIES

2.1 Health Inequalities and Prevention

2.1.1 NHS Lothian Health Inequalities Strategy 2014-17

The Board approved the NHS Lothian Health Inequalities Strategy in December 2014, a copy of the strategy is available in Appendix 1. The strategy sets out priority actions in relation to:

- Procurement
- NHS Lothian as an employer
- Planning and delivery of clinical services
- Partnership
- Monitoring and evaluation.

A detailed action plan is in place that sets out key actions, milestones and measures of progress for each of these. The local strategy group will monitor progress against each of the agreed actions. Examples of some key actions, milestones and measures are given below.

Action	Milestones	Measures
Develop use of community benefit clauses in contract specifications and procurement strategies. NHS procurement policies should support employment & income for people in communities with fewer economic levers. Actions to support staff to support the most vulnerable people and communities.	Agreed increase in targeted community benefits in project specifications – as new projects specified, review November 2015 Realisation of agreed benefits – according to projects' timescales	Numbers of training opportunities Numbers of apprenticeships Spend in Supported Businesses
Increase recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme	Programmes identified for the following groups: School leavers Vulnerable young people, including those with a disability Graduates with a disability People with learning disabilities People with autism People who have been long term unemployed Women returning to work, education or training	Numbers of people from identified vulnerable groups offered placements/ training Numbers of people recruited from identified vulnerable groups Number who sustain employment >6mths

Staff training to enable them to respond to social & economic circumstances affecting patients' health. This should include cultural competence.	Small group to be established Training needs assessment – May 2015 Training developed for different staff groups – December 2015 Delivery of training - from January 2016. Additional Needs Task Force work plan to increase uptake of additional needs. Knowledge Identity Language Tools (KILT) project provides inequalities training for staff.	Numbers and proportions of different staff groups who receive training Evaluation of training
Ensure Health & Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities	Strategic needs assessments completed including identification of inequalities, vulnerable groups, and relevant actions – April 2015 Ensure needs assessments, commissioning and financial plans prioritise prevention, early intervention, primary and community services, address inequalities across the life course and demonstrate distribution of resource allocation explicitly	Explicit demonstration of inequalities issues within each needs assessment
Continue routine use of impact assessment of new policies and plans	Complete pilot of Integrated Impact Assessment – April 2015 Identify impact assessment leads in each area to facilitate IIAs – April 2015 Audit of implementation of actions from impact assessments – ongoing	Number of impact assessments Proportion of actions implemented in agreed timescales
The Living Wage	Procurement & employment. NHS Lothian will ensure that their staff is paid a living wage. We will implement contracts and SLAs that encourage use by suppliers of the living wage.	Increased number of contracts and SLAs held with organisations that pay a living wage or are registered and working towards it.

2.1.2 Health Promoting Health Service (HPHS)

The HPHS CEL (1) sets out the strategic and delivery requirements for the hospital environment to become truly health promoting. The current year challenges us to continue to develop HPHS priority action on tobacco, alcohol, breastfeeding, staff health and wellbeing, sexual health, physical activity, active travel and increase work with MCNs. Key actions for 2015/16 will include:

- A new tobacco policy and introduction of smoke-free NHS grounds (WHO Framework for Tobacco Control)
- Attainment of UNICEF baby friendly accreditation (WHO essential interventions to prevent childhood morbidity & mortality)
- Attainment of the Healthy Working Lives award across all sites. (WHO Workers Health Action Plan)
- Increased emphasis on the promotion of Physical Activity and active sustainable travel – an action plan is in place to deliver this. (WHO Environment action plan, Cancer Prevention Plan)
- NHS procurement of healthy food.
- Reducing non communicable disease premature mortality by 2025 (i.e. <75 yrs old)

CEL (01) has been extended for another year to 2015/16. During this time Health Scotland and the Scottish Government will discuss the post 2016 direction of the programme. Indications are that there will be an increased focus on health inequalities and a more outcome focused reporting framework.

2.1.3 Workplace Health and Employability

The quality of work affects wellbeing and health. The workplace health programme, including Healthy Working Lives (HWL), works with employers to support good practice in relation to employee wellbeing and safe working through guidance, advice, training and the provision of practical resources. In 2015/16 we will continue to provide:

- Support for the HWL Award programme.
- Training opportunities on key issues such as managers' understanding of workplace mental health, stress, substance use and health & safety issues.
- Specialist consultation and practical resources on a range of topics.
- Links with Workers Health Action Plan targets

We will continue to prioritise small, medium enterprises (SME), particularly for support in relation to health & safety as they are more likely to lack in-house expertise on health and safety and health and wellbeing. In particular, we prioritise SMEs more likely to be affected by health inequalities taking into account indicators such as low pay, industry sector and geographical location.

2.1.4 Preventing Obesity, Promoting Healthy Diet and Physical Activity

Work to promote healthy diet and physical activity is prioritised, and often delivered, through local partnership work involving NHS, Local Authority and Third Sector representatives to identify and address local needs.

In 2015/16 we will continue to:

Participate in food and health and physical activity partnership groups in each of our four local authority areas. Each group has representation from NHS, Local Authority and Third Sector. Each has an action plan setting out a range of activities and reports regularly against these through community planning structures.

Use the Health Improvement Fund to support interventions that aim to address inequalities in diet and physical activity through increased knowledge, confidence and skills. Each project has an action plan for 2014-17 that has undergone Rapid Impact Assessment and reports six-monthly basis on progress towards their agreed outputs and outcomes.

Use the Health Improvement Fund to support interventions that aim to address inequalities in diet and physical activity through increased knowledge, confidence and skills. Each project has an action plan for 2014-17 that has undergone Rapid Impact Assessment and reports six-monthly basis on progress towards their agreed outputs and outcomes.

Ensure there are up-to-date, relevant and effective resources available from the Health Promotion Resource Centre. Promote and make available to internal and external agencies

Maintain up-to-date information on the health promotion website and share links through partner agencies

Deliver workshops and provide support to internal and external agencies promoting the role of physical activity and healthy eating.

Provide training opportunities through NHS Lothian's capacity building programme

Implement the Allied Health Professionals Physical Activity Pledge and Health Scotland's Physical Activity brief interventions.

Continue work towards Stage 2 Baby Friendly accreditation in community and full accreditation to new UNICEF standards in hospital settings.

Continue work to increase documentation of Healthy Start eligibility and encourage eligible women to access vitamins and food vouchers, using Early Years Collaborative Improvement Methodology

Continue to deliver school and community based child healthy weight programmes.

2.1.5 Tobacco

The NHS Lothian Tobacco Strategy Board leads work on tobacco prevention, protection and cessation and has representatives from NHS, Local Authorities and 3rd sector. The group co-ordinates tobacco work to meet the aims of HPHS, cessation HEAT target and other tobacco related work linked to the WHO Framework for Tobacco Control that will lead us towards a smoke free generation.

Prevention

A sub-group of the Strategy Board has developed a 5 year action plan to improve the effectiveness of tobacco prevention. Routine monitoring systems exist and the evaluation and research aspects of the plan are supported by University of Edinburgh. Key activities include:

Pilot of Decipher-Assist smoking prevention approach in 24 secondary schools as part of Scottish Government national pilot project

Roll-out of smoking prevention programme in West Lothian College to target students 16-24 years.

Delivery of smoke-free homes project via primary schools to raise awareness and encourage more households to be smoke-free.

Youth tobacco action grants to youth-work organisations in order to involve young people in planning, organising and improving smoking prevention activities.

Improving tobacco policy implementation and practice delivery in youth-work organisations.

Involving 3rd year students in creating an interactive tobacco education computer game for use in secondary schools, with Abertay University

An action research project with young people looking at why adults supply young people with cigarettes (with University of Edinburgh

Provision of tobacco prevention training opportunities for staff & volunteers.

Protection

All NHS Lothian grounds including mental health will be smoke-free and use of ENDS controlled from 1 April 2015. The policy is agreed by NHS Lothian Partnership Forum and has senior management endorsement. There is a detailed communications plan targeting the general public, patients, staff and other NHS users - signage is being refreshed, smoking shelters removed and staff groups trained. A LearnPro module is being developed for all staff and included in induction.

Local management are responsible for policy implementation and training is being provided and performance reporting expected. To help implementation the Stop Smoking service has two facilitator posts working with staff and management groups in mental health and other acute sites. The Stop Smoking service is devoting more resources to secondary care and will provide NRT to cover hospital stays for those who do not wish to stop.

Monitoring will initially be through fortnightly meetings with management and staff groups on each of the major hospital sites, and thereafter be through complaints, Datix and informal feedback.

Cessation

Priorities for stop smoking service remain providing an effective cessation service to hospital patients (both in acute and mental health hospitals), young people, pregnant women and their families, and prisoners. We will set local targets for each of these priority groups once we have the new HEAT target for 2015-16. We will work with Lothian's prisons to help them achieve smoke free status within plans in place during 2015.

Carbon Monoxide screening (to detect if individuals have been smoking) at booking and referral to stop smoking service is now well established in NHS Lothian and the stop smoking service is working with Early Years Collaborative to improve engagement with pregnant women.

We plan to re-design our stop smoking service to improve skill mix and become more cost effective. We will take a community development, asset based approach when developing services. We will also consider ways of providing prevention and cessation to young people in a more effective way.

Stop smoking service staff will complete on-line national centre smoking cessation training (NCSCT) training until a national programme is re-established for Scotland. This will improve staffs' knowledge and they will also be provided with an in-house training programme to enhance their skills and practice. A training programme will continue to be delivered to community pharmacies to enhance knowledge and skills to help increase their activity.

We will implement surveillance and address barriers to smoke free generation systematically.

We will continue to monitor progress using ISD database and performance will be reported directly to the corporate management team.

2.1.6 Alcohol and Drugs

We will support the implementation of an alcohol and drugs strategy to reduce the burden of morbidity and mortality through reduced availability and reduced consumption. NHS Lothian and other partners within each of Lothian's Alcohol and Drug Partnerships will sustain the delivery of Alcohol Brief Interventions in the three priority settings (Primary Care, Antenatal and A&E) during 2015/16. We will continue to provide support to the Substance Misuse Directorate reviews on drug related deaths at a local level with a view that this prevention/early intervention activity will contribute to work to reduce health inequalities and promote the health and well being of communities by focusing on the needs of the local population in the harder to reach groups where deprivation is greatest.

We will continue to deliver a comprehensive education and training programme for groups of staff in both statutory and voluntary agencies, for example in prisons, police custody suites, criminal justice programmes ,youth and sexual health programmes/services and welfare rights teams. This helps to ensure that disadvantaged groups receive a quality service.

Working with our partners in the three Alcohol and Drug Partnerships (ADPs) in Lothian, there will be further developments to enhance local treatment and care systems to make them responsive, person centred and recovery focused. We will continue to ensure that people access treatment promptly within 3 weeks of referral and are supported in their recovery by services provided locally and in an integrated way.

During 2015-16 we will continue to develop the inpatient rehabilitation service for patients with acquired brain damage as a result of alcohol misuse at Milestone House. The Alcohol Related Brain Damage Unit is providing intensive rehabilitative support to enable people to return to their own home with reduced use of re-admission to the acute sector.

We will work with partners to try to reduce the availability and consumption of alcohol and maintain and expand the use of take home naloxone kits to reduce the numbers of Drug Related Deaths.

2.2 ANTENATAL AND EARLY YEARS

2.2.1 NHS Lothian Strategy for Children and Young People 2014 – 2020

Aligned with Our Health, Our Care, Our Future in November 2014, and NHS Lothian Strategy for Children and Young People 2014-2020 'Improving the Health and Wellbeing of Lothian's Children and Young People' was launched having been signed off by the NHS Lothian Board. The strategy is attached in Appendix 2. The Strategy:-

- is underpinned by the Getting it Right for Every Child (GIRFEC) approach
- is aligned with the United Nations Convention on the Rights of the Child
- was widely consulted on and took account of the views of 351 children and young people aged between 3-25
- is outcome focussed and supported by an implementation plan that includes actions to take forward the requirements of the Children and Young People (Scotland) Act 2014 (The Act).

The Scottish Government have requested that we set out the local actions we will take to ensure relevant parts of the workforce will have the capacity, training and relevant protocols to carry out the duties under The Act. The table below provides an extract from the strategy Implementation plan that sets out key actions NHS Lothian will carry out during for 2015/16 to implement our duties under the Act. In addition, we will be carrying out a series of GIRFEC pathways workshops for health visiting and maternity staff which will inform development of a local protocol on joint planning during the antenatal care pathway to support implementation and transition of the Named Person role after birth. Further, we will be rolling out information to staff throughout NHS Lothian (including GPs, Substance Misuse services, adult Mental Health services) regarding our duties under the Act and establishing any additional support required to enable staff to fulfil these duties. We have also established an NHS Lothian Act Implementation Group to develop our work plan for implementation and we will continue to work closely with the 4 Children's Partnerships on implementation.

Our other key priorities for 2015/16 to further improve our approach to early intervention and primary prevention will include:-

- During 2013/14, NHS Lothian carried out 7,837 27-30 month checks. This number will increase during 2015/16 with particular targeted work in areas with lower than average figures for 27-30 month review documentation, review by 28.5 months, and follow up/ future action. We'll link in with partner agencies to support uptake of review, focus earlier intervention (e.g. parenting, parental literacy) and to ensure sharing of results from health visitor to nursery/ other early year's settings.

- Whilst we exceeded the antenatal HEAT target in 2013/14 and amended the Lothian target to 88% as a result meeting the target comfortably, work will be ongoing during 2015/16 to look at the approximate 10% overall that we are missing.

- We will continue to work in partnership in our 4 CPPs to support and develop work using the Early Years Collaborative improvement methodology.

- We aim to have uptake of healthy Start vouchers by eligible women and children up to 80% (from around 75%) for Lothian overall by March 2016 through coordinated efforts during pregnancy and following birth, working with midwives, health visitors, nurseries, early years centres and voluntary sector.

- Comprehensive health assessment for all newly notified Looked After Children (including children in kinship care and those looked after at home on a supervision order) now carried out within a four week timescale.

The table below is an extract from NHS Lothian Children and Young People Strategy Implementation Plan which outline plans and progress to ensure provision of an effective and efficient workforce to meet the needs of the growing population of children and young people and to ensure an effective and efficient workforce to meet requirements outlined in the Children and Young People (Scotland) Act 2014.

Life Stage	Indicator	Target	Baseline	What we will do	Who is responsible	Comment
Early Years	Proportion of children under 5 within Lothian with a Named Person	100% by August 2016	From April 2014	We will ensure that all children aged 0-5 will have access to a Named Person as required by the Children and Young people (Scotland) Act We will increase capacity of the Health Visiting workforce	Act Implementation Group	Work plan currently in development
	Increased numbers of trained Health Visitors	Additional 10 Health Visitors trained during 2014/15 Plan for additional 26 Health Visitors to be trained during 2015-16.		Additional 26 nurses to undertake Health Visitor training for 2015/16	Act Implementation Group / Health Visiting workforce Group	As above
School Age	Increased school nurse hours spent in schools	TBD	TBD	We will consider the findings from the national review of school nursing, and develop a NHS Lothian response.	School Health Group	

2.2.2 Health Visitor Population

We currently have 133.2 WTE Health Visitors. Using the Scottish Government weighting tool and also taking account of requirements under the Children and Young People (Scotland) Act 2014, predicted child population increase and current / future predicted vacancies, the total estimated number of new Health Visitors required over the next 3-5 years is 159. Planning to incrementally scale up the number of Health Visitors is underway with plans for the next 2 years as follows:-

Academic Year	2014 -15	2015-16	2016-17
2014-15	Training 16 HVs Training 6CPT (Community Practice Teachers)	Train 26 HVs Train 10 CPTs	Train 42 HVs Train 5 CPTs

Final decisions on numbers that can be trained are dependent on confirmation from the Scottish Government on the proportionate amount that NHS Lothian will receive of the budget for recruiting new Health Visitors.

Over the past two years, CH(C) P Chief Nurses and Clinical Nurse Managers have worked hard to redesign their service and make it fit for purpose. Skill mix and the introduction of Band 5 staff nurses and band 4 nursery nurse posts have been crucial in creating stronger HV teams with the potential for succession planning built in. Pan Lothian work has been done to support the role of the staff nurse following findings from a local study which found inconsistent remit and lack of clarity in role boundaries, concerns about accountability and delegation of interventions, and lack of on going development and professional identity. Work has nearly been completed to develop a framework to standardise the remit and responsibilities of the staff nurse role, outlining the HV service interventions that can be delegated to appropriately prepared staff nurses to meet local service delivery and team needs.

There are a number of options being explored by NHS Lothian to support Health Visiting teams so they are able to meet national requirements around the role of the Named Person and additional input reflecting guidance around caseload weighting and the universal pathway:

- Enhance career pathway options for practitioners to include more advanced practitioners at Band 7 to both keep health visitors in the workforce and to provide an additional resource to support Band 6 HVs
- Further development of B5 role, noting the Scottish Government expectations of visits being done by Band 6

2.2.3 Raising Awareness of the Children and Young People (Scotland) Act 2014

We are currently rolling out of programme of presentations / discussion sessions with management teams across NHS Lothian in both adult and children's services to ensure awareness of responsibilities under the Act. This includes discussion on how to cascade information to staff and to identify any training/support issues in relation to the requirements of the Act. A training programme is under development through the NHS Lothian Act Implementation Group and will be in place by May 2015. Sessions are already planned with substance misuse services, mental health services, AHPs, local authority elected members and GPs. Work is also underway with the 4 Children's Partnerships within Lothian to develop partnership implementation plans including local workforce development needs.

A GIRFEC workshop took place in February 2015 with Health Visiting and Midwifery Services (29 managers and practitioners in attendance) to plan implementation of the Named Person role and the new Health Visitor pathway. The outcomes from the workshop will inform the development of a local protocol on joint antenatal planning which will be consulted on in May 2015. This will be further informed by Tests of Change currently underway using the Early Years Collaborative model to be carried out by midwives and Health Visitors in each of the CPPs in Lothian.

2.2.4 Family Nurse Partnership

NHS Lothian's Family Nurse Partnership service started in January 2010. Following successful implementation, which was formally evaluated by Scot Cen Social Research Centre recruitment of a second cohort of clients from Edinburgh commenced in September 2012. The appointment of a 2nd and 3rd team enabled us to offer a concurrent service of client recruitment and from late 2014 the service has achieved a fully sustainable model for all of Edinburgh City. Expansion to other areas of Lothian commenced with West Lothian in March 2013, Midlothian in April 2014. Further expansion will commence with a 4th team who we aim to have in place by July 2015. This will allow us to also offer a service to East Lothian from Sept/Oct 2015. In addition NHS Lothian is testing the delivery of a hybrid service in partnership with NHS Borders to eligible clients from August 2015.

All of NHS Lothian will reach sustainability by August 2016 if we are approved for a fifth team i.e. 1 Supervisor and 8 nurses.

2.2.5 Information Sharing

NHS Lothian is developing a child health portal which will in this phase allow the delivery of the shared core health and social care information using data from TRAK Health Care in NHS Lothian and SEEMIS CEC – further roll out across other sites will be agreed in the in due course.

There is at present no roadmap defined for sharing information between named persons e.g. health to education or sharing with lead professional.

NHS Lothian is aware the Scottish Government is developing an NHS Delivery Plan to support the Children and Young People Act (2014) Parts 4, 5 and 18 relating to named person, child's plan and assessment of wellbeing. NHS Lothian will strive to ensure that an adequate nursing workforce is in place to meet the requirements of the legislation but it is clear currently that there will be a pressure in relation to being able to recruit, train and retain the required number of Health Visitors. Reporting measures are currently being developed relating to:

- Children and Yong People Act Parent Awareness
- Health Visiting Capacity
- NHS Staff Capability
- Staff Governance
- Systems and Processes

Further details are awaited from the Scottish Government on performance measure descriptions and reporting timescales.

2.3 PERSON-CENTRED CARE

2.3.1 Patient Experience Quality Improvement Plan

Set within the context of the Person Centred Health and Care Collaborative (2012) and the aim of 90% of patients using NHS Lothian services have positive experience of care and get the outcomes they expect. NHS Lothian Board in December 2014 approved a Patient Experience Quality Improvement Plan set within the context of a person centred culture.

To realise the aim of 90% of patients using our services have positive experience of care and get the outcomes they expect, the following key aspects of the improvement plan have been identified:-

- NHS Lothian organisational culture and leadership improves patient, family and staff experience
- Direct care delivery is reliable and is delivered in acute collaboration and partnership with patients and staff including the physical environment
- Staff are engaged with the organisation to deliver services centred on the needs of people including the physical environment
- Staff are open when dealing with people raising concerns or complaints

- That there is an infrastructure in place to support system change underpinned by measurement.

Developing a systematic process for capability and reporting patient experience is central to this plan which includes the testing of Board to ward reporting, which includes:-

Tell us Ten Things - “Tell us Ten Things” (TTT) was a local patient survey programme previously based within the Universities Hospital Services. In November the questions were reviewed against best practice (Appendix 2) and aligned with the “5 must do elements” of the national Person Centred Health and Care Collaborative:

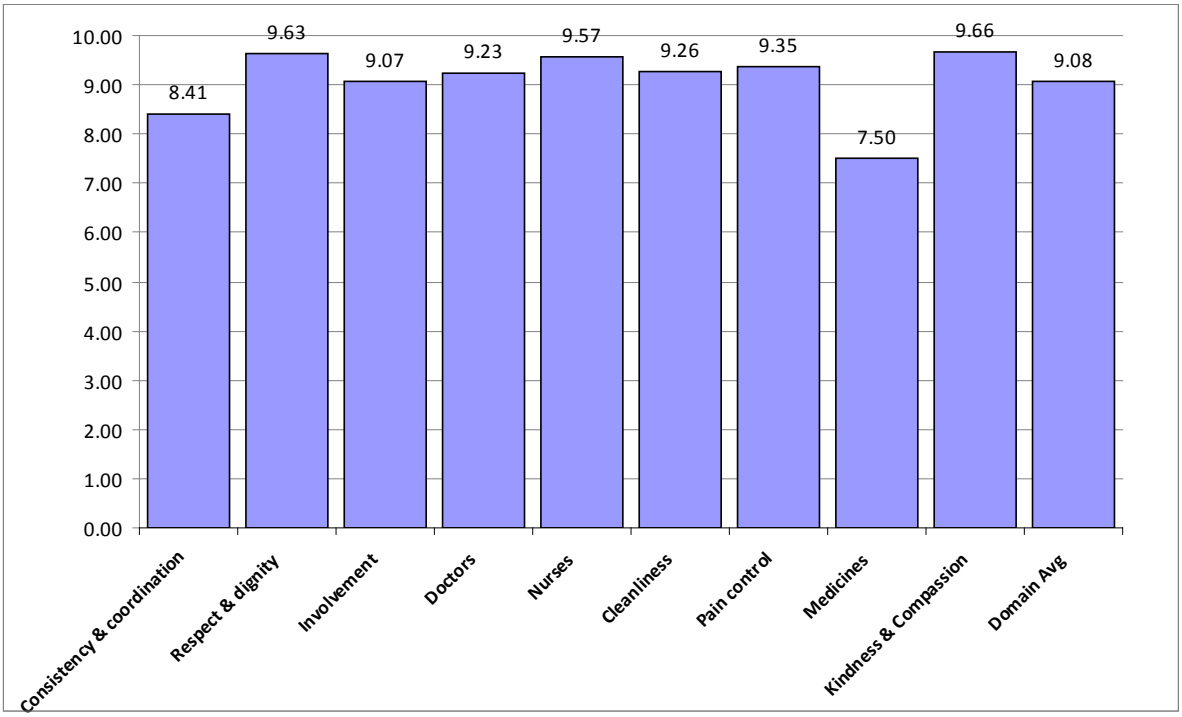
- What matters to you?
- Who matters to you?
- What information do you need?
- Nothing about me without me
- Personalised contact

In addition to TTT, NHS Lothian is testing a validated in-depth experience questionnaire in conjunction with TTT with 8 test teams as baseline data to inform a local collaborative. The in-depth question questionnaire includes the following domains based on extensive review of what matters to patients plus two appreciative enquiry questions:

- Care & Co-ordination
- Respect & Dignity
- Involvement
- Medical Staff
- Nursing Staff
- Cleanliness
- Pain Control
- Medication
- Kindness & Compassion
- 2 appreciative enquiry questions:
    - What have we got right for you?
    - What comments or suggestions do you have for improvement?

Baseline data is set out below in Chart 1.

8 wards – Patient Experience Questionnaire Results across 9 Domains



The baseline data is established on responses patients surveyed November/December 2014

Number of respondents - 228 (100%)

Number of patients on new medication - 117

NHS Lothian is using a 'Breakthrough Series' Collaborative Methodology to establish a person centred collaborative with its first learning session held on Friday 6 February 2015 at Heriot Watt University. The day was planned so that staff can hear best practice from colleagues across the United Kingdom; including Annie Laverty, Director of Patient Experience in Northumbria Healthcare NHS Trust and Erica Reid, Strategic Advisor for Improvement and Person Centred at the Scottish Government. The afternoon session gave the 8 clinical areas the opportunity to work as a multi-disciplinary team using baseline data and best practice examples to generate improvement actions for testing at service level.

NHS Lothian will continue to support a number of initiatives to deliver patient, family and carer focussed services. Examples of initiatives are outlined below:

Patient Focus

- Liberton Hospital Occupational Therapy – Patient Breakfast Group (including meal preparation and choice)
- Midlothian Substance Misuse Service – Peer support training programme

- Modernisation Team - Establishment of 7 day radiography services
- Modernisation Team – Patient flow through endoscopy service at Royal Infirmary of Edinburgh
- Occupational Therapy Rehabilitation Services – Enhanced group-based rehabilitation services at Astley Ainslie Hospital e.g. Breakfast Group and Falls Rehabilitation Class
- Establishment of 7-day radiotherapy services
- Enhanced group-based rehabilitation services at Astley Ainslie Hospital, e.g. Breakfast Group and Falls Rehabilitation Class

Family/Carer Focus

- Liberton Hospital Occupational Therapy – Carers Group for patients with memory impairment
- Rheumatology Care for Young People – Development of 'Arthur's Place' website and social networking platform – 2014 Gold Award Winner for National Rheumatoid Arthritis Society
- Establishment of Carers Group for patients with memory impairment

2.3.2 Lothian House of Care

In October 2014, a paper was submitted to NHS Lothian Board recommending that the house of care approach (illustrated in Diagram 1 below) should be supported to establish a more person-centred and integrated model of care for people living with multiple long term conditions and others with complex care and support needs. The paper was endorsed by the Board. The house of care provides a framework to facilitate delivery of the four principles of person-centeredness: affording dignity, respect and compassion; being enabling; offering personalised care and support; offering coordinated care and support.

Diagram 1

The specific recommendations of the NHS Lothian Board paper included:

- Establishing early adopter sites for the house of care approach, and;
- Working towards strategic coherence for the house of care approach.

Since October 2014, a Lothian House of Care collaboration has been formed with a multi-sectorial core group (health, social care and third sector). Working closely with the Quality Improvement Department, the core group are identifying sites and services interested in early adoption of the house of care approach. Initially the sites will be general practices, with patients who would benefit from the house of care approach being identified by the primary care team. The approach would then be facilitated by providing access to a range of development tools, training, and resources for both patients and professionals. Improvement methodology will allow on ongoing learning from these initial sites and facilitate spread and sustainability.

The house of care approach is also being considered by the four shadow Integrated Joint Boards, with potential early adopter sites in each of the four areas.

To ensure a consistent message, it is proposed that the person centred care programme for Health and Social Care be integrated into the Lothian House of Care Collaboration as its key aims are aligned with the national Person Centred Health and Care Collaborative.

The above plan outlined above includes focusing on improving patient experience. This, however, does not negate the excellent work already happening across NHS Lothian in partnership with families, staff and the voluntary sector, and some examples of which are set out below.

2.3.3 Customer Relations and Feedback Team Review

To implement the Scottish Health Council 'Listening and Learning' report and enhance NHS Lothian's management of complaints and feedback, a review has been considered. The review has two phases. The outcomes of Phase 1 will be:-

- Explore and examine the Customer Relations and Feedback service
- Present emerging themes and issues to the joint sponsors
- Assess and make recommendations to the joint sponsors which support a refreshed and redesigned vision for a robust complaints and feedback service
- Provide preferred options for wider consultation
- Facilitate two half-day workshops for staff and non-executive Board members to consult on the preferred options and design of a refreshed complaints and feedback service
- Produce a summary of the workshops including agreed ways of working engagement and actions

The nature of Phase 2 will be dependent on the findings in Phase 1 however it is likely that Phase 2 will involve communicating the new vision, engaging with staff, patients and service users and wider stakeholders. Phase 2 will include some wider learning and development work including seminars, webinars and master classes for key staff within the Board.

The approach that will be adopted will include face to face meetings, observation, a review of case studies and interviews with service users, staff and non-executive Board members. As part of this work we will undertake an analysis of other NHS complaints and feedback services. The Scottish Public Services Ombudsman, Scottish Health Council and Scottish Government policy will all form part of the approach taken. The review will include proposals for regular complaints reporting to the Board.

The review will be completed and the report delivered to the joint sponsors by the end of January 2015. Phase 2 including the design and delivery of the two half day workshops will be complete by February 2015. Following the review, a short term action plan will be put in place and thereafter a longer term implementation plan will be developed from the options with agreed timescales for approval by NHS Lothian Board.

2.4 SAFE CARE

NHS Lothian remains committed to the Scottish Patient Safety Programme across all work streams – Primary Care, Maternity, Neonates and Paediatrics, and Mental Health Services. The breadth and depth of the programme across Lothian is considerable and as such the Patient Safety Annual Report (November 2014) presented to the Healthcare Governance Committee is attached in Appendix 3. The annual report sets out priorities for action, including spread and sustainability across patient safety work streams set within a Quality

Improvement infrastructure, e.g. data reporting. The report also set out its contribution to Healthcare Associated Infections.

2.4.1 Healthcare Associated Infections

NHS Lothian will work to continue to reduce the incidents of MRSA / MSSA. Focus will be ongoing on reducing the number of

- blood culture contaminants,
- skin and soft tissue infections
- vascular access device infections
- intravenous drug users (IVDU) infections

CDifficle infections (CDI) continue to be a challenge within NHS Lothian. A significant change in the antimicrobial prescribing policy came into effect on 2nd February 2015 so the anticipated (positive) impact of this change will be closely monitored during the year.

A review of environmental cleaning and standards will be undertaken in 2015/16 with the aim of reducing CDI.

2.4.2 Initial Response to the Vale of Leven Recommendations

The Vale of Leven requirements will be progressed through the relevant local Executive Lead and professional groups. NHS Lothian will reflect the work of the national implementation and reference group as required to support delivery of the report recommendations.

NHS Lothian has developed a supporting action plan which will be subject to on-going review and update.

NHS Lothian is awaiting further communication from the Chief Nursing Officer outlining the next steps in the implementation process.

2.4.3 Adverse Event Management

NHS Lothian 'Being Open' Project supported by HIS is a project which aims to:-

Improve patient and staff experience of adverse events in inpatient neonatal and maternity services at the Royal Infirmary of Edinburgh (RIE) by December 2015

Specific objectives are to:

- Test opportunities for establishing a robust process for engaging patients/ families more fully and reliably in adverse events at point of care.
- Establish an improved culture of openness by developing mechanisms for communicating more actively with patients and their families and to ensure staff are supported in that communication when adverse events happen.
- Inform discussions nationally on the scalability of a training package across boards in Scotland and the infrastructure required at a local and national level.

The project has established a baseline by gathering experience of communication of adverse events both from the viewpoint of patients and families, staff and managers, plus focus group and one-to-one interviews. This baseline informed standalone training workshops structured around the key areas of communication based on an evidence-based process.

The content of the training was structured around the key stages in communications:

- Initial communication with the patient /family
- Multi-disciplinary professional discussion
- Personal meeting with the patient/family
- Feedback meeting with the patient/family following review of the event

Testing the process is taking place using Plan, Do, Study Act (PDSA) methodology including patient information leaflets and meeting with patients and families. This work will progress over 2015-16 to inform local and national improvement plans on management of adverse events.

2.5 PRIMARY CARE

2.5.1 General Practice

NHS Lothian meet with the Scottish Government and the BMA in January 2015 to discuss local and national issues related to building capacity and access to general practice at a national and local level. This builds on work that has been done within Lothian during 2014/15 in relation to developing the primary care agenda through close working with the GP community.

This work has manifest itself in to some key areas of action within primary care which will not only build capacity and access in primary care but support the shift in the balance of care from acute to primary care.

We will aim to improve and strengthen the capacity of practices and their teams to support patients and their carers in the community and primary care. A number of complex and resource-intensive actions will be required in order to support the fundamental policy choices and to manage demand in new ways, some of which will be invest to save, including:-

- Rapid expansion of General Practice in priority areas in view of the current severe lack of capacity; eventual expansion over time to deliver 10% more GPs; 10 more practices; reversal of recent decreases in the GP and primary care share of NHS funding;
- Establish infrastructure to support primary care's role in delivering the 2020 Vision, including a review of community nurses and other support staff; agreement on a single point of contact available 8am to 8pm daily for admissions avoidance (including transport arrangements); expansion of enhanced service funding, including those to support increased community based medical care of vulnerable and multi-morbid patients (General Practice 'Intensive Care Units'); resource weighting to cover the additional workload associated with deprivation;
- Improve IT to strengthen and make more robust administrative and communication systems aimed at enhancing the capacity and efficiency of primary care services;
- Review Lothian Unscheduled Care Service (LUCS) to match resources to workload and develop innovative schemes to support out-of-hours working;
- Improve integration with H&SC Partnerships and their relationship with GP's;
- Improve joint working with secondary care, including at locality level;
- Develop a new workforce to undertake secondary care work in the community and new ways of outpatient working;
- Maximise quality and efficiency by fully supporting GP clinical leadership roles in prescribing, referrals and admissions management and clinical investigation. Whilst some investment may be required, these developments should also create savings.

2.5.2 Primary Care Resources

The Scottish Government draft budget for 2015-16 outlines an Integration Fund of £100m over three years to support delivery of the 2020 vision. The Cabinet Secretary for Health and Wellbeing announced on 4 November 2014, £40m funding for a primary care development fund to be targeted at general practices in rural and deprived areas. In addition £100m has also been made available over 3 years to buy additional capacity to support those people delayed in hospital. The additional funding is intended to support a position that no one stays in hospital for more than 72 hours once fit for discharge.

NHS Lothian's Director of Finance is seeking clarification on these announcements and the funding likely to be available from these sources to NHS Lothian to support primary and community care developments. Until there is clarity, it is not possible to determine whether there will be a gap in funding which would need further consideration by NHS Lothian and the Scottish Government, which could only be addressed by diverting funds currently planned for acute hospital services, However in order to start to implement our agreed actions locally we have proposed to invest an additional £1m within our local financial plan for primary care development (as set out below) during 2015/16.

In the meantime, further scrutiny requires to be undertaken of population-based allocations of General Medical Services (GMS) funding, to determine further scope for savings and any potential for incentivisation to deliver required service changes. An area for the attention of H&SC Partnerships' strategic commissioning plans and locality planning will be to bring forward proposals in consultation with GPs to reduce demand on hospital care and release resources to invest in primary and community care.

The key priorities for investment in 2015/16 and beyond to support access, shift in the balance of care, support from frail elderly in the community, workforce and IT&M are outlined in the table below.

Deliverable / Milestone	***Expected Delivery Date***
Partnership investment plans for additional and replacement/ expansion of primary care premises developed.	*Capital investment of £3m in 15/16 and £5m in each of the next 4 years*
Access - Develop proposal to support a further 10 general practice access pilots across Lothian (£100,000 investment) - Identify alternative models to support primary care access - Submission of Patient Access Reports from GP practices and discussion at practice quality visits - CHP review of 2013/14 Scottish Health and Care Experience Survey and development of improvement plans where appropriate	*Evaluation of 4 Lothian access pilots anticipated by March 2015 to inform future access models;* *3 year rolling programme of practice quality visits from 2015; there is an intention to train 8 GPs and 8 practice managers to support the 3 year cycle of visits. Funding is required to support the QI visit programme estimated to be £23,000 per annum (recurring to 2017).* *There are also capacity issues for the PCCO team to facilitate and administer the visit programme.*
List Expansion Grant Uplift (LEGUp) and Initial Practice Allowance -Develop further proposals to alleviate current practice list restriction position and discuss with GP Chairs Sub Group supported via initial £200,000 investment	*Further investment of an additional £200k bringing a recurring total investment of £400k proposed to extend to a further 10 practices in 15/16*

Deliverable / Milestone	***Expected Delivery Date***
Support for Frail Elderly in Community Settings – Care Home, In Patient Complex Care, Step Up and Step Down, Delayed Discharge, Out of Hours, enhancement of rapid response teams (frailty). Further investment required to support investment as the model of care to support the elderly in the community develops.	*Linked to development of community nursing workforce capacity and capability, and review of medical support to community intermediate services for older people.* *IJB strategic plans will prioritise investments. Funding allocation of £14.2m over 3 years to 4 partnerships to reduce delayed discharges from Scottish government. In addition to the circa £14m over three years for the Integration Fund.*
Review of 2014/15 investment in care home enhanced service	*Development of proposals relating to care homes, anticipatory care and frail elderly is ongoing, a final report on each of these developments is to be taken to the Primary Care Joint Management Group in 2015.*
Shifting the Balance of Care Business Case to Support Investment of diabetes type 2 enhanced service as invest to save through mitigating rising hospital demand	*Cost £350K; to be considered in context of 15/16 financial plan*
Roll out of near patient testing (warfarin)- in place in East and Midlothian	*Proposal for further roll out and expansion to level 4 testing being developed- implement 15/16.*
Audit and review of domiciliary phlebotomy service	*A phlebotomy activity audit was undertaken in Sept / Oct 2014 which indicated the domiciliary phlebotomy local enhanced service is an appropriate delivery model and supports general practice to provide a highly cost effective service. A proposal to develop wider community phlebotomy service is being developed- implement 15/16.*
Further VLARC (very long acting contraception) investment	*Capacity uncapped during 14/15. Review impact and consider further opportunities with sexual health team and partnerships in 15/16.*

Deliverable / Milestone	***Expected Delivery Date***
Workforce Development of primary and community care workforce plans within each Health and Social Care Partnership:	*District Nursing Review to commence February 15 in Edinburgh. Redesign, skill mix, IM&T opportunities to be considered.* *Development of Advance Nurse Practitioner roles for practices and elderly care to be progressed.* *Additional Health Visitor trainees required to support' named person' legislation*
Progress consultation on LUCS review and proposed changes to hours/number of bases to maximise efficiency and meet demand	*Business case by end of February 15. Complete and implement during 15/16.*
IM and T Progress proposal to improve reliability of GP practice systems through investment in central server solution which provides rapid central updates and maintenance	*Draft proposal – capital cost £2.5m* *Revenue consequences £300,000* *Being discussed with GP Sub-committee*

The benefits expected as a result of the priority actions outline above include:

- Increased capacity in primary care to see patients; reduction in GP time lost to dealing with faulty IT systems which increase clinical capacity and productivity.

- Reduction in the number of restricted practice lists (June 2014 – 19 practices 'open but full' and 10 practices operating a 'restricted list). Benefits measured through regular reports. At October 2014, list sizes had increased in capacity by 1,633.

- Improved access to general practice appointments as a result of the additional 10 access pilots demonstrated through access pilot monitoring and evaluation reports. Detailed evaluation reports are expected in mid March / April 2015.

- Provision of a Type 2 Diabetes Enhanced Service to support shift in the balance of care from hospital based care to the community to support an estimated 33,000 people with diabetes across Lothian; monitoring via practice uptake of enhanced service and new referrals to hospital.

- Development of locality workforce plans to support new models of care particularly relating to frail elderly**,** measured through improved performance in the reduction in time people are delayed for discharge, reduction in emergency admission / repeat hospital admission.

Priority	Investment
Stage 2 Phlebotomy	£ 360,000
Type 2 Diabetes Enhanced Service	£ 350,000
VLARC	£ 100,000
LEGUp / Initial Practice Allowance	£ 200,000
Advanced Nurse Practitioner Training (6 months)	£ 74,400
Further Access Pilots (3 practices)	£ 30,000
Total	**£1,114,400**

A paper outlining the further details and plans to deliver priority areas for investment in primary care and community services in 2015/16 and beyond will be taken to a meeting of NHS Lothian Board in June 2015.

2.5.3 Lothian Unscheduled Care Service (LUCS)

The General Medical Services Contract in 2004 permitted General Practitioners to opt out of providing Primary Care services in the Out of Hours period (OOH). The responsibilities for this care delivery transferred to Scottish NHS Boards and NHS24. NHS Lothian established the Lothian Unscheduled Care Service (LUCS) with a multidisciplinary and multi site care model.

LUCS provides OOHs urgent primary medical care services across Lothian from 6pm to 8am Monday to Thursday, from 6pm Friday to 8am Monday and on Public Holidays.

Requests for healthcare from members of the public come to the LUCS hub from NHS24 following triage for doctor advice, home visit or to attend a Primary Care Emergency Centre. Patients are transferred to LUCS and A&E departments and from LUCS to A&E departments under established protocols.

People also attend the sites without triage or appointments to access health care and are also referred to as 'walk ins'. An agreed transfer of un-triaged calls from NHS24 is also triaged by LUCS. LUCS also provide telephone advice to other health, social care and emergency service professionals called a Professional to Professional line. This includes a clinical service to the laboratory services to interpret and action abnormal results. More recently LUCS has absorbed the provision of medical care to a range of NHS Lothian patients, it is also provided planned patient reviews requested by in hours GPs.

The provision of unscheduled care is a key priority for NHS Lothian and concerns were expressed about the safety and sustainability of the service. Key issues related to

- Safety of the current service and clinical model
- Activity changes and additional area of service demands
- National and local recruitment and retention challenges especially for GPs
- Professional and leadership issues with Emergency Nurse Practitioners
- Sustainability of a 5 site delivery model

In light of the concerns raised, a review of LUCS was undertaken during 2014/15. The review suggested a number of key recommendations to strengthen and focus on the delivery of Out of Hours Primary Care. Recommendations relate to:

- Improving the relationship with GPs, increasing the number who provide OOH care
- Agreeing 2 clinical models and escalation processes to maintain patient and staff safety, and provide clarity in the contribution of Emergency Nurse Practitioners
- To move the service forward as suggested through the review recommendations, it will be necessary to strengthen and realign both the service and clinical management
- Influence the national agenda relating to interface improvements with NHS24 and GP numbers
- Agreeing the medical model, responsibilities and finances for in hours and out of hours. Primary care for patients in NHS Lothian IPCC, step down, winter beds, hospital to home, delayed patients, patients in care homes and patients who choose to die at home etc
- Delivery the LUCS Improvement plan, rename the service and work with the public and partnership representatives to support Right Patient, Right Place, Right Time
- Maximising the localisation of services aligned to the new integrated Health and Social Care Partnerships

The recommendations associated with the service review have been the focus of a recent public consultation; a consultation report will be taken to the Corporate Management Team in April 2015. Further work relating to an options appraisal will be taken forward during 2015-16.

The on-going national review which is due to report in September 2015 will provide further clarity on the future provision of out of hour's services.

2.5.4 Pharmacy

NHS Lothian have a Pharmacy Strategy 2013-16, this is currently used as a baseline to take forward the service. The ambitions of Prescription for Excellence (PfE) are aligned to the strategy with a plan to ensure pharmacists are working with clinical colleagues to enable patients to maximise benefit from their medicines. SGHSCD identified Polypharmacy and dispensing doctor practices as the priorities to address under PfE in the first year and NHS Lothian has recruited 5 additional pharmacists, who will be independent prescribers to address the polypharmacy agenda. NHS Lothian does not have dispensing doctor practices. The 4.4wte pharmacists work within primary care contributing to enhancing clinical capacity in primary care, driving improvements in quality and efficiency of medicines use for elderly patients. (2 GP practices have requested input and support for polypharmacy programmes and the additional capacity is designed to support this.

To support implementation of Prescription for Excellence, a stakeholder event was held on 3 November 2014, with over 60 attendees. A follow up event took place on 10 March 2015 and again had 60 attendees; a further evening event for 25 May 2015 is planned. This evening meeting will allow increased attendance from community pharmacy. This showcases innovative practice in Lothian and provides stakeholders with an opportunity to steer delivery in the future.

The programme for the events focusses on:

- Models of Prescribing Practice
- Integrated Care Pharmacists
- Polypharmacy Project in Lothian – Teach and Treat Model
- Building Clinical Capacity in Lothian

In addition, NHS Lothian pharmacy staff are chairing, and participating in a number of the SGHSCD work streams under PfE, this enables our practitioners to provide leadership locally and nationally and to share practice across Scotland. Prescription for Excellence is a 10 year Vision and Action plan, divided into 3 time bands, years 1-3, 4-6 and 7-10. Developing clinical capacity is an immediate priority in the first 3 years and the additional capacity recruited and now being trained in NHS Lothian enable us to move forward in line with PfE timescales.

Allied to this NHS Lothian has a Prescribing Action Plan 2014-16 (Appendix 4), during the financial years 2014/15 and 2015/16, individual Community Health (and Care) Partnerships (CH(C)Ps) will continue to be accountable for their General Practice and Nursing locality prescribing budgets. Governance arrangements are being developed in anticipation of the Scottish Government's Act to integrate health and social care services.

This will lead to the formation of Health and Social Care Partnerships following the dissolution of the CH(C) Ps and may have financial implications in terms of fiscal accountability for the prescribing budget in the future.

In developing the plan, the CH(C)P Prescribing Forum has focused on prescribing actions that support NHS Lothian's strategic intent referred to earlier in the LDP.

The NHS Lothian Prescribing Action Plan formalises actions for 2014/16, which will determine clear strategies to support high quality, cost-effective, evidence-based prescribing. To further promote whole system working across NHS Lothian, a corporate CH(C) P Prescribing Action Plan has been developed using a joint framework. Individual CH(C) Ps will continue to produce local delivery plans that reflect and address local variations and pressures. Within this a discussion about investing in an acute hospital electronic prescribing system is being pursue

This plan has been developed by the NHS Lothian Primary Care Pharmacy Team and progressed through the CH(C) P Prescribing Forum as the management group with collective responsibility for primary care prescribing.

2.5.5 Dentistry

During 2015/16, the SEAT Dental Public Health Network will begin to support work to refresh the NHS Lothian Oral Health Strategy. An NHS Tayside draft Oral Health Equity Strategy has been developed for consultation and it is proposed to adapt the Tayside strategy for Lothian, bringing in the 4 Lothian patient pathways and ensuring fit with the NHS Lothian Strategic Plan 2014 – 2024.

As a starting point in the development of a Lothian strategy, trend data has been sourced and core group will be convened to take forward this work. The Lothian Dental Division Executive Group will oversee the development of the strategy, particularly as the Integration Joint Boards will require oral health input to their local strategic commissioning plans.

2.5.6 Optometry

A Lothian Eye Health Network is being established in 2015/16. This network is a system of collaboration between GPs and optometrists to have patients with eye problems assessed in the community and when necessary to utilise the new optometry SCI gateway referral pathways to allow effective triage by ophthalmology services. It is hoped this collaborative network will encourage individuals with eye problems to approach optometrists as a first point of contact rather than GPs.

The national rollout of eReferral and ePayment schedules is progressing in Lothian. eReferral will support eye care integration with optometrists and specialist eye services.

2.5.7 Edinburgh Headroom

The aim of the Edinburgh Headroom Initiative is to significantly improve outcomes for people in areas with concentrated economic disadvantage. The Headroom approach recognises the distinct challenge and opportunities for more effective intervention by primary care through working in partnership.

There are two areas in Edinburgh participating in Headroom:

'Eastern' Edinburgh which is already recognised in a 'Total Place initiative (population of circa 50,000 with 9 GP practices involved)

'Western' Edinburgh which is already recognised as one of the City's 12 Neighbourhood Partnerships supporting Edinburgh's Community Planning arrangements (population of circa 40,000 with 6 GP practices involved.

The key outcomes of the Headroom initiative relate to:

- Demonstrable impact on local health inequalities
- Successful locality working and GP contribution to Total Place
- Strengthened GP leadership and development
- Offer opportunities to influence future iterations of the Scottish GP contract

Headroom East

The following initiatives are being supported through Headroom East:

House of Care – presentations were given at a recent meeting of the Headroom East Steering Group highlighted a diverse range of projects which focus on social prescribing. Practice visits took place in March 2015, further priorities relate to continued funding, information technology and workload. A joint Headroom event which will take place in Ma7 2015 is currently being planned with input from all practices involved.

New Headroom East Practices – Baronscourt Surgery joined the Headroom East cohort at the end of January 2015. Baronscourt will focus on a project relating to Social Isolation and Frequent Attenders. Southfield Practice will input to meetings from mid March 2015. Restalrig Practice continues to receive information relating to East activities and support is being provided to Ferniehill Surgery to attend the Liberton Practice 'Team Around the Cluster' meetings.

Social Prescribing Data – initial submissions are showing a month on month increase in the number of recorded social prescribing interventions.

Total Place – attendance at Total Place for is seen as a good use of GP time and GP presence is valued by members of these groups e.g. Children's Services Management Group.

Headroom West

The following initiatives are being supported through Headroom West.

Health Coaches – funding has been awarded to the Edinburgh Voluntary Organisations Council (EVOC) for health coaches. Further discussion will take place in mid March 2015 to discuss the health coach job description and location of staff.

House of Care (West) Pilots – South West Edinburgh practices are carrying out test of change associated with their individual areas of focus:

> Whinpark – care plans for patient with BMI>40, who have chronic pain and are prescribed opiates.
>
> Slateford Medical Practice – focus on ethnic women presenting ante or post natally.

Wester Hailes Foundation Programme – over 50 people from the Wester Hailes Healthy Living Centre, local school, Sighthill Health Centre, Edinburgh CHP, 3rd sector and private organisation attended a programme event. Early discussions are taking place relating to an induction 'passport' for new staff.

Trauma Service – The Consultant Psychiatrist, Rivers Centre (assessment and treatment of trauma related problems) has joined the South West Steering Group to promote the services provided as there are very few referrals from South West Edinburgh.

Mental Health – The Strategic Programme Manager for Mental Health will attend a meeting in mid April 2015 to discuss the launch of new mental health services for South West Edinburgh.

Health Inequalities Group – this group has recently been re-established.

Social Prescribing Data – initial submissions are showing a month on month increase in the number of recorded social prescribing interventions.

Other Headroom Activities

Edinburgh Headroom is also linking to other projects, initiatives and opportunities, examples are outlined below:

Hibernian Public Social Prescribing (PSP) – involvement in development of the PSP is seen to be an excellent opportunity to support social prescribing.

NHS Scotland Conference – Headroom has been invited to present at the conference in June 2015.

Education – the Joint Clinical Lead Headroom East is delivering a workshop on integration / social prescribing to medical students and a conference poster will be submitted to the GP Trainers Conference

Prescribing – a meeting is being convened involving Headroom GPs to meet with the Consultant in Public Health Pharmacy.

Conference Attendance – Headroom GPs will attend the International Integrated Care Conference and Scotland Policy Conference session relating to priorities for integrating health and social care in Scotland.

2.5.8 Primary Care Telehealth Developments

A key primary care telehealth initiative to be taken forward in 2015/16 relates to the scale up of supervised self-monitoring of blood pressure involving potentially up to 2,500 individuals.

This initiative will be taken forward in collaboration with NHS Lothian, the four partnership areas in Lothian and the University of Edinburgh (Telescot). Starting initially with 4 GP practices in Lothian (500 people), successful implementation and evaluation at this stage will then see the scaling up of this to a target of 20 to 25 GP practices (2,500 people) by the end of year one.

This development will build on a previous Lothian trial of home blood pressure monitoring which involved 456 patients. This proved to be popular with patients and resulted in highly significant reductions in blood pressure.

Unlike the previous trials, this approach will utilise low cost, digital technology to enable the patient to electronically submit their BP readings (via mobile telephone, landline or internet) for summarisation into a forma presented through routine GP data flows (Docman) which will streamline access to the data as has been requested by clinicians.

2.6 INTEGRATION

2.6.1 Integration Joint Boards

NHS Lothian has worked with the Local Authorities across Lothian to complete the Integration Schemes required for the Public Bodies (Integration)(Scotland) Act 2014. In Lothian there will be four Integration Joint Boards (IJBs) and each one will, as a minimum, meet the requirements of Scottish Government regarding clinical and care professional representation in the strategic planning group.

In East Lothian there is a plan to expand the clinical professional membership to reflect more strongly the localities and the hospitals (both the main acute hospitals that provide treatment for East Lothian residents and hospitals that the Chief Officer of the IJB has operational responsibility).

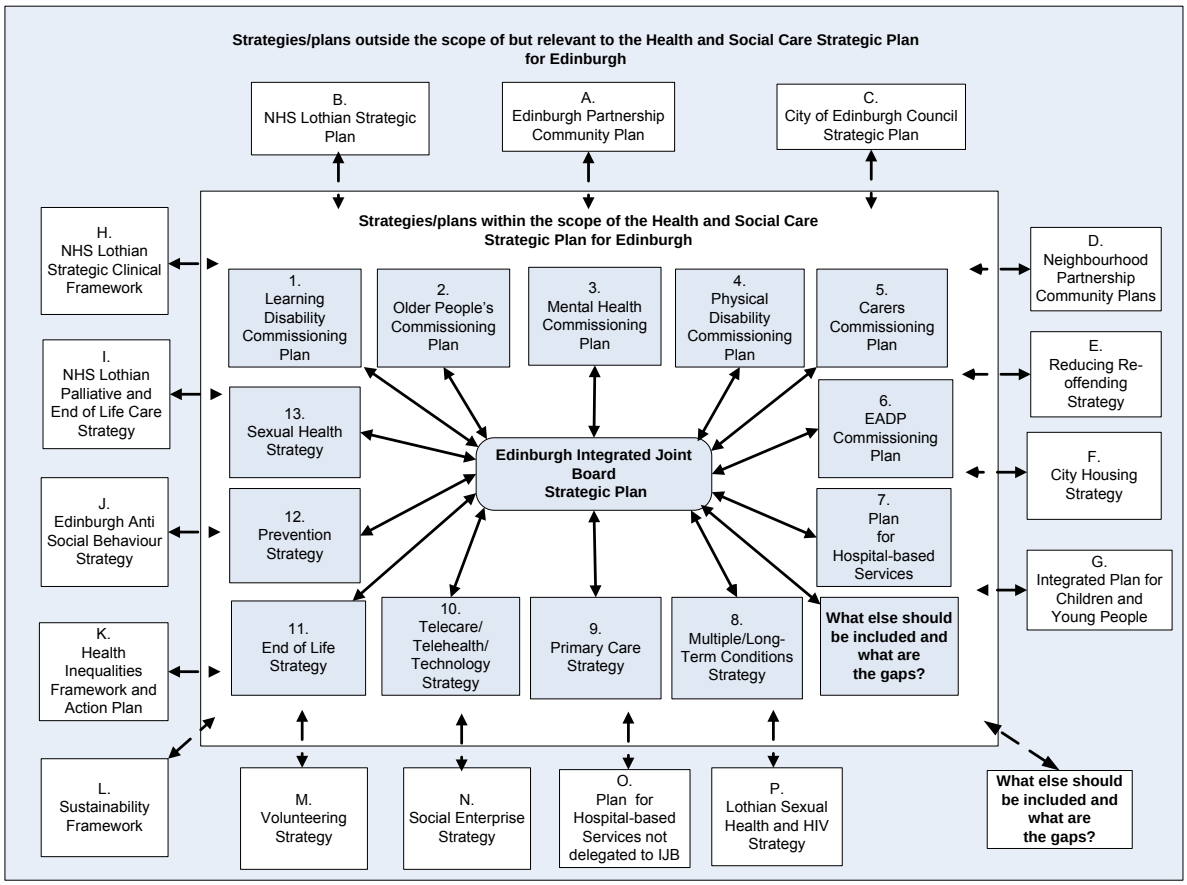
In West Lothian a small working group has been formed to determine the membership of the strategic planning group there and the expectation is that the shadow strategic planning group has started meeting by the end of February 2015.

In Midlothian the IJB will combine direct clinical representation at the IJB and Strategic Planning Group with culture of broader engagement through workshops and multidisciplinary locality debates. Direct clinical engagement via the Midlothian Clinical Director (a Midlothian GP) will formalise the relationship between the IJB, the Strategic Planning Group and the Midlothian Professional Forums. The Clinical Director and the Chief Social Work Officer will represent the Joint Quality Improvement Team on the IJB and Planning Group.

In Edinburgh a Strategic Plan Steering Group has been established to plan for and oversee the establishment of the Strategic Planning Group which will have its first meeting in mid-March. The Professional Advisory Committee (PAC) will nominate a health professional and social care professional to become members of the Strategic Planning Group. These individuals will be supported to engage with an agreed wider constituency of professional groups and forums such as the Professional Advisory Committee itself, the Local Medical Council, and Local Practitioner Forum etc. The Strategic Plan for Edinburgh will also be the subject of widespread public consultation giving individual practitioners the opportunity to contribute to the Plan.

2.6.2 Mapping of existing local plans

The diagram below outlines the mapping of key local plans for health and social care for the Edinburgh partnership. Similar maps are being developed in East, Mid and West Lothian.



2.6.3 Key Redesign Priorities

The redesign priorities will be set out in the Integration Joint Boards' Strategic Plans and will build on the existing strategic plans of NHS Lothian, Councils and local community planning partnerships to improve the outcomes for people using health and social care services.

There has been work to develop draft Strategic Plans and Strategic Needs Assessments ahead of the establishment of the IJBs. This work has been supported by the members of the shadow Integration Joint Boards which have been set up in each area to facilitate the transition from CHP or CHCP into Integration Joint Boards. It is expected that this process will mean that when the IJB is formally established that there is already an ownership of the priorities identified in the draft strategic plans.

Many of the redesign priorities are already stated within existing strategies that have been developed joint by NHS Lothian and the Local Authority (e.g. Mental Health, Older People, and Learning Disabilities).

The development of draft strategic plans is at a different stage in each IJB area in Lothian. The Midlothian shadow board produced a consultation document in summer 2014 which identified the strategic priorities for the IJB. In East Lothian a more detailed strategic plan has been written which is currently out for consultation. West Lothian and Edinburgh have not yet produced similar work.

In general the redesign priorities for the IJB in the next 18 months to 2 years will be to develop capacity and integrated systems of care in communities which reduce unscheduled utilisation of acute hospital services and reduce the impact of patients with a delayed discharge.

East Lothian

The redesign priorities in East Lothian are framed by rising demand, high costs, reduced budgets and people experiencing poorer outcomes than other parts of Lothian. The reasons for change in East Lothian are

- The need to be better at preventing ill health
- The importance of care closer to home
- There is rising demand for health and social care
- There are health inequalities across East Lothian
- East Lothian population use hospitals in a way that is unsustainable
- Resources available could be used more effectively

The redesign priorities in East Lothian are:

- To make universal services more accessible and develop our communities: We want to improve access to our services, but equally to help people and communities to help and support themselves too
- To improve prevention and early intervention: We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises.
- To reduce unscheduled care: We want to reduce unnecessary demand for services including hospital care
- To provide care closer to home: We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can.
- To deliver services within an integrated care model: We recognise the need to make people's journey through all our services smoother and more efficient.
- To enable people to have more choice and control: We recognise the importance of person centred and outcomes focused care planning
- To further optimise efficiency and effectiveness: We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face

- To reduce health inequalities: We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.

To address these priorities the IJB will direct resources using the following five building blocks.

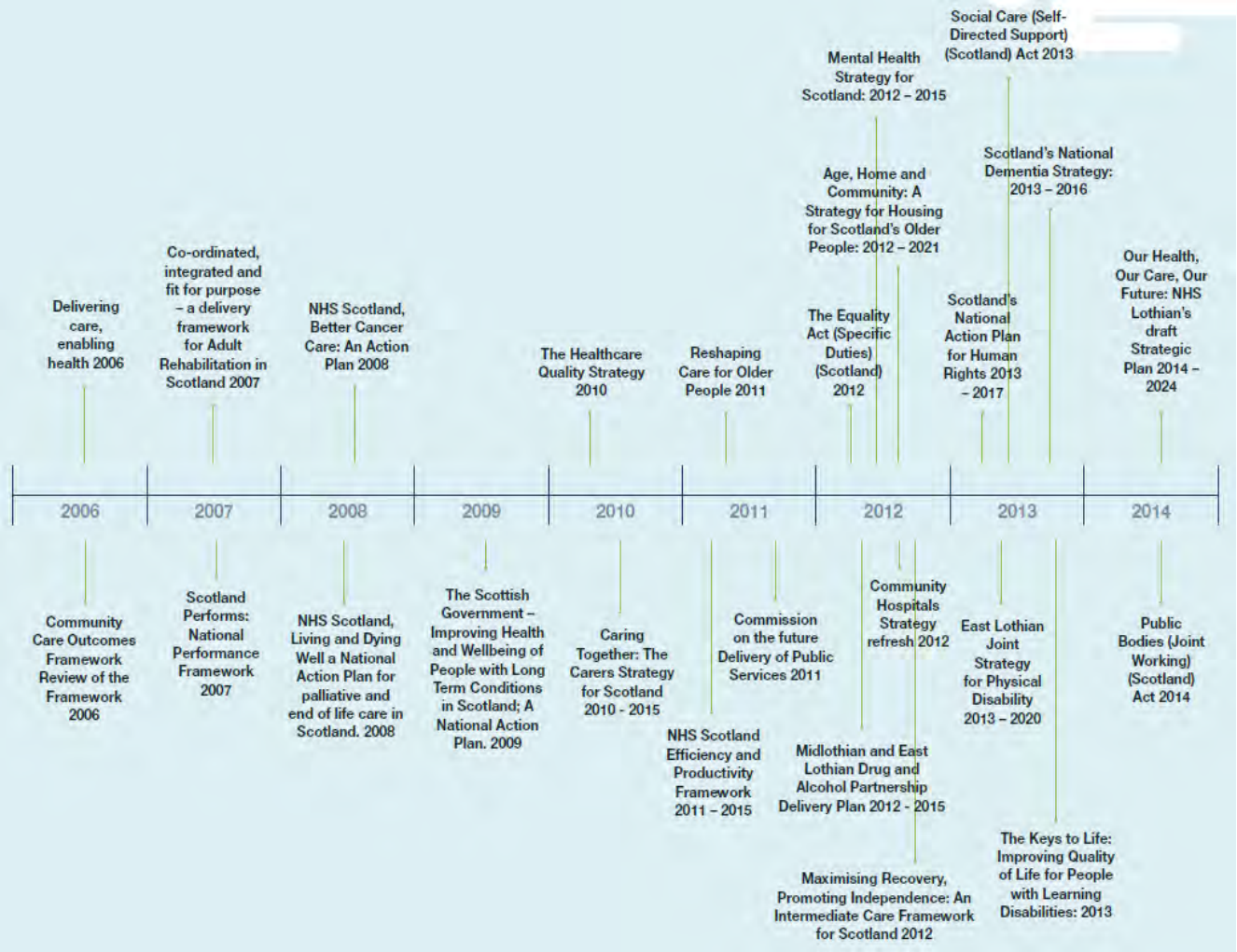
- Healthy Active Ageing and Support for independence across the lifespan
- Accessible and effective support at time of crisis
- Person centred and dignified long term care
- Support to live well with long term (chronic) conditions
- Excellent post crises support

During the work in East Lothian to write joint-strategic needs assessment the following gaps were identified:

- Dementia
- Primary Care
- Carers
- Day Centres
- Integrated working
- Information and Data sharing
- Anticipatory Care and Prevention
- Transition between services
- Estates and bed modelling
- Potential unmet need

East Lothian Key Local Plans for Health and Social Care

The plans in East Lothian that are informing the strategic plan are summarised in the graphic below.



West Lothian

The legacy of close partnership working between the Health Board and the Council in the West Lothian Community Health and Care Partnership leads to a shared understanding of the likely redesign priorities of the West Lothian IJB.

The redesign priorities for West Lothian Integration Joint Board will be:

- Change the system of care for frail older people with less dependency on hospital service
- Increase well being and reduce health inequalities
- Healthier and more independent living

A key redesign priority for West Lothian IJB is to lead a programme of change across the whole frailty pathway for people living in West Lothian. The importance of meeting the needs of this population do not need restating here and the objective of this programme is provide a system of care for frail older people which results in improved quality, financial sustainability and cost effective service provision. The impact of this programme will be to reduce the hospital admission and readmission rate and maintain the impact on patients from delayed discharges to a minimum.

The principles underpinning the programme on frail elderly are:

- No-one is in an acute hospital that does not need access to the specialist medical and diagnostic facilities there
- Home based frail elderly care is the norm
- We prioritise continuity of care at home
- Admission to a care home from community becomes the norm instead of admission to hospital
- The health and care service landscape is simple to understand and simple to navigate

The West Lothian Strategic Plan will be informed by the following local plans for health and social care:

- Public Protection Strategy (2014-2017)
- Older People Joint Commissioning Plan (2013-2023)
- Physical Disabilities Joint Commissioning Plan (2013-2016)
- Mental Health Joint Commissioning Plan (2013-2016)
- Alcohol and Drugs Partnership Joint Commissioning Plan (2013 -2016)

Midlothian

The Midlothian Shadow Integration Joint Board developed a Midlothian Strategic Issues paper in summer 2014 which underwent a three-month consultation. This was a key stage in the development of the final IJB Strategic Plan which is expected will be approved by the Midlothian IJB in summer 2015.

The redesign priorities identified by the Midlothian Shadow IJB are:

- Shifting emphasis to prevention, recovery and personalisation
- Making better use of primary care services
- Supporting people with long-term conditions
- Making best use of our hospitals
- Strengthening the relationship between housing and health and social care planning
- Supporting people with dementia
- Removing barriers for people with physical disabilities
- Promoting recovery from mental illness
- Preventing misuse of alcohol and drugs and supporting recovery

The consultation has led to the reframing of the Midlothian Strategic Plan to take account of the key messages.

The Midlothian Vision will be that people will lead longer and healthier lives by getting the right advice, care, and support, in the right place, at the right time.

To achieve the redesign priorities for the IJB are:

Support People to Stay Healthy and Well

- Provide advice and support to help people to lead a healthy lifestyle
- Reduce Health Inequality
- Provide Health Screening and Checks
- Support people to stay safe
- Promote Peer Support
- Tackle Social Isolation

Make it Easy to Get Health and Social Care Services

- Provide good information about our services and how to get them
- Provide high quality GP, Pharmacy, Dental, Optometrist, Health Centres, and Social Work Services
- Identify the cause of people's symptoms or illness in good time
- Assess people's need for Care Services in good time
- Involve people in planning their care, treatment and support

Provide Excellent Quality Care, Treatment, and Support

- Provide well coordinated care that is right for people
- Provide our services locally in Midlothian if we possibly can
- Support people to manage their own care and recovery, in their own home if possible
- Identify and support unpaid and family carers
- Work in partnership with Communities and Voluntary Providers

Edinburgh

The redesign priorities for Edinburgh will be fully articulated in the Strategic Plan for Edinburgh informed by:

- the priorities of the Edinburgh Community Planning Partnership as articulated through the Single Outcome Agreement
- the strategic plans of NHS Lothian and the City of Edinburgh Council
- The Joint Strategic Needs Assessment that has been undertaken to support the development of the Plan.

It is anticipated that the redesign priorities will include:

- improving the health and wellbeing of the people of Edinburgh and reducing inequalities including health inequalities
- planning, designing and evaluating services around people and communities with their active involvement
- minimising the amount of time that people are delayed in hospital
- reducing avoidable admissions to hospital
- using shared resources more effectively to improve outcomes for people

2.6.4 Integrated Care Facilities (ICF)

NHS Lothian's Strategic Plan 2014 – 2024 described a Lothian model of healthcare services, where more patients are able to live at home with a greater range of support from health and care services, where specialist hospital inpatient provision is delivered through four key sites (Royal Infirmary of Edinburgh, Western General Hospital, Royal Edinburgh Hospital and St John's Hospital) and where existing continuing care and other hospitals are replaced by modern, integrated care facilities (ICFs).

These require the design and development, together with local councils and other community partners, of a different range of integrated health and social care services to replace current delayed discharge hospital and continuing care bed provision. ICFs would be a purpose-designed, social care-based model taking the place of the current NHS hospitals including, in Edinburgh, the Royal Victoria, Liberton and Astley Ainslie, as well as re-designation of community hospitals in East, West and Midlothian. Flexible design of accommodation and staffing would suit a range of client needs and peripatetic, specialist NHS staff would provide expertise on an in reach basis as required. ICFs will include current services aimed at avoiding unnecessary hospital admission as well as delivering intermediate care, rapid re-ablement and rehabilitation and avoidance of delays in hospital discharge.

It is proposed to design and develop two ICFs in Edinburgh, at the site of the current Royal Victoria Hospital to serve North Edinburgh and at the edge of the Royal Edinburgh Hospital site to serve South Edinburgh, each of which would provide up to 90-120 care home type places, together with a range of supported housing and the co-location of new GP teaching practices. In addition, consideration is being given to Midlothian Community Hospital being redesigned and reconfigured to become an ICF and Roodlands Hospital incorporating a purposed designed ICF to serve the people of East Lothian.

Current	Future
Royal Edinburgh Hospital – 364 beds	**Royal Edinburgh Hospital** The future role for the REH will be a multipurpose site providing acute mental health, learning disability, substance misuse and neuro and brain injury services as well as facilities for frail elderly, continuing care and an integrated care facility for the south side of the city **South Edinburgh Integrated Care Facility** – as part of an enhanced phase 2, there is capacity for 90-120 care home places which could support the replacement of a range of services currently provided in outmoded facilities at Astley Ainslie and Liberton Hospitals
Royal Victoria Hospital – 81 continuing care and 56 winter/ delayed discharge beds	**Royal Victoria Integrated Care Facility –** the proposed plan would involve closing delayed discharge and continuing care beds on or as close to the 1st April as possible and moving patients to Gylemuir House (capacity 120 beds) to allow moves and closure of wards to take place. Then develop 120 care home places, with the possibility of also including supported housing units, social housing units, and GP training practice and community hub services including rehabilitation.
Astley Ainslie Hospital –90 beds, neuro/stroke rehab, orthopaedic rehab, amputees (SMART centre)	**South Edinburgh Integrated Care Facility** – as part of the accelerated phase 2 of the REH Redevelopment, replace all services from Astley Ainslie in modern facilities on the REH site, enabling closure and disposal of the Astley Ainslie Hospital site
Roodlands Hospital – 62 beds, Elderly rehabilitation and complex care	**East Lothian Hospital and Integrated Care Facility -** New facility will open in 2017/18 – original community hospital brief used for Initial Agreement under review for Outline Business Case to include integrated health and care services which will support repatriation of East Lothian patients from Midlothian and Edinburgh. This is a key element in the remodelling of care for frail elderly people.

Current	Future
Herdmanflat Hospital – 12 beds elderly psychiatry	The development of the new East Lothian Hospital and ICF in 2018 and the remodelling of care for the frail elderly would enable the transfer of the old age psychiatry service from Herdmanflat and the closure and disposal of the Herdmanflat site. Early transfer as part of the decant strategy for Roodlands is being considered.
Belhaven Hospital – 12 GP beds, 16 care home beds and 5 IPCC beds.	East Lothian Partnership is currently developing joint proposals as part of the remodelling of care for the frail elderly.
Edington Hospital – 9 beds	East Lothian Partnership is currently developing joint proposals as part of the remodelling of care for the frail elderly.
Midlothian Community Hospital – 88 beds – elderly psychiatry assessment and elderly complex care	**Midlothian Integrated Care Facility -** proposed redesign to better integrate service delivery between acute and community services. Proposals include repatriation of rehabilitation services from Liberton Hospital, review of day hospital, more integrated working between care homes and inpatient services and expanded use of outpatient's facilities.
Tippethill Hospital – 60 beds	**West Lothian Integrated Care Facility -** proposed redesign/modernisation of patient pathways as part of redesign of the older people's services across West Lothian, reducing reliance on St John's Hospital and the outmoded facilities at St Michael's Hospital.
St Michaels Hospital – 30 beds	
Maple Villa – 30 beds	
Corstorphine Hospital – service reprovided	Beds re-provided on the Royal Victoria hospital; main hospital now closed and subject to disposal.

2.6.5 Older Peoples Services Capacity Development (Delayed discharges and Integration Fund Monies)

Pan Lothian

The Board, through the work of the Corporate Management Team and the Integration Joint Boards needs to consider the recent allocation of £100m over three years to support the reduction in the number of people delayed in hospital. As part of this there is a requirement to ensure that patients who are fit for discharge don't wait any longer than 72 hours.

This money is in addition to the £100m available nationally for integration. The four partnerships have submitted plans for expenditure against this allocation. This will continue much of the capacity that was set up under the Change Fund plus more i.e. rapid response and crisis response and support; day hospital development and challenging behaviour support as well as funding for a variety of services to support older people at home. The new Integration Fund monies must also support a younger group i.e. 45-65 with multiple co-morbidities in the community.

Avoiding admissions work via Hospital at Home Teams was shared at a planning session with Partnerships in December 2014. This is a core component of the comprehensive range of services to support older people within partnerships at different stages of development.

East Lothian

20 intermediate care beds opened September 2014. A business case for enhanced ELSIE model covering patients with dementia and 7/7 operation is to be developed by end of January 2015.

West Lothian

Demand and capacity planning underway across primary care, community nursing, crisis care, re-ablement, care at home, to be completed by March 15 2015.

Mid Lothian

A range of additional supports now in place including step down beds. Further plans being developed include: single contact point for discharge hub to access social care; expanding re-ablement to deliver more rapid response; creating additional step down beds; expanding MERRIT to 7/7 and extended days; extending hospital in-reach team; creating interim care home beds.

Edinburgh

Current work underway includes : discharge process review; Royal Victoria Care home project – October 2016 target; interim integrated care home commencing admissions from January 2015; work underway to evaluate step down facilities - December 2014; plans to expand care home, care at home, re-ablement, intermediate care capacity – by March 2015.

2.6.6 Delivery of the Delayed Discharge Standards

NHS Lothian is working closely with the four Lothian partnerships to support delivery of the two week and 72 hour standards and the development of proposals associated with the utilisation of the new Scottish Government Delayed Discharge allocation.

East Lothian

The delayed discharge situation in East Lothian remains challenging. There has been improvement in the delayed discharge position over the latter months of 2014/15.

The East Lothian partnership has established a Delayed Discharge Task Group which meets weekly. The remit of the Task Group is to reduce the total number of delays, meet the four week target and then progress towards delivery of the two week target. The task group will also develop prioritised proposals for the new delayed discharge allocation. These proposals will focus on improving assessment times and increasing capacity in home care.

Edinburgh

Discussions are on-going on the use of the delayed discharge allocation to support delivery of the standards. It is anticipated funds will be utilised to fund additional care home staff, support the resolution of delays within the Royal Edinburgh Hospital through an opportunity to negotiate a contract for 12 specialist dementia beds and to support plans to open 60 interim step down beds at Glyemuir House.

Midlothian

Good progress has been made in the reduction of delayed discharge in Midlothian during 2014/15. This reduction in delays has been achieved through increased capacity in primary and community care services, including:

- Midlothian Enhanced Rapid Response and Intervention Team
- Hospital In-Reach Team
- Intermediate Care Beds at Highbank
- Support systems for people with dementia
- Addressing the impact of social isolation
- Care at Home Capacity
- Complex Care – delivering in the community

In order to deliver the 72 hour commitment, there will need to be further investment of the new delayed discharge allocation in community based services and closer working with the acute sector to support early discharge planning. The key areas for further investment will focus on:

- Intermediate care beds at Highbank. The longer-term plan will be to move to having 40 beds available and investment is required to ensure the appropriate staffing model is in place for this additional capacity

- Hospital In-Reach Team. The existing hospital in-reach team has developed strong working relationships across the acute sites and there is good evidence of the impact the team are having in facilitating early discharge. An increase in activity will require additional capacity within the team

- Discharge to Assess. A test of change model has been developed to support patients being assessed after being discharged home to avoid unnecessary delays within an acute setting waiting for assessment

- Re-ablement Hospital Discharge Team. To expand the capacity within the re-ablement service to avoid these delays between when the packages of care are agreed and when they can start

- Discharge Hub. A Single Point of Contact for all discharge related enquiries from the Hub will be channelled through a single number and triaged to the relevant local service

- Supported Discharge. This involves working with British Red Cross to put in place a structure to support transport home from hospital. This service also ensures the patient is home safely, has sufficient food available and, where necessary, will stay with them to ensure they are settled in following discharge

- MERRIT (overnight carers). This development will provide additional capacity to resolve the recurring issue of having insufficient overnight care in place in order to facilitate discharge and/or avoid hospital admissions

<u>West Lothian</u>

To support delivery of the delayed discharge standards, the approach in West Lothian is to utilise the delayed discharge allocation to support development of a programme of change across the whole frailty pathway to meet the health and social care needs of frail elderly adults and to minimise delays in discharge as well as reduce hospital admission and readmission.

This programme of change encompasses four work streams:

- Comprehensive Geriatric Assessment (CGA) and Frailty Pathway in Hospital to ensure CGA is undertaken as early as possible to achieve the best outcomes and reduce the chance of delays in care.

- Frailty capacity modelling to inform the shape of future bed and service configuration, this is assist to identify where investments are targeted

- Mental Health Service to redesign the older people care pathway with more preventative, assessment and outcomes focus with an emphasis for caring for people in their own homes
- Supporting Health and Care in the Community, this work stream will analyse current arrangements and performance and advise on investments to ensure critical activity can be stained, this include service delivery models associated with Re-ablement, Crisis Care, the newly developed Interim Care Home Team and specification of the new Care at Home Framework Agreement

3. LDP STANDARDS

3.1 Monitoring and Reporting Performance

NHS Lothian will continue to monitor and report performance against delivery of the 2015/16 LDP standards through the appropriate local and national systems and submission of monthly performance reports for review and action via the Corporate Management Team and NHS Lothian Board.

Performance against the delivery of the LDP standards will be maintained through lead directors, committees and local management groups.

The table below provides commentary on delivery of the 2015/16 LDP standards, actions to support achievement and mitigation of identified risks.

People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)

31 days from decision to treat (95%)

62 days from urgent referral with suspicion of cancer (95%)

Early diagnosis and treatment improves outcomes.

Detect Cancer Early (DCE)

Detailed analysis of our performance via the national monitoring reports but also via our use of local data is undertaken to assist forward planning in the programme. The DCE programme baseline position is measured using the 2-year 2010 and 2011 period. Since the DCE programme baseline position, NHS Lothian's performance has moved from 22.64% (Scotland: 22.96%) to 25.80% (Scotland: 24.30%), based on national, validated ISD published data.

Our local programme management information to date (covering the period 2013 and part of the calendar year 2014) shows a further positive movement to 26% of breast, lung and bowel cancers diagnosed at stage 1. NHS Lothian's LDP target for the 2013 and 2014 period is set at 25.6%.

A national target of 29% breast, lung and bowel cancers combined, diagnosed at stage 1 is likely to be reached by the end of 2015.

A number of risks to the DCE programme have been identified relating to :

- Increase the proportion of stage 1 breast and bowel cancer screening programmes
- Unknown exact allocation of funding for Year 4 (2015-16) of the national programme
- Anticipate additional staff hours to support targeted schemes

Mitigating actions to support delivery of the LDP standard are outlined below.

The SE of Scotland Breast Screening Programme is developing plans to support further targeting and increased update of screening, with support from the Lothian DCE Programme Board including the Public Health Breast Screening Programme Co-ordinator.

Across public health, the screening service alongside strategic planning are taking forward planning and development of the DCE and national Breast Screening Review Programmes integrating the work to ensure local implementation best supports equity of access and maximises uptake.

In bowel and breast screening, ten Lothian General Practices have participated in a Lothian DCE programme pilot scheme to support better uptake of screening in both the breast and bowel programmes. The findings from the pilot are now being taken forward and in particular are running a pilot of issuing bowel screening kits from general practice directly to targeted individuals.

The additional needs task force is building on the achievement of the ethnic coding task force and the cancer team is involved in piloting equity standards as part of a wider initiative.

Referral guideline implementation is being supported by guideline incorporation into refhelp and Gateway. This work is being supported directly by the clinical leads in bowel, breast and lung cancer. Much work has been done in 2014-15 to update our refhelp and e-referral protocols. This should assist performance in 2015-16.

For lung cancer, the leadership of the lung cancer service and associated pathway development has been placed with the Royal Infirmary of Edinburgh respiratory team. This team now includes a new DCE funded respiratory medicine consultant, which increases the focus on the lung cancer pathway and its continuous development. The RIE team, in collaboration with the respiratory teams at the Western General Hospital and St John's Hospital will ensure that pathways and protocols for lung cancer access and performance, including DCE, are standardised across all sites, as appropriate

61 and 32 Day Standards

NHS Lothian continues to meet 61 and 31 day cancer standards.

For Quarter 4 (Oct – Dec) 2014 performance is 95.6% against the 62 day standard and 97.0% against the 31 day standard.

Key risks identified which may impact on delivery in 2015/16 relate to:

- Pressure on the system due to increased referrals through ageing population and lifestyle choices
- Pressure on inpatient services (e.g. cancellations due to pressure on beds)

Laparoscopic prostatectomy. There is evidence that this is having a negative impact on NHS Lothian performance of about 1.1% against the 62 day target. Although it is reported all cancer networks are supporting laparoscopic procedures, NHS Lothian is receiving referrals from all networks, suggesting networks are not supporting provision. As a result, NHS Lothian is developing a waiting list and is being unfairly penalised for delivery which should be provided by other cancer networks. NHS Lothian continues to have ongoing discussion with SGHD regarding this issue.

People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support

Enable people to understand and adjust to a diagnosis, connect better and plan for future care

Alzheimer Scotland Post Diagnostic Link workers are in post in West Lothian, Midlothian and City of Edinburgh, recruitment is underway in East Lothian. The link workers are delivering 5 pillars model of post diagnostic support.

Data is being submitted to ISD, there have been data/recording issues on the ISD management reports and this is being followed up by Mental Health and Well-being Programme.

Work is on-going with secondary care and community mental health teams to identify and record post diagnostic support which they undertake and this will be included in future submissions to ISD.

For people at a later stage of the dementia journey, Midlothian is a test site for the 8 pillars dementia practice co-ordinator role.

12 weeks Treatment Time Guarantee (TTG 100%)

18 weeks Referral to Treatment (RTT 90%)

12 weeks for first outpatient appointment (95% with stretch 100%)

Shorter waits can lead to earlier diagnosis and better outcomes for many patients as well as reducing unnecessary worry and uncertainty for patients and their relatives.

NHS Lothian recognises the importance of patients being seen within the expected timescales. Unfortunately despite the investment made over the last three years to improve our waiting times performance difficulties still remain. The effect of the number of people boarding or delayed remains a significant risk as does the number of people presenting at our Accident and Emergency departments. All of these pressures make it difficult to protect elective beds. We continue to be dependent on the independent sector as highlighted in our acute recovery plan 'Delivering for Patients'. The rate at which we wished to repatriate and build internal capacity has not to be realised.

Recovery and honouring the commitment on waiting times to patients is a focus for 2015/6 with timescales currently under discussion with Scottish Government Health Department's Access Support Team whilst moving to resolve the issues which have impacted on compliance to date.

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation

Antenatal access supports improvements in breast feeding rates and other important health behaviours.

In 2014/15 NHS Lothian achieved the 80% standard and revised a local trajectory to deliver a target of 88%. Work on going to target the approximate 10% who are not booked for care by the 12th week of gestation.

Eligible patients commence IVF treatment within 12 months (90%)

Shorter waiting times across Scotland will lead to improved outcomes for patients.

NHS Lothian is meeting the forthcoming standard on the commencement of IVF within 12 months, with additional capacity supported through national monies to both maintain local waiting times and help reduce waiting times elsewhere in Scotland.

Continued use of this additional funding is again expected in 2015/6 given heightened referral numbers and would again be used to ensure that those eligible couples seeking treatment are seen within the expected time.

18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

Early action is more likely to result in full recovery and improve wider social development outcomes.

Target of all children and young people starting treatment with 18 weeks of referral was not met by Dec 2014. An agreed recovery plan with funding for substantive posts and additional non-recurring posts was agreed with posts recruited during Oct/Nov. Good progress is now being made against agreed trajectory. The agreed revised trajectory predicted that the target would be met by end of May 2015. However a significant increase in referrals in the last quarter of 2014 and January 2015 along with reduced capacity due to accommodation issues may delay meeting the target till end of June /July 2015. There were 428 patients waiting over 18 weeks at the end of January 2015. For patients seen for a 1st treatment in January, 51% were seen within 18 weeks. This level of performance will continue as services focus on clearing the backlog of patients over 18 weeks.

18 weeks referral to treatment for Psychological Therapies (90%)

Timely access to healthcare is a key measure of quality and that applies equally to mental health services.

The target of 18 weeks for referral to treatment for a psychological therapy was not met by December 2014. Performance against the target was 44% at end of January. There continues to be a significant and increasing backlog of patients waiting over 18 weeks for a psychological therapy. At the end of January there were 3,095 patients waiting for psychological therapy with 1,201 (39% of all those waiting) currently waiting over 18 weeks. Further demand and capacity work has highlighted the requirements for increased capacity to deliver psychological therapies. A further paper outlining service improvements completed to date and Demand, Capacity, Activity, Queue (DCAQ) modelling which demonstrates that additional recurring resource is required to meet demand for psychological therapies was discussed at the Corporate Management Team meeting in February with an update requested in March with a view to a full report being presented to the NHS Lothian Board in April 2015. Given the current position it is highly unlikely that this target will be met before the summer of 2015.

Clostridium difficile infections per 1000 occupied bed days (0.32)

SAB infections per 1000 acute occupied bed days (0.24)

NHS Boards area expected to improve SAB infection rates during 2015/16. Research is underway to develop a new SAB standard for inclusion in LDP for 2016/17.

CDifficle infections (CDI) continue to be a challenge within NHS Lothian. A significant change in the antimicrobial prescribing policy came into effect on 2nd February 2015 so the anticipated (positive) impact of this change will be closely monitored during the year.

A review of environmental cleaning and standards will be undertaken in 2015/16 with the aim of reducing CDI.

Further guidance is awaited for new SAB standard.

Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)

Services for people are recovery focused, good quality and can be accessed when and where they are needed.

Working with our partners in the three Alcohol and Drug Partnerships (ADPs) in Lothian, there will be further developments to enhance local treatment and care systems to make them more responsive, person centred and recovery focused. We will continue to work to ensure that people access treatment promptly (within 3 weeks of referral) and are supported in their recovery by services provided locally and in an integrated way.

During 2015-16 we will continue to develop the inpatient rehabilitation service for patients with acquired brain damage as a result of alcohol misuse. The Alcohol Related Brain Damage (ARBD) Unit is providing intensive rehabilitative support to enable people to return to their own home with reduced use of re-admission to the acute sector.

Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas

Enabling people at risk of health inequalities to make better choices and positive steps toward better health.

Alcohol Brief Interventions

NHS Lothian and other partners within each of Lothian's Alcohol and Drug Partnerships will sustain the delivery of ABIs in the three priority settings (Primary Care, Antenatal and A&E) during 2015/16. This prevention/early intervention activity will contribute to work to reduce health inequalities and promote the health and well being of communities by focusing on the needs of the local population in the harder to reach groups where deprivation is greatest.

We will continue to deliver a comprehensive education and training programme for groups of staff in both statutory and voluntary agencies, for example in prisons, police custody suites, criminal justice programmes ,youth and sexual health programmes/services and welfare rights teams. This helps to ensure that disadvantaged groups receive a quality service.

We will work with our local ADP and 3rd sector agency in West Lothian to develop a care pathway for persons entering police custody suites/criminal justice settings and evaluate and report outcomes.

Working with local neighbourhood partnerships across the city we will facilitate ABI training and further develop our ABI toolkit for local authority staff. We will ensure that staff working in Keep Well, and other specialist projects which have been established to address the needs of people from disadvantaged communities, receive ABI training e.g. the Access Point (working with homeless people), specialist midwifery staff (working with gypsy travellers and temporary residents)

We will continue to monitor and evaluate the ABI e-learning module and further develop our local Training for Trainers module in order to sustain ABI training in the wider community. Working with Queen Margaret University we will further develop and evaluate the training module for Allied Health Professional students and embed the module in the core curriculum for undergraduates.

NHS Lothian's target for ABI delivery in 2015/2016 from the Scottish Government is 9757 with 80% delivered in the priority settings.

It is expected that NHS Lothian will exceed the target as illustrated in previous years

Phase 1 – HEAT Target 2008-2011

Outcome: NHS Lothian delivered 29,884 ABIs which represents 127% of the original target (23,594)

Phase 2 –HEAT Target 2011-2012

Outcome: NHS Lothian delivered 17,093 ABI's in 2011/12 which represents 172% of the original target (9,938)

Phase 3- HEAT Standard 2012-2013

Outcome: NHS Lothian delivered 18,275 ABI's in 2012/2013 which represents 184% of the original target (9,938)

Phase 4 –HEAT Standard 2013-2014

Outcome: NHS Lothian delivered 23,735 ABI's in 2013/2014 which represents 239% of the original target (9,938).

NHS Lothian will meet the new ABI delivery target in the priority settings and will report accurate data quarterly to Information Services Division (ISD) by submitting further demographic data e.g. age gender, postcode. Further data will be obtained around hard to reach groups where deprivation is greatest.

We currently await updated ABI National Guidance from Scottish Government due to be published in late March.

Smoking Quits

NHS Lothian will sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas by providing an accessible cessation service.

Priorities for the service remain providing an effective cessation service to hospital patients (both in acute and mental health hospitals), young people, pregnant women and their families, and prisoners. We will set local targets for each of these priority groups once we have further information regarding national targets for 2015-16.

CO monitoring at booking and referral to stop smoking service is now well established in NHS Lothian and the stop smoking service is working with Early Years Collaborative to improve engagement with pregnant women.

We plan to re-design our stop smoking service to improve skill mix and become more cost effective. We will take a community development, asset based approach when developing services. We will also consider ways of providing prevention and cessation to young people in a more effective way.

Stop smoking service staff will complete on-line national centre smoking cessation training (NCSCT) training until a new national training programme is established for Scotland. This will improve staffs' knowledge and they will also be provided with an in-house training programme to enhance their skills and practice. A training programme will be continued to be delivered to community pharmacies to enhance knowledge and skills to help increase their activity.

We will continue to monitor progress using ISD database and performance will be reported directly to the corporate management team.

48 hour access or advance booking to an appropriate member of the GP team (90%)

Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients.

Performance against these GP access standards is monitored using the results of the bi-annual Scottish GP Health Care Experience Survey. The latest data available is from the 2013/14 survey published in May 2014, relevant results outlined below:

Patients can speak with a doctor or nurse within 2 working days : (% positive score)

Lothian = 82% (Scotland 83%)

Lothian practice variation : 60% - 100%

Patients are able to book an appointment 3 or more working days in advance : (% positive score)

Lothian = 75% (Scotland 76%)

Lothian practice variation : 20 – 100%

In 2015/16 survey results will be analysed and a briefing report prepared for the Healthcare Governance Committee. Based on this analysis a further report is submitted to NHS Lothian Board. The results will be summarised and circulated at partnership level to General Managers and Clinical Directors for action as appropriate.

Overall NHS Lothian GP practices perform relatively well against the GP access standard and the results are consistent with those for practices across Scotland. It should be noted GP access indicators were removed from QOF in 2011/12 therefor there is no specific requirement per se under the GP contract for practices to meet the indicators i.e. the modest financial incentive was removed.

The relatively low level performance for these 2 indicators against the previous HEAT standard (90% target) consistent across Scotland probably reflects the pressure GP practices are under in terms of primary care investment to tackle population growth and on-going workforce issues relating to recruitment and retention.

Sickness absence (4%)

A refreshed Promoting Attendance Partnership Information Network Policy will be published in 2015.

At 31st December 2014 NHS Lothian's sickness absence was 4.50%

NHS Lothian performs well in comparison to other NHS Boards, however continues to be challenged in achieving the 4% target on a sustainable basis. The added dimension of NHS Lothian's aging workforce will make this standard more challenging.

In order to manage delivery of the standard, NHS Lothian's Promoting Attendance Policy will be reviewed and refreshed when the network policy is published in 2015. HR continues to provide appropriate technical support and governance frameworks to support managers to achieve the target.

Guidance will be developed on managing the health of an aging workforce and NHS Lothian will continue to champion a strong partnership ethos to managing staff sickness absence.

HR resource is allocated to support manager to review and monitor individual staff absence. A financial risk relates to continued use of 'bank shifts' to cover sickness absence, particularly in the nursing and medical workforce.

4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

High correlation between emergency departments with 4 hour wait performance between 95 and 98% and elimination of long waits in A&E which result in poorer outcomes for patients

Achievement of the 4 hour target remains challenging. However, NHS Lothian will continue to develop NHS Lothian's Lothian Unscheduled Care Plan to capture the necessary actions across acute, primary and social care sectors in order to improve performance.

In 2016-16, NHS Lothian will build on the significant work undertaken during 2014-15 in reviewing capacity and service models across Lothian.

Outputs from this overall review to date include:

- An additional 31 beds made available on the RIE site
- New Day Medicine and Medical Admissions Units have now opened on the WGH site.
- A new Surgical Assessment Unit on WGH site
- Expand ARAU Beds adding an additional 10 beds to the Medical Admissions Unit on the WGH site
- Work with local GPs to introduce Day Medicine 'Hotline'
- Review of Bed Bureau and the Transport Hub.
- Joint winter planning approach with Local Authority partners.

Further work across a range of services will be required during 2015-16, including Medicine of Elderly, Stroke and Orthopaedics

NHS Lothian will continue to submit weekly and monthly performance reports to the Scottish Government as required.

The high level of delayed discharge currently experienced impacts on hospital flow, patient safety and experience. Significant work is being undertaken to help address the issues of delayed discharge. This includes Community Clinical Support Workers, the commissioning of 'Hospital to Home', hospital admission prevention models such as REACT and COMPASS, Discharge Hubs. We will also review our joint venture with City of Edinburgh Council regarding additional nursing home capacity within the city (Gylemuir House).

Considerable reviews of current models for unscheduled care across NHS Lothian have been undertaken during 2014/15. This has involved reviewing front door models of care at our acute hospitals, the roll of out of community frailty models to reduce re-admission, analysis of patient flow systems and tackling Delays.

We have also been mindful to ensure sufficient capacity during the winter period (Jan-Mar 2015). Overall there have been more beds available than during last winter. Significantly a number of these beds are out with the acute hospitals and avoid use of substandard facilities. Such additional temporary capacity allows NHS Lothian to continue to provide safe and effective person centred care while supporting improved performance measured against HEAT targets and related national standards.

We will continue to undertake a planned approach to winter capacity planning working with an array of stakeholders across health and social care.

NHS Lothian has recruited a number of Emergency Medicine Consultant posts to support completion of a 3 year consultant expansion programme. Appointment of Clinical Development Fellows will commence in August 2015 to cover a number of specialties including Emergency Medicine. These positions have proved to be both attractive in filling gaps in A&E and front door specialties.

The largest financial risk in achieving the 4 hour target relates to flow. Activity is on going to reduce the number of delayed discharges, speed up the discharge process, increase the amount of people seen in an ambulatory care setting rather than via direct admission. There is also a significant amount of work to discharge earlier in the day. These actions are all aimed at improving flow through the system and maintaining the 4 hour target. Additionally, discussions are on going with council colleagues around maximising the social care packages and external places to improve transfers through the system.

Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

Sound financial planning and management are fundamental to effective delivery of services

NHS Lothian continues to assess the financial plan for 2015/16 with the aim of achieving a balanced position. Work is on going to support services in the delivery of efficiency savings to meet the challenging LRP target.

4. FINANCIAL PLANNING

4.1 Financial Context

The financial outlook presented to the Board in December 2014 and Finance and Resources Committee in January 2015, set out an extremely challenging financial position for 15/16 and 16/17. This is within the context of growing population and particularly a growing elderly population, and at the same time we are seeing more people with more complex needs requiring community and hospital support. Alongside this increases in prescribing within acute care and new and more expensive drugs are also driving up costs. Aligned with this is the growing expectation from the general public that health and social care services should be able to deliver the increased capacity required to meet the growth in their needs.

The current assessment of the financial plan for 15/16 shows a recurring gap of £14m offset by non recurring resources to achieve a balanced financial position. This assumes an in year delivery from efficiency savings via the local reinvestment programme (LRP) of £30m. With LRP delivery around £25m in each of the previous two years and with only a small number of schemes currently low risk, achievement of this value will be a challenge for the organisation. The non-recurring resources available to achieve a balanced plan include a number of assumptions on the level of resource anticipated from the autumn statement and further rates rebates. Further work is ongoing to identify and deliver additional savings, the details of which are noted below.

In particular, consideration of the draft financial plan also indicated that once again additional resource requirements were largely acute sector driven through scheduled and unscheduled care capacity requirements, medicines in secondary care (although not entirely) and pay/pension costs.

In addition to these additional costs, the plan recognises the financial pressures already generated across our Acute Hospitals from;

- A high level of delayed discharges across the system which has resulted in both additional beds being opened, and the reopening of RVH.
- The requirement for significant investment at the front door to ensure senior decision making about admissions

- Access to medicines utilising the PPRS benefit which might otherwise have been available to offset the impact of volume increases in primary care prescribing and the price increases from short supply

- An increasing difficulty in identifying efficiency schemes that deliver cash savings.

Despite the development of a draft strategic plan which outlines the Boards response to the challenges it faces it has not been able to develop a financial framework which is capable of supporting the investment in acute infrastructure, capacity in primary care and community services in particular (to start addressing the 2020 vision), and freeing up capacity to deliver changes in patient pathways.

Recognising the need to develop a balanced financial plan which not only generates options to reduce costs but frees up resource to start addressing the 2020 vision, a small "Delivering Financial Balance" Core Steering Group has been established. This is being led by the Chief Executive, and includes the Director of Finance, Director of Strategic Planning and the Director of HR. This Core Group has been working with each Executive Director to consider existing and emerging plans and options to achieve financial balance over the next 3 years.

This has incorporated discussion on Strategic Plan propositions to ensure that where these support financial sustainability (in addition to patient safety and quality) they are prioritised.

The total LRP target for 2015/16 has been set at £48m, including carry forward. It is recognised that this level of recurring delivery is unlikely in-year, particularly in the context of current service demands. The present iteration of the financial plan assumes delivery of £30m. This situation presents a daunting and unprecedented challenge.

Work to date has identified a wide range of areas where there are opportunities for savings, although some will be a longer timescale in terms of delivery. Included in this are:

- Several corporate work streams focussed on procurement, office accommodation, catering, working with third parties

- Service reviews including frail older pathways in West Lothian, Cancer pathways, LUCS, Out-patient Services

- Delivering a sustainable workforce looking at skill mix, management costs, workforce numbers and an administrative and clerical review.

To secure this magnitude of change will be a challenge within the context of no compulsory redundancy and no detriment protection of earning. Facilitating the change will require access to funds for voluntary severance. Another significant enabler would be the merger of corporate services across the region.

The Board is continuing to make progress to deliver a balanced financial plan for 15/16, however further work is still required. Three key areas of focus will support delivery of this objective:

1. Minimise unavoidable commitments. All forecast 'step-ups' need to be rigorously reviewed and challenged.

2. Continue to work with Scottish Government to identify potential additional funding sources and to achieve greater flexibility in current allocations.

3. Maximise recurring LRP delivery. The impact of the core group needs to materialise into a stepped increase in LRP performance.

In summary, current financial plans, taking into account expected income, rates of expenditure and savings plans requires further work in order to deliver a balanced budget in the short term, let alone deliver the longer term strategic ambitions set out in this Plan.

4.2 LDP Financial Plan

The draft LDP Financial Plan and Risk Schedule was submitted to the Scottish Government on 16 February 2015 (Appendix 5); a further update plan will be submitted on 13 March 2015. The key assumptions / risks associated with the LDP are outlined in the table below.

Very High Risk	Bed Reductions, Income Assumptions, Social Care Investment
High Risk	Local Reinvestment Programme, Scheduled Care, Unscheduled Care, Delayed Discharge, Changes to IPTR Process, Parental and Adoption Leave, Hepatitis C Drugs, SGHD Allocations, Capital Programme, Equal Pay
Medium Risk	Pay (Terms and Conditions), Prescribing, Rebates and Property Sales

4.3 Property and Asset Investment Programme

A Five Year Property and Asset Investment Programme was presented to the Finance and Resources Committee in January 2015, and an updated version is included in Form 8 of this LDP submission. This plan is constantly updated to reflect known and emerging capital schemes in line with the Strategic Plan, outputs from the Masterplanning groups and efficiency plans with a capital component.

Emerging schemes currently under consideration include reprovision of the Edinburgh Cancer Centre; proposed expansion of the St John's Hospital site; reprovision of the Princess Alexandra Eye Pavilion and potential use of the Bioquarter site adjacent to the Little France Campus.

Given the significant quantum of these schemes, and the anticipated constraints on capital funding, it will be necessary for the Board to prioritise projects to ensure business cases submitted to the Scottish Government reflect the most urgent needs of the organisation and maximise potential benefits.

There are a number of risks inherent in the Property and Asset Investment Programme. Throughout the timeline of this plan and beyond there is pressure on resources and capacity to deliver significant developments over a number of acute sites in parallel. A more immediate impact is the potential delay in achieving the programme for Financial Close for the Lothian Bundle, future revenue funded schemes, due to outstanding ESA10 interpretation issues.

Commitments identified for 2015/16 include on-going enabling expenditure for the Royal Hospital for Sick Children and Department of Clinical Neuroscience reprovision; investment in the modernisation of Primary Care premises; capacity developments at St. John's Hospital, Royal Infirmary of Edinburgh and Western General Hospital; and continued investment in medical equipment, statutory compliance, eHelalth priorities and LRP enabling schemes.

5. WORKFORCE

5.1 NHS Lothian Workforce

The model of delivery for health and social care is changing. With rising demand projected from the demography and epidemiology it may well be that overall the number of people employed in the health and social care field will increase. However the balance of who provides what, where, between the NHS, local authorities, and the third sector, will change significantly and will therefore impact on the profile of our workforce. Our workforce plans over the longer term will need to model this change to ensure we are best placed to meet our aspirations in relation to the delivery of our strategic plans.

NHS Lothian employs approximately 20,538 whole time equivalent, with a pay bill of circa £850m per annum, which represents the single largest element of expenditure.

In the short to medium term there are a number of factors that will influence our workforce profile. As we move to implement the 2020 Quality Strategy with more care provided at home or in a homely setting we will be less reliant on acute hospital beds and this factor will impact on the number of staff we employ and the skill mix of the workforce. Implementing the balance of care shift from acute hospital services to primary care and community services, will see future investment in primary care with additional resources being topped up by a disinvestment in acute care. There will be workforce implications and reductions as a consequence of this. This will be ongoing as the future investment in primary and community care impacts on referral patterns to the acute sector.

In the immediate future we need to bring forward a balanced budget for 2015/16. The LRP target in our financial plan of £47m means that workforce terms and applying a percentage equivalent to the proportion of overall total cost, this would equate to a reduction in staffing of 840wte which translates into approximately 1050 in headcount terms.

In recent years the size of NHS Lothian workforce has fluctuated. Generally the trend has been upwards. At the time of writing NHS Lothian has never in its history employed as many people as it does today. From April 2012 to today, our WTE figure has gone from 18,553 to 20,538 an increase of 1985. In year 2015/16 a staffing reduction of 840 WTE would take us to the staffing levels we enjoyed in November 2013.

Site closures, skill mix, tight control of corporate services, management and administrative costs, will all have an impact on the workforce profile. Supplementary staffing, bank and agency expenditure is of the order of £78m per annum. Measures have been put in place to reduce spend in these areas, and of course some supplementary staffing costs in, for example, bank and extra programmed activities for senior medical staff are useful, appropriate and value for money. Yet there is more that can be done to reduce costs in this area. We cannot reduce the size of the workforce in order to live within our means simply to see our supplementary staffing costs or overtime costs rise.

The delivery model for care is changing. The redesign of clinical services needs to follow the model care. We require sustainable workforce plans which contribute to delivery of financial balance in a manner which delivers quality care. Shifting the balance of care inevitably means the deployment of resources between the acute sector, and community care and the use of the third sector, will require planned change. In the short term we need to put in place an affordable, sustainable, trained workforce.

5.2 Everyone Matters: 2020 Workforce Vision Implementation Plan 2015-16

NHS Lothian is supporting local implementation of the 5 priorities outlined in Everyone Matters: 2020 Workforce Vision Implementation Plan 2015-16. Actions to support implementation of the workforce vision are outlined in the sections below.

5.2.1 Healthy Organisational Culture

NHS Lothian's organisational values were developed in 2013/14 with the direct involvement of 3,000 staff through over 80 workshops. In order to continue to support embedding of NHS Lothian's values, a number of approaches have been taken, these include:

- Induction programmes for all new employees
- Features as a key element of all learning and development programmes
- Value based recruitment for all senior managers positions
- A communication strategy which ensures the values are embedded in staff communications and newsletters and the Celebrating Success Staff Awards are judging is based on the organisational values

Staff engagement structures have been reviewed resulting in the establishment of 12 new local Partnership Forums. The remit of these forums includes responsibilities for putting values into action and developing local staff governance action plans. The Organisational Development team have been supporting and facilitating specific staff engagement events based on our values and helping teams with difficulties.

The new management models for Health and Social Care Partnerships and Acute Services which will be in place in 2015-16 have robust clinical engagement arrangements and staff engagement plans as part of their implementation.

Staff engagement in 2015-16 will include working with Team Leads to ascertain what would help them embed the values within their specific teams. The iMatter tool will be piloted within Public Health and the Royal Edinburgh to assist with embedding our values and staff engagement.

5.2.2 Sustainable Workforce

To support delivery of NHS Lothian's LRP target, a number of key actions will be taken forward in 2015/16 to support a reduction in workforce expenditure.

Clinical Skill Mix

A number of areas are being reviewed to introduce a more efficient skill mix which will both provide efficiencies whilst also assisting the management of workforce supply challenges. The specific areas of focus are theatres, critical care, radiology/radiography, laboratories, maternity care, AHPs, community nursing and psychology. New models will have to take into account the adherence to appropriate clinical governance standards

Corporate Services

In order to protect clinical services there is a need for a continuing focus on trying to reduce costs in corporate areas as much as possible. The national work on shared services will in time support further reductions this in the medium term.

Management costs

A redesigned integrated and efficient management structure is being implemented across acute services, the integrated joint boards and also the board to support a reduction in workforce costs. The acute service and IJBS each have targeted cost reductions to make in 2015/16.

Administrative Services

NHS Lothian has however already the lowest percentage of administrative staff when compared with similar Boards and therefore this will be an area of challenge. However with the implementation of technology and adoption of new ways of working for secretarial support such as voice recognition dictation may provide opportunities for further efficiencies.

Supplementary staffing and agency

There is currently considerable expenditure on supplementary staffing to cover for short-term workforce gaps and opening of short term bed capacity. There will be considerable focus on reducing this expenditure and in particular to reduce reliance on external agency staffing.

Redesign of clinical services

Notwithstanding the work streams above, we will continue to redesign service provision to support delivery of our clinical strategy to support the provision of efficient and effective services.

Demographic change within the workforce

There are also a number of other substantial challenges in sustaining the workforce in the medium term around workforce demography and changes in the pension provisions, which may impact on retention. Scenario modelling is being developed to better understand the impact on sustainability in key areas of the workforce. This will inform workforce development, recruitment and retentions strategies.

Medical workforce recruitment and retention

NHS Lothian faces recruitment difficulties within a number of medical specialties, in line other Boards in Scotland and the UK. NHS Lothian has a process of medical workforce risk assessment in place for all key specialties which will be refreshed and updated in 2015/16. Additional Clinical Development fellows and International Training Fellowships will operate in 2015/16 to help provide both attractive high quality training opportunities and sustain 'front door' specialties.

Improving workforce data quality

NHS Lothian will continue to work with the national Eess HR System team to implement all aspects the system, which will ultimately help improve data quality. In 2015-16 the development of comparable workforce measures across health and social care will be important in supporting the development of workforce plans for Integrated Joint Boards (IJB).

NHS Lothian will focus on using workforce information and scenario modelling to assess workforce supply challenges in the short, medium and long terms to support sustainability of services.

5.2.3 Capable Workforce

The refreshed NHS Lothian Learning and Development Strategy contains six strategic aims:

- Enable Fitness to Practice.
- Improve governance and accountability.
- Equip and support our leaders and managers to succeed.
- Improve access and create career opportunities.
- Embed quality into our education and training activity.
- Support innovative practice and encourage technological opportunities

Action plans to support delivery of these six strategic aims have been developed and will be utilised in 2015/16. This strategy will be subject to on-going review to support enhanced capacity and capability of our workforce. A new Leadership and Management Development Framework will be developed to support development opportunities for leaders / managers.

Integrated Workforce

The four Lothian Health and Social Care Partnerships are currently developing integrated management structures which will both support the work of the IJBs. The structures that are being developed will ensure that there is capacity and capability to deliver services to local communities and support delivery of the partnership's strategic commissioning plans. It is recognised there will be a number of challenges associated with the establishment of Health and Social Care Partnerships with a backdrop of two separate employers, to support this process, an agreement has been put in place to regarding the application of the relevant organisational change policies through a memorandum of understanding agreement.

When these structures have been implemented our priorities will focus on development of integrated teams led by integrated team managers. This work will be underpinned by a Leadership and Management development programme.

Health and Social Care Integration

Each of the 4 partnerships within Lothian have developed and have begun to implement a human resources and organisational development work plan for integrating the health and social care workforce. The partnerships have formed working groups that includes NHS Lothian partnership representatives and trade union representatives from Councils, in addition to operational and Human Resource representatives. The work plan includes a number of work streams, two of which focus on the implementation of an integrated senior management model and an organisational development plan respectively.

The organisational development plan, agreed by all partnerships is currently being implemented. This is a comprehensive plan which covers staff communication, staff engagement, staff and team development, leadership development and the training needs for those staff members who will be responsible for managing integrated teams. In particular, it includes the procurement of team and leadership development programmes, which is being supported by the transition funds.

It is the intention that when the Partnerships develop their strategic plan this will include a workforce plan to support the implementation of their plans to provide patient centred services and support delivery of the Scottish Government 2020 vision.

The organisational development and workforce plans will be finalised following completion of the initial strategic plans and will be refreshed annually to ensure the development needs of staff are supported to meet the needs of integrated functions.

5.2.4 Effective Leadership and Management

To support and strengthen management at all levels HR On-line has been and will continue to be developed to provide managers and employees with easy access on a wide range of electronic resources covering:

- Recruitment
- Learning and development
- Employee relations
- Support for managers around leading and managing change
- Performance management
- HR Policies
- Job evaluation
- Workforce planning support and information

In addition as part of NHS Lothian's implementation of Our Values into Action and in particular our commitment to the values of 'Openness, Honesty and Responsibility' an In-House Mediation service has been developed to:

- promote a leadership approach that managers can adopt in supporting a culture of openness and honest
- build management capacity and confidence in dealing with conflict at work
- enable staff to resolve their conflicts quickly and locally

A tailored training package has been developed, implemented and facilitated to involve teams in reviewing values within their area and agreeing areas for improvement.

In 2015/16 a revised learning plan and leadership and management development framework will be developed which will support managers in addressing and developing the core skills of managers to ensure they manage their staff within a values based approach. Tools and training/support will be developed for leaders and managers to enable them to embed the values, specifically in:

- Appraisal
- Innovation
- Personal Development
- Communication

A leadership and team development framework and toolkit will be developed to support and assist managers who lead integrated teams from two or more employers.

Based on the feedback from the staff survey and through local HR processes a key focus for 2015-16 will be to work with managers to enable them to proactively identify problem areas through local feedback and information. The roll out of iMatter following piloting will help to further support both managers and employees.

5.3 Workforce Areas Where There is a Risk to Service Delivery

5.3.1 Nursing and Midwifery Workload and Workforce Planning tools

NHS Lothian plans to run the community workload tool for 5 consecutive days in May 2015 involving all district nursing, health visiting and school nursing teams across Lothian. The findings will in turn be fed into wider work on virtual ward teams in the community.

NHS Lothian participated fully in the 2014 national runs of the mental health (including learning disabilities) and midwifery tools. The Board runs the neonatal and SCAMPS tools on a twice daily basis and performed a Lothian wide run of the adult in patient tool and professional judgement tools was undertaken in September / October 2014, with every ward recording data for a 2 week period. A schedule to stagger the use of the tools over 2015/16 is being developed.

Vacancies

Across the Board the establishment gap is monitored monthly. The Board has continued to use a generic recruitment process founded on "1 application 1 interview 1 decision" to manage all band 2 and band 5 nursing vacancies, to good effect. The establishment gap target is around 5%, this will allow for use of flexible staff to cover predictable absences.

Theatre Nursing

There are workforce capacity pressures with the theatre workforce, with increasing activity, working towards 3 session days and a workforce with approximately 25% of its staff eligible to retire within 5 years. The service would benefit from additional places being commissioned on the 3 year ODP training programme at Glasgow Caledonian and the development of training programmes for Clinical Support Workers to up skill for scrub work in specific procedures (this is ongoing national work).

Health Visiting

There are also significant workforce capacity pressures within Health Visiting (HV), with 27[1] WTE vacancies In February 15 and a further 4 WTE anticipated in the next 4 weeks) across Lothian. It is anticipated that there will be 16 newly qualified heath visitors to fill vacancies in September 2015, when they graduate from Queen Margaret University. Work is underway to quantify the number of Practice Teachers (CPTs) that are required to support additional HV students and 8 student CPTs are currently completing the two year course. It is anticipated that a maximum of 26 students will be supported to undertake the HV course for 2015/16. However, as of February 2015, 54% of the Band 6 health visitors are over 50 years of age (72.3 WTE), so there remains a potential risk of unfilled vacancies. The increased number of Health Visitors in training is being supported by a combination of national and local Board funding.

Work is underway to explore anticipated time-lines to be able to meet the requirements of the Children and Young People's Act (2014) and the statutory obligations around the Name Person. In addition, consideration is being given as to how additional skill mix can be incorporated into health visiting teams to support teams to take on additional responsibilities associated with the Act. The implications of the HV universal pathway and the caseload weighting tool are being calculated.

School Nursing

Pan Lothian work is being undertaken for School Nursing in order to meet the national recommendations published in September 2014. It is recognised there is a need to refocus provision of the school nurse within schools, the undertaking home visits, running drop-in clinics and supporting prevention and case management work. The are substantial demographic pressures within the school nursing workforce with 79% aged over 50 years of age with the potential to retire over the next 5 to 10 years.

To support school nursing workload challenges, a team of nursing staff has been established to deliver immunisations across the population, to deliver the routine programme of immunisation and to provide support in delivery of specific immunisation campaigns.

District Nursing

Lothian continues to develop models of anticipatory care/hospital at home type schemes – REACT in West Lothian; IMPACT and Compass in Edinburgh; ELSIEs in East Lothian and MERRIT in Midlothian. These models of care are dependent on district nurses developing advanced clinical and decision making skills and qualified to support independent prescribing. As with other nursing teams, there are similar demographic pressures associated with district nursing teams with 43% of Band 6 district nurses over the age of 50 years.

Lothian continues to developed innovative services, in partnership with council colleagues to facilitate earlier discharge from hospital and to support provision of nursing and social care packages.

5.3.2 Medical Workforce Risks

The overall in-post consultant workforce has increased from 711wte to 792wte between 2011 and 2014, an increase of 81wte (9.7%). This investment supports the response to increasing demand from a growing population and provides additional capacity to support delivery of treatment time guarantees. This increase in workforce has, in the main, been funded through an increased national resource funding allocation (NRAC), designed to provide additional support for boards where there is a disproportionate increase in population or deprivation. The main areas consultant workforce increase has been in Paediatrics, Surgery, Anaesthetics, Emergency Medicine and Obstetrics & Gynaecology.

There have also been a number of areas where it has not been possible to grow the workforce to the extent that has been identified by capacity planning and where posts have not been able to be filled where staff have retired. This represents one of the key workforce risks faced by NHS Lothian along with other Health Boards in Scotland.

Since June 2013 a regular Medical Workforce Risk Assessment paper has been prepared to highlight the areas of high risk and the actions underway to reduce the level of risk. Over this time there have been on-going updates around Emergency Medicine, Paediatrics and Obstetrics &Gynaecology as these were identified as key areas of risk as part of the medical workforce risk assessment process.

Within emergency medicine there has been significant progress in implementing a workforce plan to build sustainability and it is no longer considered as an area of high risk following successful recruitment of additional trained doctors. Clinical development fellow posts have been created to support out of hours cover and the implementation of an updated model of care at St John's Hospital (SJH).

Obstetrics

Over the last three years, funding has been made available for eight new consultant posts to contribute to the resident middle grade rota at RIE; from February 2015 all of these posts will be filled. A workforce plan to support recruitment of up to a further ten additional posts over three years has been submitted to be considered for inclusion in the 2015/16 financial plan. This further recruitment is intended to ensure sustainability of medical staffing and enhance patient safety with 24/7 resident consultant cover. It is anticipated recruitment to these posts will take several years therefore as an interim measure, funding will be used for fixed term appointments of clinical fellows to contribute to the rotas.

Paediatrics

Recruitment within paediatrics at St John's hospital remains difficult particularly in relation to out of hours cover, with only four of the nine out of hours slots filled on a substantive basis. There is continuing, heavily reliance on a small number of staff doing additional night and weekend shifts which can be prone to short notice disruption due to sickness or other unplanned absence. Considerable effort has been made to ensure that a safe and sustainable medical rota is developed for Paediatric and Neonatal Services, particularly at St John's Hospital. Unfortunately, the middle grade medical rota at St John's remains unstable due to vacancies and on some occasions Advanced Nurse Practitioners and or Paediatric Nurse Practitioners are required to support the rota.

Recent successful recruitment to medical and nursing posts in neonatology at St John's hospital has helped improve sustainability within the neonatal service.

Clinical Development Fellowships and International Fellowships

Within the training grade medical workforce, rota pressures continue due to trainees taking maternity leave or leave to support research activities. Funding is not available to support cover for maternity leave resulting in financial pressures and it is difficult to fill a Locum posts for less than a year resulting in reliance of bank or agency staffing to provide cover.

The introduction of a clinical development fellowship programme has been key in helping support sustainability within the a number of 'front door' specialties, whilst also providing high quality supervised training opportunities and the opportunity to complete an MSc. This initiative has been expanded in 2015-16 with 32 fellowships in the following areas:

- Trauma & Orthopaedics
- Medicine for the Elderly
- Acute medicine
- Emergency Medicine
- Obstetrics and Gynaecology
- Vascular
- Cancer
- Acute and General Medicine
- Colorectal
- Infectious Diseases

NHS Lothian is also participating in a Scottish Government led initiative to recruit to a number of international fellow posts in the following specialties:

- Colorectal
- Transplant
- Oncology
- Acute Medicine
- Oral and Maxillofacial Surgery
- Obstetrics and Gynaecology

- Paediatric Anaesthetics
- Paediatrics
- Anaesthetics /Critical Care
- Plastic Surgery
- Medicine and Regional Infectious Diseases Unit

Career Grade Job Planning

In 2013, NHS Lothian invested in an electronic job planning system for all Career Grade medical Staff (Consultants, Associate Specialists, Specialty Doctors and Clinical Academics). The system will go live from 1 April 2015 and all job plans will be are loaded onto the system. Data from all job plans will enable comparisons with activity data and support service and workforce planning at both a service and board level.

The Lothian Medical Workforce Group which has representation from Acute and Primary care services, workforce and financial planning services oversees the response to medical workforce challenges. The remit of the group is to:

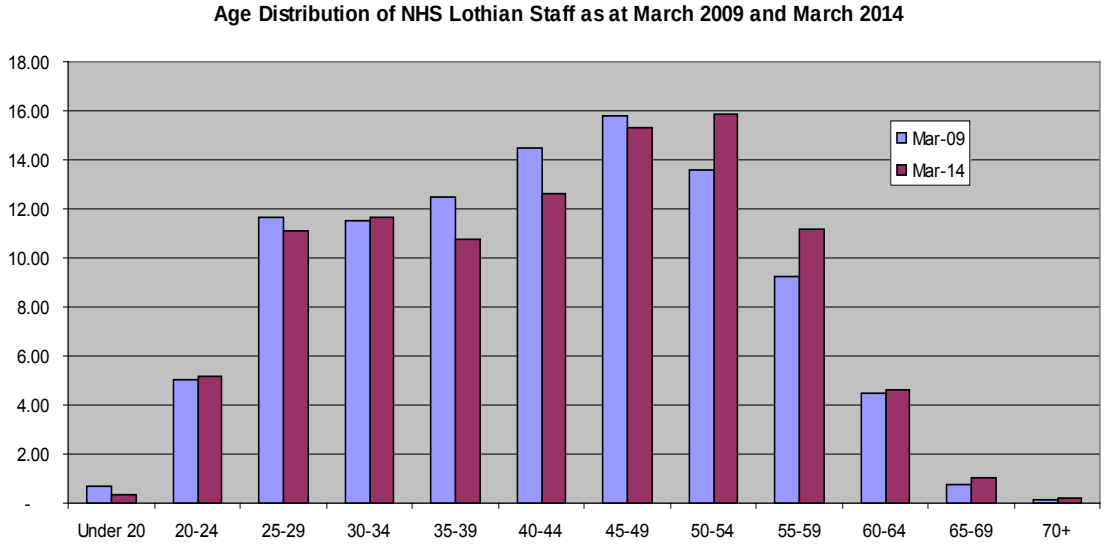
- Develop a vision for the Medical Workforce that is integrated, safe and sustainable.
- Oversee the medical workforce risk assessment process and develop actions to address key areas of risk.
- Support services in planning sustainable medical workforce models that are both achievable and affordable.
- Agree priorities and a work plan consistent with the delivery of the LDP, financial and other planning cycles.
- Oversee the implementation of electric job planning within the trained medical workforce.
- Take action to resolve local or national barriers to effective medical workforce planning.
- Link as appropriate to SEAT medical workforce planning group, regional specialty groups and national workforce planning activities.

This forum provides services with the opportunity to discuss risks and challenges and supports the formulation of actions to support sustainability.

5.3.3 Demographic pressures

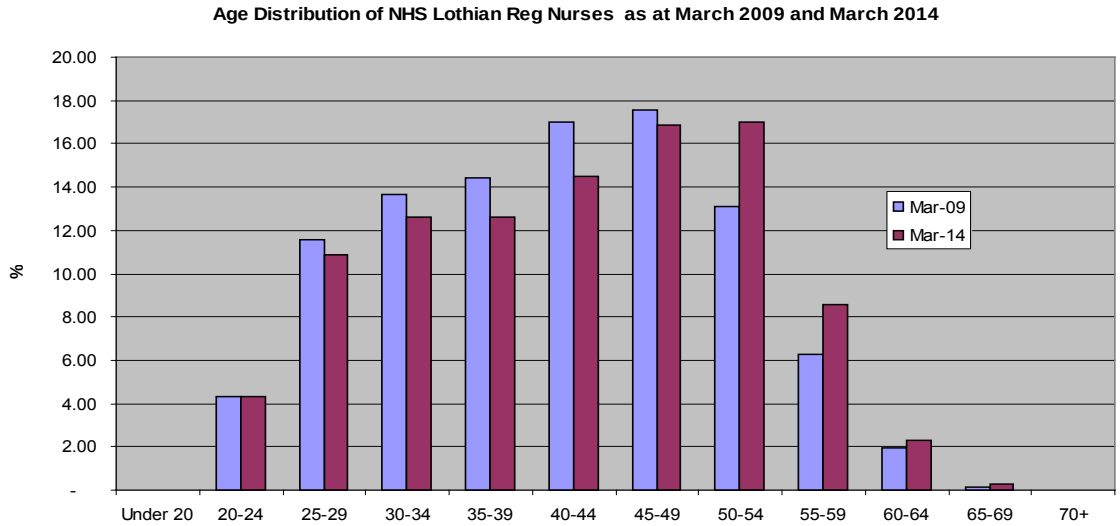
Demographic change within the population is one of the most significant drivers for service change and redesign. The following section details how this change is becoming evident within our workforce and will require NHS Lothian and other boards to develop recruitment and retention strategies to mitigate for the retirement of a significant proportion of the workforce over the next 5 to 10 years. The development of additional supply channels will be undertaken to support adequate recruitment in the face of competition from other sectors.

Overall age distribution



In March 2014 17.1% of the total of NHS Lothian workforce were aged over 55 years old compared to 14.6% in March 2009. The age grouping with the largest percentage (15.82%) has also shifted from 45-49 years old in 2009 to 50-54 in 2014 (15.88%). These changes clearly illustrate the ageing that is taking place within the overall workforce. Whilst this overall profile clearly shows the demographic imbalance within the workforce it is through looking at the individual job families that specific challenges arise.

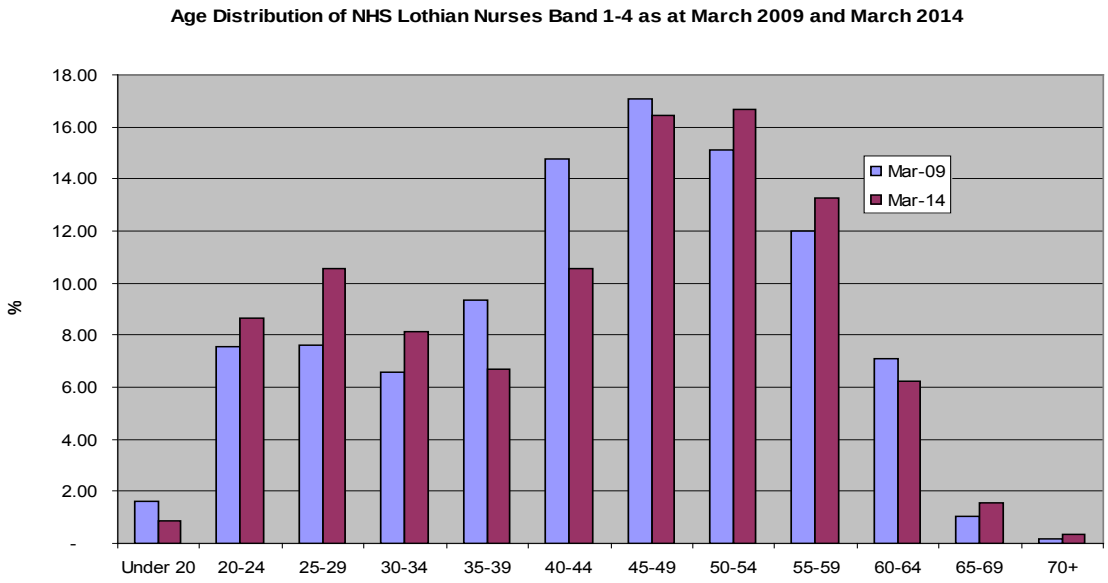
Age distribution within registered nursing



Within registered nursing the ageing of the workforce is already pronounced, between March 2009 and March 2014 the proportion of staff aged over 50 has increased from 21.4% to 28.2%, an increase of nearly 7% in 5 years. The median age has however only increased from 41 to 42 years old as a result of the increase that there has been in the younger age groups. This suggests that whilst there is increasing ageing within the workforce there would appear to be sufficient supply should retrial patterns remain the same. However proposed changes to pensions will see the retiral age gradually increase to 68 years old, protection will be in place for those within 10 years of retirement. Within this age grouping a significant number of staff hold special class/mental health officer status and as such can retire at 55 without any actuarial reduction being applied to their pension. This means potentially staff within the 45-49 age category and above may consider retiral; this equates to 46% of the registered nursing workforce.

Research carried out by NES, SEAT and NHS Lothian (2010) found that there were a very limited number of examples of how NHS organisations have proactively used existing policies to retain such staff. This is an area that will need to be developed at a local and national level if the national Everyone Matters: 2020 workforce vision is to be achieved.

Age distribution within non-registered nursing



Source – NHS Lothian Payroll

Within the non-registered workforce there is a similar pattern, between March 2009 and March 2014 the proportion of staff aged over 50 has increased from 35.4% to 38.1% an increase of 2.6% in 5 years. The median age has however only increased with a median age of 45 years old to 46 years old in this timescale. This suggests that whilst there is increasing ageing within the workforce there has been significant growth in the 20 to 34 age group.

The age distribution also varies significantly by site and service, with particular pressures within community nursing and health visiting. There are significant workforce demographic challenges that are being faced by Health Visiting Services and support and funding has been given for additional 10 health visitors. Given that one in three Health Visitors is already aged 50 or over with in many cases the retained ability to retire at 55 years old understanding likely retrial patterns is key and a survey has recently been carried out to understand what might be done to aid retention. The results are currently being analysed and the findings will be detailed in the workforce plan.

NHS Lothian will be contributing to a national review of the District Nursing workforce. This review will look into workforce supply and demand, drivers and pressures and identify the actions required to sustain the workforce in the medium and long term.

NHS Lothian in conjunction with SEAT and ISD is developing a scenario modelling tool which will enable modelling of demographic change based on historic trends. This tool is intended to influence strategy at a local, regional and national level.

Managing the demographic pressures and changes in pension arrangements will be key in achieving the 2020 vision for services. There is a need for both local and national strategies to ensure that there is sufficient workforce supply in both numbers and skills.

Radiotherapy workforce

The growth in radiotherapy activity and demand for radiotherapy workforce has created shortages of experienced staff with specialist skill sets. The Edinburgh Cancer Centre (ECC) has found it increasingly difficult to recruit to senior clinical scientist posts within the radiotherapy medical physics team, despite advertising at a UK and international level.

In 2013 NHS Lothian and SEAT produced a detailed workforce profile which highlighted workforce sustainability challenges within the radiotherapy workforce. The Scottish Government Radiotherapy Programme Board, to address sustainability challenges has supported the following actions:

- Increase in the number of clinical oncology medical training places nationally
- Funded additional post graduate radiotherapists
- Funding for clinical technologist and engineer training programmes via NES

These developments are a positive step to assist in building a sustainable radiotherapy workforce in the medium term.

Reprovision of the Royal Hospital for Sick Children (RHSC) and Department of Clinical Neurosciences (DCN)

The new RHSC and DCN will provide a modern 'state of the art' hospital, specifically designed around the needs of patients in a modern and efficient environment. The building will be collocated at the RIE and will enable Children's services to provide enhanced age appropriate services. The reprovision also provides the opportunity for enhanced clinical capacity for regional and national services such as paediatric intensive care. Detailed work has been undertaken to identify the changes required in workforce numbers and these are in the process of being reviewed with the other boards across the region. There will be increases within both the clinical workforce as a result of additional capacity within both the RHSC and DCN and also within the support services workforce that will service the building.

6. COMMUNITY PLANNING PARTNERSHIPS

NHS Lothian, through CH(C) Ps supported by Strategic Planning and Public Health colleagues, continues to be actively involved in community planning throughout Lothian. CH(C)Ps are actively engaged in leading the development and delivery of the health related outcomes within each of the four SOAs in Lothian, with clear performance processes in place to demonstrate progress.

Development of the local SOAs for 2015 onwards has had significant involvement from NHS staff, particularly CH(C) P, Strategic Planning, Performance Reporting & Information and Public Health & Health Policy. This involved reviewing previous outcomes and indicators in previous SOAs, participation in local consultation events and membership of and engagement with various themed groups. Communication across NHS staff engaged in development of the four SOAs has reinforced NHS Lothian's Strategic Clinical Framework priorities, which include prioritising prevention and reducing inequalities in health.

There has been willingness to identify common outcomes and indicators across Lothian to enable opportunities for benchmarking and provide continuity for recording data, especially for Lothian-wide services. This has mainly been achieved across the four CPPs; however, there is some local variation due to this being a locally focused process. Examples of the outcomes that have been developed across the Lothian CPPs and NHS Lothian has contributed to include:

- Improved health and wellbeing with reduced inequalities in health.
- Children and young people enjoy their childhood and fulfil their potential.
- Communities are safer and have improved physical and social fabric.
- Fewer people are affected by drug and alcohol misuse
- Enhance support services for carers

Although NHS Lothian is represented and contributes at different levels within each CPP it has recognised that its support and commitment to community planning can be improved and has taken steps to address this.

A crucial link between NHS Lothian and the Community Planning Partnerships are the Joint Directors of Health and Social Care in each Local Authority area.

In September 2014 the NHS Lothian Chief Executive and Director of Strategic Planning, Performance and Information reviewed the NHS Lothian executive director representation on the CPPs and changed the representation to as described in the table below. These directors are supported by senior manager within the Strategic Planning, Performance and Information Directorate.

CPP	NHS Lothian Executive Representative
Edinburgh	Chief Executive
East Lothian	Director of Finance
Midlothian	Director of Strategic Planning, Performance and Information
West Lothian	Director of Public Health

The Joint Directors of Health and Social Care also attend the CPP.

In January 2015 the NHS Lothian Director of Strategic Planning, Performance and Information and the Director for Midlothian Health and Social Care co-hosted a multiagency workshop to explore how to strengthen NHS Lothian's engagement in community planning. The main themes that emerged from this event are:

- NHS Lothian has committed well to the thematic groups of the CPPs but attendance at the CPP has been mixed and it is sometimes felt by other partners that senior NHS staff are at these meetings because they *have* to be there rather than they want to be there.

- There is some concern the focus on integration of health and social care will distract senior NHS staff away from the wider remit of the Community Planning Partnership.

- There was a consensus that NHS Lothian should be actively involved in the CPP post-integration. There is a risk that the IJBs will lead to NHS Lothian becoming less involved in the CPPs because the strategic planning of the NHS services the CPP will be most interested in influencing will be led by the IJB. But the IJB will not have a strategic responsibility for children's services. Also, because NHS Lothian will continue to employ staff and be responsible for the operational delivery of most health services for these two reasons it is important that NHS Lothian is actively involved in community planning

- All partner agencies need to avoid the risk that their input is restricted to attending meetings and not contributing with meaning or commitment and not sustaining that commitment. For CPPs to work they need agencies to commit for the long term and engage in the issues of CPP.

- CPP core business should be prevention and activity that spans more than one partner. The public sector financial situation has led to organisations prioritising financial balance ahead of investment in preventative activity. The CPP needs to counter this tendency and partners need to hold each other to account on preventative activity.

NHS Lothian will work internally and with partner organisations in the CPPs to respond to these themes during 2015.

APPENDICES (available at http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx)

Appendix 1 NHS Lothian Health Inequalities Strategy 2014 - 2017
Appendix 2 NHS Lothian Strategy for Children and Young People 2014 -2020
Appendix 3 Scottish Patient Safety Programme Annual Report
Appendix 4 NHS Lothian Prescribing Action Plan 2014 - 2016
Appendix 5 Draft LDP Financial Plan and Risk Schedule

NHS LOTHIAN

2.7

Board Meeting
1 April 2015

Director Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - CORPORATE OBJECTIVES 2014-15

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• The Board is asked to review progress towards delivery of the 2014-15 Corporate Objectives	1.1
• The 2014-15 corporate objectives are set against the Scottish Government triple aims	2.1
• The previous "amber" status outlined in previous update reports to the Board has been removed due to the subjective nature of this status	2.2
• Objectives which have not been achieved relate, in the main, to the HEAT performance targets and standards	3.2
• The most recent reports relating to performance and mitigating actions have been embedded within the 2014-15 Corporate Objectives and are also reported to the Board on a bi-monthly basis	3.3

Alyson Cumming
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17 March 2015
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NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

CORPORATE OBJECTIVES 2014-15

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board on progress towards delivery of the NHS Lothian 2014-15 Corporate Objectives.

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

2 Recommendations

2.1 To provide an update to the Board on delivery of the 2014-15 Corporate Objectives (Appendix 1). The objectives are set against the Scottish Government triple aims to improve the quality of care, improve the health of the population and secure value and financial sustainability of health and social care services.

2.2 To note the previous "amber" status associated with the Corporate Objectives has been removed due to the subjective nature of this status plus the inability to ensure a consistency of approach in relating to a measure that would allow for any variation and tolerance of being out with the target of trajectory.

2.3 To receive assurance from lead directors that mitigating actions are in place for those objectives with red status.

3 Discussion of Key Issues

3.1 The status of the overall 2014-15 Corporate Objectives have been marked with nil, red of green. The overall summary of the achievement of the objectives is noted in the table below.

Definition of Status	Status of Objective	Number of Objectives with this ranking	%
Delivered or on track to be delivered by the timescale or numerical target achieved	Green	40	61%
Stalled, not achieved and off trajectory or more than 10% out with the numerical target	Red	20	30%
No status has been provided by CMT Lead	Nil	6	9%
	Total	66	100%

3.2 Where objectives have not been achieved i.e. "red" status, these in the main, relate to achievement of the HEAT performance targets and standards relating to:

- Smoking Cessation
- Access to CAMHS and Psychological Therapies
- Compliance with Treatment Time Guarantees
- A&E 4 Hour Standard, 8 and 12 Hour Trolley Waits
- Reduction in the Delayed Discharge, Patients Boarding. Reduction in Emergency Bed Days and delivery of a Lothian Model of Care for Frail Elderly
- Reduction in Healthcare Associated Infection (HAI)
- Stroke care bundle
- Delivery of Efficiency and Productivity Plan to achieved the Local Reinvestment Plan

3.3 Bi-monthly reports are taken to NHS Lothian Board to outline progress towards achievement of the HEAT targets and standards. Links to the most recent reports which provide the most accurate and up to date position relating to our performance and include accompanying, action orientated narrative are embedded within the 2014-15 Corporate Objectives.

3.4 In providing this report against our achievements in delivering the corporate objectives it is important to note the context against which these must be understood i.e. that the position across many other systems in terms of ability to deliver a range of targets such as 4 hrs; delayed discharges; CAMHS and psychological therapies is very challenging. That said NHS Lothian has invested significantly in CAMHS and psychological therapies whilst also investing in tackling the number of people delayed or boarding in the wrong place, whilst also investing additional funding to support the delivery of the treatment time guarantee.

3.5 It is important to note that significant progress against a number of objectives has been met during the year. We still continue and deliver above the required performance for 31 and 62 day cancer; we are in the leading group of Boards for delivery against the antenatal target as well as our work in delivering alcohol brief interventions and drug treatment. We continue to be on target for delivering the number of people receiving IVF treatment. We have also met the deadlines for the development of our strategic plan and the revised progress report as well as delivery of the four draft integration schemes being signed off by the Board and the four Councils by the 31st March. We have also continued to develop the children's agenda both at a strategic level as well as through the integration agenda.

3.6 Work in ensuring that we reduce the number of people with pressure ulcers and falls continues to do well as does ensuring that the four partnerships have the required number of people identified as dementia link workers to provide the right level of support to patients and their families one year post diagnosis.

4 Key Risks

4.1 The key risks relate to the 2014-15 Corporate Objectives highlighted with a "red" status.

Not all risks have a risk status assigned i.e. those objectives flagged with a "nil" status therefore do not have an agreed measure of success.

5 Risk Register

5.1 There is a need to ensure all risk associated with the delivery of the 2014-15 Corporate Objectives are highlighted in the appropriate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 As a report on progress, this paper has not be subject to an impact assessment. The Corporate Objectives are reporting against measures of success which have been individually impact assessed.

7 Involving People

7.1 This paper does not propose any strategy, policy of service change..

8 Resource Implications

8.1 There are no resource implications relating directly to this report. The financial implications of delivering the Corporate Objectives are reported as appropriate to the Board, Corporate Management Team and other NHS Lothian Committees.

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17 March 2015
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List of Appendices

Appendix 1: Corporate Objectives 2014-15

NHS Lothian Corporate Objectives 2014/15

Green Status	delivered, on track to be delivered by the timescale / numerical target achieved
Red Status	stalled, not achieved and off trajectory /more than 10% outwith numerical target

Domain #	Primary Objective #	Secondary Objective #	Measure of Success	Timing	Lead CMT Member	Linked Strategic Proposition	Risk Register	Status	Comments
Quality of Care	1 - Improving Staff and Patient Safety	1:1 -Implement the 4 work streams of the Scottish Patient Safety Programme to prevent harm: • Acute Care • Primary Care • Maternity Care • Mental Health	Reduce hospital mortality by 20% (NHS Scotland Measure) Achieve 95% harm free care Specific SPSP metrics in each work stream as set out in CEL 19	Mar-15	DF	5.1.32 (patient safety) 5.1.5 (QOF quality and safety domain	Patient and staff safety	Red	Contribution to Scottish goal of 20%. Reduction HSMR:- RIE: -18.06% SJH: -7.37% WGH: -12.38% - Latest ISD publication - Achieved 95% harm free care (99.7%) - Need increase in sustainable compliance with CEL 19 Essentials - plan in place. Refer to NHS Lothian Board monthly report which provides details of process and outcome measures. http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx
Quality of Care	1 - Improving Staff and Patient Safety	1:1 -Implement the 4 workstreams of the Scottish Patient Safety Programme to prevent harm: • Acute Care • Primary Care • Maternity Care • Mental Health	Pressure Ulcer (PU) Prevention: • Grades 2-4 new measure of number of days between, as of April. • All patients will be risk assessed within 6 hours of admission.	Mar-15	MJ	5.1.32 (patient safety) 5.1.5 (QOF quality and safety domain	Patient and staff safety	Green	Scottish Patient Safety Indicator (SPSI) work is now in progress with test wards identified over Adult Hospital sites. Focused work has started in these areas to drive their improvement work. Dr Elizabeth Bream, Public Health, has provided quality support across the organisation, particularly in Maternity and with regards to C.Difficile. A mini –collaborative approach has been developed to support both falls and PU improvement work.
Quality of Care	1 - Improving Staff and Patient Safety	1:1 -Implement the 4 work streams of the Scottish Patient Safety Programme to prevent harm: • Acute Care • Primary Care • Maternity Care • Mental Health	Falls Prevention: • 25% reduction in all falls • 20% reduction in those In patient falls that result in harm 20% reduction in falls with harm achieved. Fully continue to sustain.	Mar-15	MJ	5.1.32 (patient safety) 5.1.5 (QOF quality and safety domain	Patient and staff safety	Green	Recent data shows a normal variation with no improvement, deterioration or trends in falls. The collaborative approach described above includes both PU and Falls work and as this work progresses more improvement data will be available. 20% reduction in falls with harm achieved. Need to now sustain. **Primary Care** - There are two elements in QOF that are linked to patient safety, Trigger tools and safequest safety climate survey. Practices are requested to submit this evidence to demonstrate both these indicators by 15 March 2015. Currently we are unaware that any practices have opted out so should reach full compliance with both indicators. The only exception to this are the 10 S17c redesign practices who are exempt from submitted actual evidence but demonstrate compliance in their annual report. Both these indicators in QOF are quality assured for compliance by myself and CGST NHS Lothian is well ahead of the SG target of 95% of all practices in Scotland are involved in patient safety work by 2016
Quality of Care	1 - Improving Staff and Patient Safety	1:2 - Develop the Safety culture including leadership which is open, fair and enhances safety awareness	• Safety Culture Survey results and improvement plans for acute inpatient sites • Staff experience • Implementation of Significant Adverse Event Improvement Plan • Number of leadership walk rounds in month - Safety Culture Survey in Theatres/Anaesthetics/General Practice/Maternity show improvement in culture required at all levels across the organisation. - Leadership work undertaken - 72% outcome complete.	Mar-15	DF		Patient and staff safety	Red	Safety Culture Survey in acute hospitals is to be conducted in Oct/Nov 2014. Leadership Walk rounds taken place: April 2013-May 2014: • RIE including Lauriston - 14 • WGH - 10 • SJH - 12 • RHSC - 3 • Liberton - 2 • Roodlands - 1 • REH - 6 • Total - 48 • Cancelled - 1 Safety walkround report with those involved for comment.
Quality of Care	1 - Improving Staff and Patient Safety	1:3 - Reduce Healthcare Associated Infection	Achieve SAB and C.Diff HEAT targets and timescales [Baseline end March 14 SAB 0.30 (243 infections), CDI 0.51 (425 infections)]	Mar-15	MJ		Healthcare Associated Infection	Red	SAB : January 2015 - 227 episodes so far in year, rate 0.34 per 1,000 beds (target <184 or 0.24) CDI : January 2015 - 341 episodes so far in year, rate : 0.49 per 1,000 bed days (target <262 or 0.32) February 2015 HAI Board Report http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx

Quality of Care	1 - Improving Staff and Patient Safety	1:4 - Reduce harm to staff	No of incidents of Violence & Aggression recorded on DATIX	Mar-15	AB			Green	January 2015 update for Quarter 3 (Oct - Dec) 2014 indicates the number of violence and aggression adverse events was 557 of which approximately 50% resulted in some form of recorded harm to the staff member. The mean over the last 3 years is circa 700 per quarter therefore the Q3 2014 position indicates a reduction in reported incidents. 50% of reported violence and aggression incidents occur within REAS therefore activity to support further reduction in incidents focus on this service. Regular update reports are submitted to the Health and Safety Committee.
Quality of Care	2- Improve Patient and Staff Experience	2:1 - Agree NHSL approach to person centred Health & Social Care in line with national programme and local need	Patient experience surveys and reports - Initial testing of reporting and responding to patient experience taking place. Improvement Plan agreed plus update January 2015 at HCG.	Mar-15	MJ	5.2.1 patient experience; 5.1.1 engage people	Patient Experience	Red	The national aim is that by December 2015 90% of service users will have a positive experience and get the outcome they expected. The "five must do's": 1. What matters to you 2. Who matters to you 3. What information do you need 4. Nothing about me without me and 5. Personalised contact have been incorporated in to survey work and currently we have 11 test teams across NHS Lothian. Reports from the 11 test sites and NHS Lothian aggregated have been reported and the information form the third rounds of patient surveys is currently being analysed. MJ is setting up a Person Centred Programme Board, which will provide structure and leadership to align a number of existing work streams that is focused on listening, learning and improving. A paper proposing new ways of working with those from the NHS Board 'Improving patient experience group and the Involving people's group were approved and plans are now in place to have the first of the new style workshops in late September. These workshops will help direct the future agenda and framework for involving the public and patients in the patient experience agenda.
Quality of Care	1 - Improving Staff and Patient Safety	2:1 - Agree NHSL approach to person centred Health & Social Care in line with national programme and local need	Reduce number of complaints (on-going target, no percentage given) Acknowledgement of 100 per cent of complaints within three working days. Response to 85 per cent of complaints within 20 working days.	Mar-15	MJ	5.2.1 patient experience; 5.1.1 engage people	Patient Experience	Red	Acknowledgment of 100% of patient complaints within 3 working days - November 2014 - 88.9% Respond to 85% of complaints within 20 working days - November 2014 - 49.7%
Quality of Care	2- Improve Patient and Staff Experience	2:2 - Implement the Values into Action plan	Staff experience surveys/reports Team surveys used Investors in People Standards	Mar-15	AB	6.3 Implement Values		Green	Work is on-going to embed NHS Lothian values. A communication plan has been agreed including reference in site newsletters, pop up stands and posters, details on the intranet, screen saver on some PCs and referenced on NHS Lothian stationary. At recruitment applicants receive information on our values and a dedicated values session is included at induction. The 12 new partnership forums remit includes putting values into action.
Quality of Care	2- Improve Patient and Staff Experience	2:3 - Implement the recommendations from the patient pathway development work in order to improve patient experience	Pathway work undertaken, recommendations made, recommendations implemented: for Hannah, Scott, Callum and Sophie	Mar-16	AMcM	5.1.2 multi-morbidity; 6.8 (patient pathways, MCNs)		Green	Hannah pathway event undertaken in June 2014, with 3 work streams to oversee progress on informed, engaged patients, staff collaboration, and good conversations. Progress relating to Sophie pathway will be submitted to the Planning Committee in May 2015. Two Callum workshops have taken place and output integrated with mental health and substance misuse implementation plans. Further development of House of Care model through SG funding and British Heart Foundation. House of care early adopters have been identified and work progresses to implement and evaluate this model in Lothian. National improvement plans relating to heart disease and diabetes were published in June and November 2014. Work is on-going via the Heart Disease Programme Board and Diabetes MCN to develop action plans to support delivery of the national priorities. Further guidance is awaited from the Scottish Government relating to reporting templates and timescales. Scott pathway discussions are influencing propositions around development of primary and community care models for care of older people. Health and Social care partnerships are considering how needs of typical patients can be reflected in strategic commissioning plans
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:1 - Deliver the waiting times recovery plan to clear backlog	Inpatients/day cases waiting > 12 weeks. [Baseline End March – 534 inpatients/day cases waiting > 12 weeks at month end (402 TTG patients, 132 non TTG)] Patients waiting > 12 weeks [End March – 2003 outpatients waiting > 12 weeks at month end]	Dec 2014 March 2015	JC	5.1.37, 5.1.38, 5.1.41 (out-patient review)	Achieving national waiting times targets	Red	NHS Lothian Board informed in November 2014 that compliance with delivering for patients trajectories. Recovery timescales are currently under discussion with Scottish Government and anticipated during 2015/16. Most recent position outlined in February 2015 Performance Management Paper. http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:2 - Comply with Treatment Time Guarantee (TTG)	Compliance with 12 week treatment guarantee [Baseline End March14– 574 TTG breaches treated during the month]	Dec 2014	JC	5.1.34(E&P) 5.1.35 (new service configuration) 5.1.36 (increase day surgery)		Red	As above
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:2 - Comply with Treatment Time Guarantee (TTG)	18 week RTT [Baseline End March14 18 week RRT performance: Performance – 84.7% Linkage – 86.2% Outcoming – 84.4%]	Dec 2014	JC	5.1.34(E&P) 5.1.35 (new service configuration) 5.1.36 (increase day surgery)		Red	As above.

Quality of Care	3 -Improve the way we deliver Scheduled Care	3:3 - Implement Delivery for Patients	Access to CAMHS [Baseline End March14 - 240 waiting > 26 weeks, 459 waiting > 18 weeks for CAMHS	Dec 2014	JF			Red	Target of all children and young people starting treatment with 18 weeks of referral was not met by Dec 2014. An agreed recovery plan with funding for substantive posts and additional non-recurring posts was agreed with posts recruited during Oct/Nov. Good progress is now being made against agreed trajectory. The agreed revised trajectory predicted that the target would be met by end of May 2015. However a significant increase in referrals in the last quarter of 2014 and January 2015 along with reduced capacity due to accommodation issues may delay meeting the target till end of June /July 2015. There were 428 patients waiting over 18 weeks at the end of January 2015. For patients seen for a 1st treatment in January, 51% were seen within 18 weeks. This level of performance will continue as services focus on clearing the backlog of patients over 18 weeks.
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:3 - Implement Delivery for Patients	Access to psychological therapies [Baseline End March14 - 813 waiting > 18 weeks for psychological services]	Dec 2014	JF			Red	The target of 18 weeks for referral to treatment for a psychological therapy was not met by December 2014. Performance against the target was 44% at end of January. There continues to be a significant and increasing backlog of patients waiting over 18 weeks for a psychological therapy. At the end of January there were 3,095 patients waiting for psychological therapy with 1,201 (39% of all those waiting) currently waiting over 18 weeks. Further demand and capacity work has highlighted the requirements for increased capacity to deliver psychological therapies. A further paper outlining service improvements completed to date and DCAQ modelling which demonstrates that additional recurring resource is required to meet demand for psychological therapies was discussed at the CMT in February with an update requested in March with a view to a full report going to the Board in April.
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:3 - Implement Delivery for Patients	IVF treatment [Baseline End March14 2 waiting > 365 days for ART (but not all recorded on TRAK at that point)]	Dec 2014	JC			Green	At December 2014, data published by ISD indicates NHS Lothian's performance on the number of patients receiveing IVF treatment within 12 mponths was 100% against a target of 90%, placing NHS Lothian top (with NHS Borders) in delivery compared to other NHS Boards for which figures are available. NHS Lothian is meeting the standard which is due to come into force from March 2015
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:3 - Implement Delivery for Patients	31 and 62 day cancer standards [Baseline End March14 cancer performance – 96.9% for 31 day target and 94.4% for 62 day target]	Dec 2014	JC			Green	The most recently published data Quarter 4 (Oct - Dec) 2014 relating to cancer standards indicated performance relating to the 62 day standard was 95.6% and 97.0% for 31 days (improvement on the March 2014 baseline)
Quality of Care	3 -Improve the way we deliver Scheduled Care	3:4 - Develop recurring demand and capacity equilibrium plans	Workforce recruitment and retention numbers	Mar-15	JC	5.1.33 DCAQ models;		Red	On-going, difficulties noted in; Anaesthetics, ENT and Urology consultants. Theatre Nursing.
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:1 - Implement Lothian Unscheduled care action plan across the system (LUCAP 2)	A&E 4 hour waiting time Standard [Baseline End March14 – 92.2% all sites]	Mar-15	MJ/JD	5.1.25 (rapid assessment, ambulatory care); 5.1.3 (palliative care); 5.1.16 (services for frail older people); 5.1.17 (reduce delayed discharges); 5.1.19 (care village concept); 5.1.29 (7 day working)	Unscheduled Care	Red	4 Hour Waiting Time Standard NHS Lothian's unscheduled care performance against the 4 hour standard for the month of December 2014 was 92.34 % (94.08% during November). • RIE – 92.27% (94.51%) • WGH – 85.80% (88.90%) • SJH – 92.63% (94.34%) • RHSC – 97.64% (97.4%) Current performance is hampered by upward trend in Delayed Discharges. Most recent update available in February 2015 Unscheduled Care and Winter Plan Paper http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:1 - Implement Lothian Unscheduled care action plan across the system (LUCAP 2)	Reduced No of 8 and 12 hour trolley waits [Baseline End March14 – 206 8-hour breaches and 25 12-hour breaches in the month]	Mar-15	MJ/JD		Unscheduled Care	Red	No of 8 and 12 hour breaches In October 2014 there were 2164 8-Hour breaches, and 21412-hour breaches. In November 2014 there were 87 8-Hour breaches, and 12 12-hour breach. In December there were 179 8-hour breaches and 15 12-hour breaches.
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:1 - Implement Lothian Unscheduled care action plan across the system (LUCAP 2)	Reduced No. of Delayed discharges [Baseline End March14 – 49 delayed discharges]	Mar-15	MJ/JD		Unscheduled Care	Red	Delayed Discharges In October 2014 there were 196 total delays, and in November there were 164. In December there were 196 total delays. Data published by ISD up to 15 January 2015 shows NHS Lothian's performance was 100 patients waiting more than 2 weeks against a target of 6 patients. Monthly joint reporting (NHS Lothian and 4 Local Authorities) to Scottish Government commenced in January 2015.
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:1 - Implement Lothian Unscheduled care action plan across the system (LUCAP 2)	Reduce No of Patients Boarding	Mar-15	MJ/JD		Unscheduled Care	Red	Cumulative Boarding Numbers (weekly) In the week ending 18/01/2015 there were 1127 boarders. The previous week there were 1252

Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:1 - Implement Lothian Unscheduled care action plan across the system (LUCAP 2)	Stroke - For 2014-15 measurement of performance for stroke changes from a single measure (admission to a stroke unit within 24 hours) to a bundle; Stroke - For 2014-15 measurement of performance for stroke changes from a single measure (admission to a stroke unit within 24 hours) to a bundle; "By March 2015, an increased number of patients admitted to hospital with a diagnosis of stroke must receive all the key elements of the stroke care bundle." The Stroke Care Bundle measures performance against all of the key elements of acute stroke care currently measured in the Scottish Stroke Care Standards, i.e. • admission to stroke unit (90% by day after admission) • CT scanning (90% within 24 hours) • swallow screening (90% on day of admission) • aspirin administration (100% by day after admission) Performance at 31st March 2014 against this target was 52%, and at end April 2014 was at 60%. The agreed trajectory is to be at 65% at 31st March 2015	Mar-15	MJ/JD	5.1.26 (stroke service outcomes)	Unscheduled Care	Red	a) Access to a stroke unit by the day after admission continues to fluctuate – October 2014 – 63.2%, November 2014 – 72.9%, December 2014 - 68.5%, January 2014 - 62.9%] (local target = 85%) b) Imaging undertaken within 24 hours – remains stable and above the national target [October 2014 97.3%, November 2014 98.1%, December 2014 98.1%, January 2015 97.1%] (national target = 90%) c) Swallow screen – increased from 64.9% to 73.3% [October 2014 – 64.9%, November 2014 – 82.7%, December 2014 - 77.4%, January 2015 - 73.3%] (local target = 90%) d) Aspirin – has increased from 93.2% to 94.1% [October 2014 – 93.2%, November 2014 – 86.5%, December 2014 -84.2%, January 2015 - 94.1%] (local target = 90%) The agreed local target for bundle performance is 65%, and overall performance against the bundle over the last few months - 36% in October, 55.7% in December and 45.7% in January 2015. Winter bed pressures have contributed to the lack of access to the stroke unit across all sites, and this continues to challenge any performance improvement for the bundle across all sites
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:1 - Implement Lothian Unscheduled care action plan across the system (LUCAP 2)	Reduce emergency bed days >75 [Baseline Target April 2014– 4,867 reducing to 4,709 at March '15]	Mar-15	MJ/JD		Unscheduled Care	Red	The latest data published by ISD on rate of occupied beds days per 1,000 population (75+) covers upd to 30/09/14 shows that NHS Lothian's performance was 5,004 against a target of 4,790. This was 4.5% above target , placing NHS Lothian 6th out of the 14 NHS Boards monitored.
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:2 - Develop a Lothian Model of Care for Frail Elderly to deliver right care, right time, right place	No Measure	Mar-15	MJ/JD	5.1.28 (expand acute receiving and assessment capacity); 5.1.6 (anticipatory care, poly-pharmacy)	Unscheduled Care	Red	Work is underway to develop plans to support the management of frail elderly in the community, a comprehensive plan will be taken to the NHS Lothian Board meeting in June 2015. COMPASS and COMPASS Plus in place within Edinburgh City Council. In East Lothian, business case for enhance ELSIE model covering patient with dementia and 7 day working to be developed by the end of January 2015Midlothian, additional support in place including step down beds, further developments include single point of contact for discharge hub to access social care expansion of re-ablement, expanding MERRIT to 7 day working and extended days, extend hospital in reach team and creating interim care home beds. Work on-going to support the development of Integrated Care Facilities at the Royal Victoria and Liberton Hospitals. Redesign of South side Medicine of the Elderly pathway across acute taking place, during July and August. West Lothian REACT model continues to develop. The appointment of a geriatrician from September 2014 with sessions within the community will increase medical capacity. Further planned physician expansion in 2015.
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:3 - Improve the effectiveness of care for priority groups: Long term conditions Multi-morbidity Chronic pain Dementia	Improved management of Chronic Pain measures to be developed. Improved management of multi-morbidity - measures to be developed	Mar-15	DS	5.2.8 (integrated COPD pathway)		Nil	**COPD** invest to save project funding has been extended to December 2015, KPI s up to December 2014 indicate occupied bed days and admission rates have reduced. **Adult acute pain service**: In September 2014 the Pain Clinic appointed a new Consultant and the General Queue clinics increased by one per week. This enabled an additional 168 new patients per annum to be seen. A new Nurse Specialist was appointed in October 2014, holding 5 clinics per week for review patients. SOP standards are in place and new patient clinics are 100% utilised with last minute cancellations being re-booked. Due to the type of patients seen at the Pain Clinics there is a high DNA rate ,to help tackle this problem a telephone reminder service has been introduced with reminders one week before appointments. No patients waiting longer than 12 weeks and 100% of patient appointments are being booked in less than 9 weeks.
Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:3 - Improve the effectiveness of care for priority groups: Long term conditions Multi-morbidity Chronic pain Dementia	Dementia post diagnostic support [Reporting methodology still to be agreed by Scottish Government]	Mar-15	DS	5.1.11 (dementia link workers)		Green	Alzheimer Scotland Post Diagnostic Link workers are in post in West Lothian, Midlothian and City of Edinburgh, recruitment is underway in East Lothian. The link workers are delivering 5 pillars model of post diagnostic support. Data is being submitted to ISD, there have been data/recording issues on the ISD management reports and this is being followed up by Mental Health and Well-being Programme. Work is on-going with secondary care and community mental health teams to identify and record post diagnostic support which they undertake and this will be included in future submissions to ISD. For people at a later stage of the dementia journey, Midlothian is a test site for the 8 pillars dementia practice coordinator role. Chronic Pain Service Improvement Group and Sub Groups have been established to support service development and an options appraisal has been developed to support co-location of the pain management service.

Quality of Care	4 -Improve the way we deliver Unscheduled Care	4:3 - Improve the effectiveness of care for priority groups: Long term conditions Multi-morbidity Chronic pain Dementia	Reduction in emergency presentations for diabetes, COPD	Mar-15	DS	5.2.8 (integrated COPD pathway)		Nil	WELPACT undertaking work to support readmission reduction as well as improve pathways for patients with long term conditions (COPD, Diabetes). Respiratory MCN is supporting redesign of the Sleep Apnoea pathway and discussion on-going with the LMC to approve the pathway revisions. COPD - see update noted in comments above
Quality of Care	5 -Develop whole system capacity to deliver care closer to home	5:1 - Develop a demand, capacity and access plan for Primary care and community workforce, including Review out of hours primary care delivery (LUCS)	Improved management of multi-morbidities: Increase the number of Type 2 diabetes care managed in primary care Reduced emergency presentations at hospital	Mar-15	DS	5.1.7 (review primary care capacity); 5.1.10 (diabetes services); 5.1.24 (review LUCS)		Green	5.1.7 Review of primary care capacity has been undertaken, £200k funding to support practice capacity expansion (10 practice) via LEGUp has been supported. 5.1.10 T2 diabetes enhanced service proposal to support management of T2 diabetes in the community has been developed, however funding to be confirmed. Edinburgh CHP has supported recruitment of 2 community diabetes specialist nurses (June / August 2014) who are working with secondary care services to follow up and support individuals with diabetes in the community who have experienced emergency admissions 5.1.24 LUCS review has been completed, a consultation is underway to consider site options and work is on-going via the E&P team to support implementation of the review recommendations.
Quality of Care	5 -Develop whole system capacity to deliver care closer to home	5:2 - Develop availability and use of primary care data	No Measure	Mar-15	DS	6.9 (develop clinical informatics)		Nil	The Primary Care Data Group continues to meet to progress developments. The remit of this group is to co-ordinate support to Primary Care Forward Group, Primary Care Joint Management Team, Health and Social Care Partnerships and GP Sub to make informed decisions on strategic and operational issues by collating and analysing data, reviewing evidence and writing reports. Work is on-going to develop a Primary Care Key Indicators Framework.
Quality of Care	5 -Develop whole system capacity to deliver care closer to home	5:3 - Implement 'More Scottish' GP Contract	No Measure	Mar-15	DS	5.1.4 (primary care modernisation-on)		Nil	Meeting involving SG, BMA and NHS Lothian took place on 29 January 2015 to discussion the new GP contract and development and investment in primary care / community services.
Quality of Care	5 -Develop whole system capacity to deliver care closer to home	5:4 - Develop a primary care premises plan	Premises plan for each partnership in place	Mar-15	DS	5.1.8 (review GP practice premises)		Green	Premises priority plans have been developed for the 4 Lothian partnerships. Capital funding to support premises development and expansion is included in NHS Lothian's financial plans. Partnerships are required to develop business cases for submission of funding approval.
Quality of Care	5 -Develop whole system capacity to deliver care closer to home	5:5 - Review opportunities for changes to locally enhanced services i.e. care home support	Develop proposals for local enhanced services to support a shift in the balance of care	Mar-15	DS	5.1.9 (shift balance of care)		Green	Proposals are being developed to support further roll out of near patient testing (Warfarin), stage 2 phlebotomy and further investment in VLARC (provision uncapped in 2014/15). Access pilots to be evaluated in March / April 2015. IT&M plan to be developed to improve reliability of GP practice systems. A costed list of proposals will be presented to NHS Lothian Board in June 2015.
Quality of Care	5 -Develop whole system capacity to deliver care closer to home	5:6 - Review opportunities for community specialist roles	No Measure	Mar-15	DS	5.1.10 (diabetes services);		Nil	Edinburgh Community Health Partnership has invested in provision of 2 Community Diabetes Specialist Nurses. Proposal for Advanced Practitioner Nurse role to be developed to enhance capacity and capability in GP practices. Proposal to train 8 practice nurses developed and for consideration as part of primary and community care development proposals. Review of community nursing capacity and skills development , sponsored by Nurse Director, is a key action to progress during 2015/16.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:1 - Deliver population screening and immunisation programmes	Screening uptake (Baseline to be added) Immunisation rates • Uptake seasonal flu immunisation >70% in over 65s • Uptake seasonal flu immunisation >50% in at risk groups (with specific improvement looked for in liver disease and pregnant women) • Increased uptake seasonal flu immunisation among staff Influenza (childhood flu immunisation) pilot programme effectively implemented and rolled out to all primary school children via CVT (aspirational target of 75%) Influenza pilot programme effectively implemented and rolled out to all pre-school children via GPs (aspirational target 60%) Zoster programme effectively rolled out to 70, 78 and 79 year olds Uptake improved in zoster programme to 60% New catch up men C programme effectively implemented for young people under 25 entering higher education Effective implementation of change to HPV programme to two doses 12 months apart with uptake of >90% for both	Mar-15	AKM	5.2.5 (health improvement initiatives; 5.2.2 (Health inequalities strategy); 45.2.4 (community planning)	No	Green	**Cancer screening**: Latest local (unvalidated) data shows bowel screening uptake increased from 52.7% baseline to 56.4% in 2014. There was a relative reduction in non-responders of 8%. 2014/15 Breast & Cervical screening data is due in August 2015 and as we are moving away from absolute targets to informed choice and assessment of individual's risk, its likely that there will be a difference (previous uptake thresholds are no longer valid). 2013/14 Breast & Cervical screening uptake data were provided in September/October 2014 via link to ISD website http://www.isdscotland.org/Health-Topics/Cancer/index.asp?Co=Y and to the Board via the Cancer Strategy in late 2014. **AAA screening**: We have caught up and completed our catch-up campaign to offer men AAA screening as they turn 65. This from a baseline of being 5,000 behind in late 2013. The seasonal **flu programme** started 1 October 2014. By week 1 Jan 2015, uptake in over 65s had reached 76%. Uptake in pregnant women at risk was 68%, substantially exceeding the Scottish average. More vaccine than ever before was ordered for the staff flu programme, 16,000 doses which has all been used. A new programme of **Men C** to new entrants to Higher Education Institutions was instituted in July 2014.A new programme of provision of teenage vaccinations in independent schools was successfully implemented. The **HPV** (cervical cancer) immunisation programme was amended and offered in Lothian schools from Jan 2015 The first year of the **shingles programme** was completed in Sep 2014 achieving 57% uptake in 70 year olds. The programme was expected form Sep 2014 with offer to 78 year olds (as well as 70 and 79 year olds as last year)

Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:1 - Deliver population screening and immunisation programmes	Detect cancer early [Reporting methodology has not yet been agreed by SG]	Mar-15	AKM	5.2.5 (health improvement initiatives; 5.2.2 (Health inequalities strategy); 45.2.4 (community planning)	No	Green	Detect Cancer Early (DCE) - The DCE baseline programme is measured using the 2-year 2010 and 2011 position. Since the DCE programme baseline position, NHS Lothian's performance has moved from 22.6% (Scotland 22.9%) to 25.8% (Scotland 24.3%), based on national, validated ISD published data. This places NHS Lothian 2nd out of 14 NHS Boards. Local programme management information to date (covering 2013 and part of 2014) shows a further positive movement to 26% of breast, lung an bowel cancers diagnosed at Stage 1. NHS Lothian's LDP target for 2013 and 2014 period is set at 25.6%. A national target of 29% is to be reached by the end of 2015.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:1 - Deliver population screening and immunisation programmes	Smoking cessation Target is 1,765 Quits - expected to be split between: Pharmacies(50%); Pregnant Women (10%); Prisons (7%); Young people(2%); Hospital services(14%) and Generic community cessation service(18%).	Mar-15	AKM	5.2.5 (health improvement initiatives; 5.2.2 (Health inequalities strategy); 45.2.4 (community planning)	No	Red	Smoking Cessation – As as January 2015 we remain 40% behind trajectory on the HEAT target. The impact of e cigarettes/ vaporisers' seems considerable with their use now outstripping other licensed forms of NRT. There has been a 26% reduction in referrals to Stop Smoking services (Apr –Sept) compared to same period last year. The biggest drop has been in those accessing community pharmacies where referrals have more than halved. This continues to be affected by software problems with implementing the new CP contract (being addressed nationally) with data being under-recorded and is most probably also affected by many pharmacies selling e cigarettes. The picture is similar across Scotland, the budget was £2million and has gone down to £1.5m and is facing a further 10% reduction. Despite these reductions the number of pregnant women being referred and setting quit dates has increased as have the number of prisoners being supported. SG still expects us to strive to achieve the HEAT target. However the plan to focus activity aiming for 5% prevalence by 2034 is seen as a priority.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:1 - Deliver population screening and immunisation programmes	Alcohol Brief Interventions [HEAT Standard – to deliver 9938 ABIs]	Mar-15	AKM	5.2.5 (health improvement initiatives; 5.2.2 (Health inequalities strategy); 45.2.4 (community planning)	No	Green	Alcohol Brief Interventions: From the onset of the HEAT Target in 2008 and progressing to the HEAT Standard onwards from 2012 NHS Lothian has delivered 88,8987 (53,408) Alcohol Brief Interventions (ABI's) achieving 167% of the overall NHS Lothian target and remains one of the highest performing boards in Scotland. In 2013/14 NHS Lothian delivered 23.735 ABI's achieving 239% of the target (9938) with a good spread across all settings with a particular increase in the wider settings. 2014/215 NHS Lothian target ABI delivery will increase in excess of 239% aiming to embed ABI delivery into all practitioners practice.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:2 - Deliver population health improvement interventions and health components of single outcome agreements with partners	Increased healthy life expectancy	Mar-15	AKM	5.2.5 (health improvement initiatives; 5.2.2 (Health inequalities strategy); 45.2.4 (community planning)	No	Nil	Healthy Life Expectancy at birth is a theoretical measure of the number of years that a new-born baby would live in a 'healthy' state if they experienced the death rates and levels of general health of the local population at the time of their birth, throughout their life. It is unlikely to be a true prediction of HLE for any individual, since death rates may increase or decrease during a person's lifetime, and people may move to areas with different mortality risks and views of their own health. The census and Scottish Household Survey are used to measure self assessed health (to estimate the healthy bit of healthy life expectancy) and Scottish Health Survey and other data sources re used to validate measures of self assessed health Life expectancy among men has increased 1.4 years in the last 5 years and 3 years in the last 10. For those interested improved in rank from 7 to 5. Life expectancy has increased in Lothian, however is improving more slowly in areas of deprivation. Vigilance is required when considering the about the adverse impact on health of the recession, increase in suicide and drugs related deaths and provision of mitigation programmes such as welfare rights support in GP surgeries.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:3 - Implement the Health inequalities strategy	Develop measures of determinants of health inequalities and use these in monitoring the impacts of this and other strategies.	Mar-15	AKM	5.2.5 (health improvement initiatives; 5.2.2 (Health inequalities strategy); 45.2.4 (community planning)	No	Green	Health Inequalities Strategy was approved by the Board in December 2014. Now working to ensure structures are in place to deliver the action plan.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:4 - Strengthen public protection arrangements	Compliance with MAPPA and child and adult protection standards [LAC Health Assessment] [Attendance at MAPPA meetings]	Mar-15	MJ		Public/ MAPPA And	Green	From August 2014 100% of LAC children will have a comprehensive health assessment and mental health screen within 28 days / 4 weeks of notification. From April 2014 100% compliance of attendance at Level 3 MAPPA Meetings.
Improving Health of the Population	6 - Protect and Improve Health in Lothian for All	6:5 - Implement actions for emergency preparedness and limit risk (resilience)	Ensure robust resilience standards are met for business continuity and emergency planning • Compliance checks • Training delivered • Exercises Comply with the Public Records Scotland Act requirements	on-going	AKM/ AMcM		Prepared-ness for Emergency Planning	Green	In the past 12 months NHS Lothian has undergone an internal audit of emergency preparedness, appointed a new Emergency Planning lead officer, and NHS Scotland has published national guidance on Resilience Preparing for Emergencies – Guidance for Health Boards in Scotland (2013). All the recommendations of the internal audit have been completed and declared closed by auditors. An NHS Lothian Resilience Committee, with joint Executive Director chair has been established, along with supporting workgroups. This has approved a work-plan which is being implemented.
Secure Value and Financial Sustainability	7 - Ensure the Delivery of a Sustainable Financial Framework	7:1 - Deliver a balanced Financial plan	Delivery of financial breakeven against RRL and CRL. Monitor capital project spend against budget during year	Mar-15	SG/All		Achieve Financial targets Capital Plan cannot be delivered	Green	NHS Lothian anticipates achieving delivery against its financial targets for this year, with breakeven against both the RRL and CRL anticipated. The financial position is challenging with an overspend at Period 10 against the RRL, however this is expected to reduce over the final two months of the year.

Secure Value and Financial Sustainability	7 - Ensure the Delivery of a Sustainable Financial Framework	7:2 - Delivery Efficiency and productivity plan to achieve £40m LRP	Monitor recurrent of delivery against LRP target as part of monthly cycle.	Mar-15	SG/All			Red	LRP is monitored and reported monthly, however indications are that the full £40m of LRP will not be delivered. Despite this shortfall, a breakeven outturn is anticipated
Secure Value and Financial Sustainability	8 - Ensure the Delivery of a Sustainable Financial Framework.	8:1 - Implement workforce plans as per LDP and Strategic Plan	Recruitment and Retention rates	Mar-15	AB/All	6.6 Workforce plan	Medical Workforce Sustainability Lack of management	Green	NHS Lothian workforce plan was published in August 2014 following discussion with partnership. The plan set out the key changes in the workforce demand and the key supply challenges. The plan also set out the actions to address areas of pressures. There are on-going reporting of medical workforce risks to NHS Lothian Board and the NHS Lothian Medical Workforce Group to support specialities where there are key challenges.
Secure Value and Financial Sustainability	8 - Ensure the Delivery of a Sustainable Financial Framework.	8:2 - Costed capacity plans for elective, unscheduled and primary care.	Increased productivity by specialty Increase in 7 day working Increase in extended days in theatres	Mar-15	AB/All	5.3.1 capacity planning and bed modelling		Green	A new theatre IT system introduced to support theatre capacity. Plans underway to extend working days within the radiotherapy centre. Modernisation team projects are supporting capacity planning for example review of endoscopy service allowed 1 additional patient to be added to each endoscopy list. AHP delivered 5 over 7 day working on time and on budget
Secure Value and Financial Sustainability	8 - Ensure the Delivery of a Sustainable Financial Framework.	8:3 - Review and implement NHS Lothian HR and OD Strategy Aligned with the Strategic Plan	No Measure	Mar-15	AB/All	6.5 (clinical leadership)		Nil	A HR and OD Strategy January 2015 to March 2018 has been developed
Secure Value and Financial Sustainability	9 -Develop a co-production and Innovation plan	9:1 - Foster a system wide culture of innovation aligned to the development of the strategic plan and delivery of LDP	No of innovation ideas generated No of invest to save proposals developed	Mar-15	AMcM/AKM	6.10 (Innovation); 5.2.6 telehealth / telecare	No	Green	As noted below in 9.2 -the second annual NHS Lothian Innovation Event focussed on developing innovative solutions around working in collaboration with the Third Sector. Other actions to gather innovative ideas have included, three projects being approved to receive support from the Digital Health Institute, a bid that is at the final stage for approval from the UK based Health Foundation and a number of proposals that have been submitted for funding from the Edinburgh and Lothian Health Foundation. A Medical Technology workshop is being run on 10th March, which will see NHS Lothian staff with ideas for innovative technology solutions matched up with industry partners to identify potential collaborations. Approval has been given to develop a two way interactive innovation web site, that will be a means through which to gather innovative solutions to identified constraints - both internally from NHS Lothian staff and externally. In terms of telehealthcare, NHS Lothian made a successful bid to the Scottish Government Technology Enabled Care Fund which will result in additional investment of circa in the region of £380k -with initiatives to roll out home based monitoring of blood pressure, the further development of the Living It Up Website and the use of digital technology to support people and their families following the diagnosis of dementia. Work is being progressed to identify the E&P potential for two innovative solutions - one to reduce the need for endoscopies and the other to reduce the requirement for ophthalmology treatment for people with diabetic retinopathy.
Secure Value and Financial Sustainability	9 -Develop a co-production and Innovation plan	9:2 - Develop a strategic plan for working with the 3rd sector. Need to include under innovation agenda and also align with LRP process.	Organisational commitment to working with the 3rd sector	Mar-15	AMcM/AKM	5.2.7 working with 3rd sector		Green	A CMT paper setting out the strategic intent and opportunities from working with 3rd sector will be presented in March 2015. A review of 3rd sector contracts is underway within the procurement work stream to support the LRP programme. Following CMT discussion it is proposed that Principles for Investment and disinvestment are developed to support effective commissioning. The second annual NHS Lothian Innovation Event, held on 15th October 2014,focussed on developing Greater Collaboration between NHS Lothian and the Third Sector. A key outcome for the event was to develop innovative solutions to ten themed areas that could be addressed in collaboration with Third Sector partners. This resulted in over 60 ideas being formed. Following the consideration of these, the theme of Loneliness has been prioritised as the area to now progress a connected innovative solution. A networking connection made at the Innovation Event, has resulted in work being progressed to consider the potential to create a Social Investment Partnership, through collaboration between the Third Sector, NHS Lothian and the Edinburgh and Lothian Health Foundation.
Secure Value and Financial Sustainability	10 - Deliver the agreed strategic plan 2014-2024	10:1 Consult and engage on the draft strategic plan	Timetable achieved: Draft Plan to April Board Consultation and engagement Summer Final Plan October Board and progress report and final	April-July 14 October 14	AMcM			Green	Strategic Plan consultation complete. Strategic plan board development session took place in January 2015 and strategic plan progress report signed off by NHS Lothian Board on 4 February 2015.
Secure Value and Financial Sustainability	10 - Deliver the agreed strategic plan 2014-2024	10:4 -Develop the process for implementing the agreed Strategic Plan	Timetable and committee / board approvals achieved	Mar-15	AMcM/All			Green	Progress report to NHS Lothian Board signed off February 2015. Terms of Reference for the Strategic Planning Committee have been refreshed and are linked to the development of Integrated Joint Board Strategic Plans
Secure Value and Financial Sustainability	10 - Deliver the agreed strategic plan 2014-2024	10:2 -Develop and implement Site Master Plans	Plans in development for SJH, WGH, RIE, Lauriston Campus and REH and PEAP and also thinking on Bio quarter underway.	Ongoing	SG/AMcM/ MJ/JC			Green	Draft site master plans are well developed and aligned to NHS Lothian's Strategic Plan 2014 - 2024.

Secure Value and Financial Sustainability	10 - Deliver the agreed strategic plan 2014-2024	10:3 -improve sustainability of estate and facilities operations	Improve on environmental standards: Reduce carbon emissions [Baseline End Q2 2013/14 – 1.50%] Reduce energy consumption [Baseline End Q2 2013/14 – 1.13%]	Mar-15	AB/All		Yes	Green	NHSL's performance against HEAT targets for energy and CO2 reductions is better than the national performance as reported by SG Q3-2014/15. The required saving for NHSL against base year 2009/10 was 4.8% for energy and 14.0% for CO2, actual savings have been 8.9% for energy and 12.3% for CO2. Energy reduction is well ahead of target and the more stringent CO2 target is not too far short. A new investment programme with value of £2.2million is going through our governance, in addition although at this stage there is no funding able to support it. The Carbon and Energy Fund (CEF) project for St John's boiler replacement is presently out to tender, this project offers major reductions in energy consumption and CO2 emissions. NHS Lothian has recently been re-accredited with the Carbon Trust Standard which gives a true guide to overall performance and to all of the CO2 footprint arising from NHS Lothian's entire estate. At the end of Q3-2014/15, there have been major cost reductions arising from energy consumption with LRP and other efficiencies of £460k and additional weather related savings of £317k.
Secure Value and Financial Sustainability	10 - Deliver the agreed strategic plan 2014-2024	10:5 - Develop business cases or options appraisals for individual propositions.	Will be presented to the Board as each proposition is developed approvals achieved	Ongoing	AMcM/All			Green	The February 2015 strategic plan progress report identifies where business cases and options appraisals which need to be developed.
Secure Value and Financial Sustainability	11 - Improve integration of care by creating 4 Integrated Joint Boards in line with Public Bodies (Scotland) Act	11:1 - Agree functions to be delegated from NHS Lothian to the Integrated Joint Boards	Timetable met: Agreed list of functions to be delegated at June Board. Draft schemes out for consultation. Process for establishing Strategic Planning Groups and strategic plans under way.	Go live April 2015	AMcM	6.1 (Establish Health and Social Care Partnerships)	Health and Social Care Integration	Green	Lothian partnership Schemes of Establishment will be presented for sign off to NHS Lothian Board on 4 March 2015.
Secure Value and Financial Sustainability	11 - Improve integration of care by creating 4 Integrated Joint Boards in line with Public Bodies (Scotland) Act	11:2 - Develop, consult and agree Integration Schedules	Integration schemes to Dec Board – consulted and go live by summer 2015	Mar-15	AMcM			Green	Partnership integration schemes for consultation up to February 2015 and will be presented to NHS Lothian Board on 4 March 2015.
Secure Value and Financial Sustainability	11 - Improve integration of care by creating 4 Integrated Joint Boards in line with Public Bodies (Scotland) Act	11:3 -process for establishing the strategic planning groups and the strategic commissioning plans is underway. Progress report to the March Board Development session.	Apr-15	Mar-15	AMcM	6.2 (Develop Strategic Commission-ing Plans)		Green	Integrated Joint Board's strategic commissioning plans are being developed and will be subject to consultation. Update on the IJB strategic plans will be presented to NHS Lothian Board on 4 March 2015
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12:1 - Implement the Children and Young People's Strategy	88% of women in each Scottish Index of Multiple Deprivation quintile booked for antenatal care by the 12th week of gestation	Mar-15	AMcM	5.2.3 (Implement the Children and Young People's Strategy)		Green	Feb 2015: Local target revised to 88% as consistently exceeded HEAT target of 80%. Work on-going to target the approx. 10% that we are missing.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12 - 1Implement the Children and Young People's Strategy	100% of Looked After Children and Young People are offered a health assessment within 4 weeks of referral being received by NHS Lothian?	Mar-15	MJ			Green	February 2015: Comprehensive health assessment for all newly notified Looked After Children (including children in kinship care and those looked after at home on a supervision order) now carried out within a four week timescale. Mental Health screening is carried out on children over the age of five years currently using the S&D questionnaire and additional MH questions. Working towards target of 100%.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12-1 Implement the Children and Young People's Strategy	Proportion of P1 children in local authority schools that are obese, or above using clinical thresholds	TBC	AKM			Green	5.4% either obese or severely obese using clinical categories in school year 2012/13 The Child Healthy Weight team in NHS Lothian has, over the past six years, worked with local authorities and leisure trusts to deliver a balanced programme of prevention and treatment. For the period Apr 2011–March 2014 there have been a total of 2,632 interventions completed which meant that NHS Lothian exceeded the national HEAT target by 364 interventions. For the year 2014/15 Scottish Government have not applied a specific HEAT target for Child Healthy Weight. During this year instead they are working closely with representatives from Health Authorities across Scotland to inform a revised approach from April 2015 onwards. While there is no official target in place there is an expectation that NHS Lothian will continue to deliver the same level of interventions as previous years which is approximately 756 interventions for overweight and obese children and families, and we are on course to meet or exceed this figure. February 2015: The proportion of children outwith a healthy weight has plateaued and perhaps even started to reduce. The 2013/14 figures will be available probably in Feb 2015

Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12:2 - Full participation in the Early Years Collaborative	To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1,000 births in 2010 to 4.3 per 1,000 births in 2015) and infant mortality (from 3.7 per 1,000 live births in 2010 to 3.1 per 1,000 live births in 2015).	Mar-15	AMcM			Green	February 2015: Our rates for December 2014 (continuous measurement, one month behind to allow for final data processing) was 1.30 still births and 7.82 neonatal deaths per thousand over both units. It's worth noting that December was an outlier for RIE in neonatal deaths and the previous month had had none.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12:2 - Full participation in the Early Years Collaborative	To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016	Dec-16	AMcM			Green	February 2015 : 6,582 reviews were carried out in Lothian from 1 April 2014 to 31 January 2015. Of these reviews, 1,006 (15.3%) had a least one new concern identified. Of these 1,006, 143 had at least 1 referral made to the service.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12:2 - Full participation in the Early Years Collaborative	To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017	Dec-17	AMcM			Green	Feb 2015: Data not yet available - target being incorporated into community plans for 2015/16. Work being forward by Lothian Health and Wellbeing of School Aged Children Group.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12:3 -Develop children's integration agenda in Edinburgh, East and Mid and West Lothian.	Draft schemes out for consultation. Delegation of children's services is phase 2. WL wont delegate; Mid and East will and Edinburgh is putting separate arrangements in place for a children's Board of Governance.	Oct-15	AMcM			Green	February 2015: In Edinburgh, a draft remit has been developed for the Integrated Children Services Board. Draft governance structures currently being developed for East Lothian, West Lothian and, Midlothian. An update paper on children's integration schemes will be presented to the CMT in March 2015 outlining governance arrangements. Edinburgh governance arrangements will begin on 1 April 2015.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12-4 Comply with legislative requirements of the Children and Young People's Act	100% of children known to health services with a Named Person	Mar-16	AMcM			Green	February 2015: Health visitors will carry out the named persons role from birth as set our by the draft guidance on the Children and Young People's Act. All children have a named health visitor from birth with the midwife providing first point of contact for the first 10 days. An Act Implementation group for NHS Lothian is currently working on an implementation plan to ensure compliance with the statutory requirements.
Secure Value and Financial Sustainability	12 - Early Years: Implement the Children and Young People's Strategy	12-4 Increased numbers of trained Health Visitors	Increased numbers of trained Health Visitors	Jun-15	MJ			Green	February 2015: Scoping work underway to quantify increase needed in Health Visitor workforce from 2015-18. During 2014/15 we are training 16 Health Visitors with a further 26 planned for 2015/2o16 subject to confirmation of level of Scottish Government funding for 2015/16.

NHS LOTHIAN

2.8

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

NHS LOTHIAN CORPORATE OBJECTIVES 2015/16

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

• The Board is recommended to approve the Corporate Objectives for 2015/16	2.1
• The four corporate objectives are focused on the Triple Aim and an additional change enabling objective	3.1
• The actions align with the 6 improvement priorities identified by NHS Scotland within the Local Delivery Plan 2015/16	3.2
• Metrics, risks and dependencies are identified for each action	3.3
• Detailed oversight of progress with the objectives and actions has been aligned to appropriate governance committees, including the accountabilities of the Integrated Joint Boards	3.4
• Progress updates will be reported on a quarterly basis to the Health Board	3.4

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NHS LOTHIAN

Board Meeting
1 April 2015

Director of Strategic Planning, Performance Reporting & Information

NHS LOTHIAN CORPORATE OBJECTIVES 2015/16

1 Purpose of the Report

The purpose of this report is to recommend that the Board approves the Corporate Objectives for the year 2015/16, and agrees to the relevant Board and IJB committees providing oversight on progress during the year.

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

2 Recommendations

2.1 Agree the Corporate Objectives for 2015/16 (Appendix 1)

2.2 Agree that detailed oversight of progress will take place at the appropriate governance committees, as detailed in the final column of the appendix.

2.3 Agree that update reports will be provided to the Board on a quarterly basis.

3 Discussion of Key Issues

3.1 The NHS Lothian corporate objectives for 2105/16 have been developed as previously around three key objectives towards achievement of the Triple Aim with a fourth objective focused on change enabling actions as follows:

- protect and improve the health of the population;
- improve the quality and safety of health care;
- secure value and financial sustainability
- deliver actions to enable change.

3.2 The detailed actions within the four corporate objectives address the main areas we will focus on to deliver against the six strategic improvement priorities identified in NHS Scotland Local Delivery Plan guidance, and are aligned to and summarise the actions which are detailed in the NHS Lothian Local Delivery plan 2015/16, which is separately on the agenda for approval by the Board. The objectives also reflect the key strategic plan propositions, the financial and workforce plans and the actions to progress integration of Health and Social Care.

3.3 Linked to each action are the metrics by which progress will be measured, and the high level risks to be managed and dependency factors associated with each area of change and improvement. Also that we have provisionally aligned accountability to a Board Committee as well as an Exec lead.

3.4 While it is anticipated that updates on progress with the Corporate Objectives will be reported to the Board on a quarterly basis as previously, accountability for more detailed oversight and assurance on progress improvement areas have also been provisionally aligned to the relevant governance committees. The accountability for planning and performance management of the shadow Integrated Joint Boards is also reflected in the governance alignment.

4 Key Risks

4.1 There are no new risks arising from this report. The key risks and dependencies are set out in the Corporate Objectives document.

5. Risk Register

5.1 There are no new risks arising from this report for NHS Lothian's risk register. The major risks relate to achieving financial targets and workforce plans, and delivery of waiting times and whole system performance measures, including the reduction of delayed discharges and boarding in hospitals.

6. Impact on Inequality, Including Health Inequalities

6.1 This report does not propose any new policy or service change. Specific actions and change programmes either have been or will be subject to equality impact assessment.

7. Involving People

7.1 The Corporate Objectives are drawn from national and local improvement priorities and plans which have been developed with involvement of stakeholders.

8. Resource Implications

8.1 There are no new resource implications arising from this update.

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List of Appendices

Appendix 1: NHS Lothian Corporate Objectives 2015/16

Draft 4:6,17 March 2015

NHS LOTHIAN CORPORATE OBJECTIVES
2015 – 2016

For 2015/16, NHS Lothian's Corporate Objectives have been re-structured to mirror the 6 key strategic Improvement Priorities & Planning areas set out in NHSSCOTLAND 2015-16 Local Delivery Plan (LDP). We have 4 overarching corporate objectives:

- protect and improve the health of the population;
- improve the quality and safety of health care;
- secure value and financial sustainability
- deliver actions to enable change.

The delivery of NHS Lothian's objectives require to be supported by activities contained in individual NHS Lothian Strategies, Frameworks and Directorate Plans and core to NHS Lothian's Our Health, Our Care, Our Future NHS Lothian's Strategic Plan 2014-2024

Inclusive of;

- NHS Lothian's Local Delivery Plan 2015/16, detailing the organisations actions and targets as agreed with Scottish Government Health and Social Care Directorates.
- Financial Plan 2015/16
- A local implementation plan 2015-16 to deliver the Everyone Matters 2020 Workforce vision
- Key Strategic Plan propositions implementation programme
- Strategic Commissioning Plans for the 4 Lothian Integration Joint Boards
- 'House of Care' strategy including our four typical patients and associated implementation programmes

Supporting the delivery of these objectives, NHS Lothian will require to continue to improve through governance systems in order to meet national standards and best practice, including the continued evaluation of NHSL Board and Governance Committees, Risk Management Strategy and internal /external Audit Plan.

Corporate Objectives 2015/16

Corporate Objective One: Protect and Improve the Health of the Population				
2015- 16 LDP Improvement & Planning Priorities	**2015-16 NHS Lothian Corporate Objectives**	**Risk Analysis/ Dependencies**	**Metrics**	**Committee**
1.1 Antenatal and Early Years	Working closely with the 4 Children's Partnerships, implement the NHS Lothian Strategy for Children and Young People 2014/2020 by : ensure that all children aged 0-5 will have access to a Named Person as required by the Children and Young People (Scotland) Act; increase capacity of the Health Visiting workforce; Train and support health visiting and maternity staff to deliver GIRFEC pathways develop a local protocol on joint planning during the antenatal care pathway to support implementation and transition of the Named	Recruitment, retention and training of sufficient Health visiting staff	Proportion of children under 5 within Lothian with a Named Person- target 100% by August 2016; Additional 26 nurses to undertake Health Visitor training for 2015/16 EYC1) Reduce still birth and infant mortality by 15% by	Healthcare Governance Committee Staff Governance Committee Shadow Integrated joint Boards

	Person role after birth; Roll out information to staff throughout NHS Lothian regarding our duties under the Act and establishing any additional support required to enable staff to fulfil these duties; Use Early Years Collaborative (EYC) methodology to work towards: - "stretch aims" on stillbirth, infant mortality and child development - Improvements in each of the key change areas of EYC, including health and wellbeing, and income maximisation (e.g. through work on Healthy Start and referral of pregnant women and children for welfare rights advice)	Recruitment and retention of sufficient midwives	end 2015. EYC2) Increase % children achieving all developmental milestones at 27-30 months to 85% by end 2016. EYC3) Increase % children achieving all developmental milestones to 90% by end 2017. 27-30 month review aim has bundle of measures including parenting/ early education prior to review, coverage, documentation, onward referral and more. Other EYC) 80% eligible women and children in receipt of Healthy Start vouchers by end 2016 Other EYC) Leith and	

	Implement maternity services action plan to improve patient flow in maternity services across Lothian. Ensure expectant mothers have access to timely antenatal care through continuing to exceed the antenatal care target; Maintain comprehensive health assessment for all newly notified Looked After Children carried out within four weeks; Respond to forthcoming NHS Delivery Plan to support the Children and Young People Act (2014) Parts 4, 5 and 18 relating to named person, child's plan and assessment of wellbeing; Consider the findings from the national review of school nursing, and develop a NHS Lothian response; Extend Family Nurse Partnership service to		West Lothian Scottish Legal Aid Board funded projects will provide more information on the expected level of referral, uptake and outcomes of welfare rights advice. At least 80% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation. No. assessed within 4 week timescale Delivery Plan metrics to be confirmed Increased school nurse hours spent in schools-target to be confirmed East Lothian FNP service operational by October 15	

	East Lothian Test hybrid FNP service with NHS Borders		NHS Borders test commences August 15 FNP available to all expectant teenage mothers by March 16	
1.2 Health Inequalities	Implement the NHS Lothian Health Inequalities Strategy action plan in relation to: Procurement- Develop use of community benefit clauses in contract specifications and procurement strategies Procurement - implement contracts and SLAs that encourage use by suppliers of the living wage. Employment - as an employer increase	Alignment to four Community Planning Partnership Single Outcome Agreements	Agreed increase in targeted community benefits in project specifications – as new projects specified, review November 2015 Numbers of apprenticeships Spend in Supported Businesses Numbers of training opportunities Increased number of contracts and SLAs held with organisations who pay a living wage or are registered and working towards it Numbers of people from identified vulnerable groups	Finance and Resources committee Staff governance committee

	recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme Service Delivery –implement staff training to enable them to respond to social & economic circumstances affecting patients' health. Training needs assessment – May 2015 Training developed for different staff groups – December 2015 Delivery of training - from January 2016. Ensure Health & Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities: Strategic needs assessments completed with relevant actions - April 2015 Continue routine use of impact assessment of new policies and plans: Complete pilot of Integrated Impact Assessment – April 2015 Identify impact assessment leads in each area to facilitate IIAs – April 2015		offered placements/ training Numbers of people recruited from identified vulnerable groups Number who sustain employment >6mths Numbers and proportions of different staff groups who receive training Evaluation of training Explicit demonstration of inequalities issues within each needs assessment by Number of impact assessments Proportion of actions implemented in agreed timescales	Shadow Integrated joint Boards Healthcare Governance Committee

1.3 Prevention	Develop and implement Health improvement actions to promote healthy living through Health Promoting Health Service actions: • Introduction of new tobacco policy and introduction of smoke-free NHS grounds (WHO Framework for Tobacco Control) • Attainment of UNICEF baby friendly accreditation (WHO essential interventions to prevent childhood morbidity & mortality) • Attainment of the Healthy Working Lives award across all sites. (WHO Workers Health Action Plan) • Increased emphasis on the promotion of Physical Activity and active sustainable travel – an action plan is in place to deliver this. (WHO Environment action plan, Cancer Prevention Plan) • NHS procurement of healthy food. Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings		NHS grounds smoke free from 1 April 2015 Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas Target for ABI delivery in 2015/2016 is 9757 with 80% delivered in the priority settings.25% of ABI delivery will take place per quarter during 2015-16.	Healthcare Governance Committee Shadow Integrated joint Boards

Corporate Objective Two: Improve the Quality and Safety of Health Care				
2015- 16 LDP Improvement & Planning Priorities	**2015-16 NHS Lothian Corporate Objectives**	**Risk Analysis/ Dependencies**	**Metrics**	**Committee**
2.1 Deliver person-centred care	Plan, define, implement and measure service delivery provided to patients within NHS Lothian's care with the "five must do's with me" through implementing the NHS Lothian IPlan promoting person –centred culture approved December 2014 Take forward and measure the key local actions to transform the culture to support staff and the public to be open and confident in giving and receiving feedback. Define the mechanism , measures and governance to ensure that the information people need to give feedback and make complaints, is widely publicise to the population of NHS Lothian. Ensuring that learning from feedback is applied and appropriate measures and governance are in place to inform people of outcomes by:	Increased demand and delayed discharges may mean staff have less time to deliver personalised contact. Outcome of tests from 8 teams across Lothian. Oversight of Person-centred Programme board.	Data sources • Patient experience surveys and reports • complaints data • evidence of person centred approach Reduce number of complaints (ongoing target, no percentage given) Acknowledgement of 100 per cent of complaints within three	Healthcare Governance Committee Shadow Integrated joint Boards

	Implementing the actions from the Customer Relations and Feedback Team Review completed February 2015. Implement key actions to progress 2020 workforce vision for a healthy organisational culture to support staff and the public to be open and confident in giving and receiving feedback by : Implementing new internal communications plan Piloting the *iMatter* tool in Public Health and the Royal Edinburgh initially to assist embedding our values Develop tools and provide support/training to leaders and managers to enable them to embed the values,	Reduction in corporate staff resources through planned reductions may impact on organisational capacity	working days. Response to 85 per cent of complaints within 20 working days. Staff experience surveys/reports show improvements No. of team surveys/ iMatter tools used locally Investors in People Standards achieved	Staff Governance Committee
2.2 Deliver Safe care	Continue to monitor and take corrective actions to enhance safe care within areas of; acute, primary care, maternity, neonates, paediatrics and mental health services.		SPSP metrics and reports	Healthcare Governance Committee Shadow Integrated

	Continue to monitor and take corrective actions to reduce the incidents of all HAI. To reduce MRSA / MSSA, focus will be on reducing the number of: • skin and soft tissue infections • vascular access device infections *CDifficle* infections (CDI): Monitor the impact of the significant change in the antimicrobial prescribing policy which came into effect on 2nd February 2015 during the year. Undertake a review of environmental cleaning and standards in 2015/16 with the aim of reducing CDI. Agree and implement a recovery plan which includes the recommendations from the Vale of Leven report and other published reports	Compliance with antimicrobial prescribing policy	Rates of HAI Clostridium difficile infections per 1000 occupied bed days (target 0.32) SAB infections per 1000acute occupied bed days (target 0.24) HAI report will be provided to every NHS Lothian Board meeting to demonstrate progress.	Joint Boards NHS Lothian Board
2.3 Appropriate Unscheduled Care	Progress orthopaedic rehabilitation redesign collaborative; Implement stroke service redesign including creation of integrated stroke unit at RIE by August 2015; Implement "Better Cancer Care in Lothian"	Health and Social Care Partnerships' strategic plans provide more responsive and integrated	4 hours from arrival to admission, discharge or transfer for A&E treatments (95%); Number of delayed discharges >72 hours	Acute Hospitals' Committee Strategic Planning Committee

	strategy, including progressing cancer pathway redesign and cancer centre development; Ensure plans developed to ensure sufficient radiotherapy capacity for SCAN cancer network area are implemented; Progress redesign of older people's care pathways across hospital base unscheduled care and 4 partnerships to include: • Plans for Integrated Care Facilities • Reprovision of outdated hospitals in Edinburgh, East Lothian and West Lothian • Delivery of integrated set of communit y based older people's services • Review of in-patient Complex and Continuing Care Capacity • Reduction of delayed discharges to maximum wait of 72 hours and elimination of boarding in hospitals • Improve ambulatory care options and discharge processes in acute hospitals	community services; Including: Discharge to assess Successful frailty models to support older people in the community Appropriate care home and care at home capacity to meet needs IJBs are established with balanced budgets Revised national guidance on in-patient complex care is published	by health and social care partnership People diagnosed and treated in 1st stage of breast, bowel and lung cancer (29% target) Cancer standards: Treatment within 31 days from decision to treat (95%); Treatment within 62 days for urgent referral with suspicion of cancer (95%);	Shadow Integrated joint Boards
2.4 Scheduled Care and waiting times	Implement "Delivering for Patients" to increase internal capacity for scheduled care, reduce dependence on independent sector, and achieve waiting time standards for elective services. Progress key propositions (from strategic	Inability to deliver a balanced financial position during any quarter of 2015/16 will impact on ability to fund external capacity to	12 week TTG for in-patient and day cases; 95% of out-patients within 12 weeks; No out-patient waits over 16 weeks; Overall 90%	Acute Hospitals' Committee Strategic Planning Committee

	plan) • Implement Out-patient services redesign programme • Progress Eyecare redesign and modernisation programme • Progress Orthopaedic Services Redesign programme • Progress plans for regional major trauma unit at RIE as part of national programme • Implement laboratory strategy key deliverables in year	support TTG and other waiting times delivery No of acute bed days used for delayed discharges does not exceed 2014/15 level. Demand for services does not increase– new out-patients, and additions to in-patient and day case lists remains steady. Laparoscopic prostatectomy demand from external referrals is a specific risk	achievement of 18 week RTT standard 90% of referrals for CAMHS and psychological therapies commence treatment within 18 weeks 90% of eligible patients commence IVF treatment within 12 months Clients will wait no longer that 3 weeks from referral to appropriate drug of alcohol treatment that supports recovery (90%) People newly diagnosed with dementia will have a minimum of 1 year's post–diagnostic support	Shadow Integrated Joint Boards

Corporate Objective Three: Secure Value and Financial Sustainability				
2015- 16 LDP Improvement & Planning Priorities	**2015-16 NHS Lothian Corporate Objectives**	**Risk Analysis/ Dependencies**	**Metrics**	**Committee**
3.1 Financial Planning	Achieve RRL and CRL financial targets in 15/16. Develop and deliver LRP plans to achieve £30m LRP (£20m recurring, £10m non-recurring) in year. Through workstreams and other measures achieve £48m total efficiencies. To undertake a whole system diagnostic review of current service models to inform decisions on changed service models to a achieve financially sustainable future. Develop balanced budgets for the health service commissioning component of shadow IJBs Progress the development of the new children's hospital and Dept of Clinical Neurosciences within the agreed NPD contract. Progress the development of phase 1 of REH Campus development through the agreed SE HUB contract.	44% of LRP schemes are currently high risk 41% are medium risk 18% are low risk; CEC budget settlement and impact on delayed discharges; Drug cost pressures cannot be managed within allocated resources. Assumptions on Scottish Government allocations in LDP are correct. Community capacity is in place	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement Data: Monthly financial analysis reports	Finance and Resources Committee

	Develop and deliver the capital plan 15/16 within the resource limit available according to the priorities agreed. Progress major site masterplans in line with service planning requirements	to support LRP schemes including closure of winter and delayed discharge beds. Delayed discharges remain at or below current level		
3.2 Workforce Planning	Reprofile workforce through review of corporate services, management and administrative costs and supplementary staffing to reduce staff numbers to level employed in November 2013; Implement sustainable workforce review of current staffing and education/training models and identify opportunities for developing a safe, efficient and sustainable staffing model for each service area. Workstreams established will focus on review of : • Clinical skill mix • Corporate Services • Management costs • Administrative services • Supplementary staffing and agency • Redesign of Clinical Services Implement the revised learning and development strategy including measurement	Reduction in management and administrative posts reduces capacity for management action Availability of funding for severance packages; Closure of winter and delayed discharge beds; Sustainability of Medical workforce models	Indicative target is 840WTE, circa 1050 headcount reduction Sickness Absence standard (4%)	Staff Governance Committee Shadow Integrated Joint Boards

	framework Support the shadow IJBs and NHS Lothian to progress their integrated workforce plans; Use community workload tool to support review of community nursing across partnerships; undertake other reviews as appropriate;		Learning and Development measurement framework (to be confirmed)	
3.3 Develop Primary Care Capacity and Capability	Develop and implement a plan to increase primary care capacity in relation to: • GP Workforce • Community Workforce • Improved IM&T infrastructure and support • Enhanced services – diabetes type 2 care • Referrals advice and protocols • Other community and practice support e.g. phlebotomy Implement primary care premises development plan in partnership with 4 health and care partnerships to include business cases for premises developments.	Inability to recruit GPs to practice vacancies may exacerbate current pressures on practices; Availability of funding from Scottish Government or within financial plan to support investments; GP sub-committee support for development plan; Inability to deliver a balanced financial position during 2015 will	National survey results on Patient access to/ satisfaction with primary care; 48 hour access or advance booking to an appropriate member of the GP team (90%) Reduction in practice IT system downtime Reduction in no of "open but full" practices; No. of Leg-up grants approved and additional	Shadow Integrated Joint Boards Strategic Planning Committee

	Implement LUCS review to achieve efficiencies and deliver sustainable out of hours unscheduled care	impact on ability and timeline to fund primary care capacity developments	registrations delivered; LUCS Review metrics TBC	

Corporate Objective Four: Deliver Actions to Enable Change				
2015- 16 LDP Improvement & Planning Priorities	**2015-16 NHS Lothian Corporate Objectives**	**Risk Analysis/ Dependencies**	**Metrics**	**Committee**
4.1 Integration	Following Scottish Government approval of the Integration Schemes and In partnership with 4 local authorities in Lothian progress the establishment of the four Integrated Joint Boards. Support shadow IJBs to develop Joint Strategic Needs Assessments, and draft Strategic Plans in readiness for IJB formal approval; Review NHS governance arrangements to take account of IJB accountabilities	Government approval of integration schemes; Agreement of IJB budgets; Appointment of IJB chief officers and finance officers	Must be in place by 31st March 2016	NHS Lothian Board Shadow Integrated joint Boards
4.2 Community Planning Partnership (CCP) Contribution	Continue to strengthen NHS Lothian commitment and contribution to the four CPPs in Lothian, alongside the input from the shadow IJBs. Contribute to the delivery of specific CPP	That financial sustainability pressures on all partners reduce ability to contribute	Data source: CPP single outcome agreements	NHS Lothian Board Shadow Integrated joint Boards

	programmes, including: • Delivery of a funded programme of community health activities in Edinburgh that promotes social capital, healthy eating, physical activity and therapeutic use of greenspace. • In partnership with the Midlothian CPP contribute to the three strategic priorities; Early Years, Positive Destinations and Economic Growth and support the Place focus of service delivery in the three identified areas of deprivation in order to reduce inequalities. • Delivery of the West Lothian 'Eatright' and 'On the Move' programmes to promote healthy eating and physical activity • Implementation of the East Lothian Health Inequalities Strategy	and deliver the wider community outcomes within SOAs		
4.3 Deliver NHS Lothian Strategic Plan	Progress the implementation of key propositions within the strategic plan set out in February progress report, including: • Policy choices, including "Choosing Wisely" workstreams • Supporting Pathway Redesign using the Lothian House of Care framework for person-centred and integrated care	Financial position during 2015/16 will impact on ability and timeline to deliver strategic change workstreams; Reduction in management and administrative posts reduces	Indicative timelines in February progress report	Strategic Planning Committee Shadow Integrated joint Boards

		capacity for management action		

NHS LOTHIAN

2.9

Board Meeting
1 April 2015

Joint Director, West Lothian Community Health & Care Partnership/Director of Strategic Planning, Performance Reporting & Information

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

Acknowledge that only 36% of people in February (44% in January) were able to access psychological therapies against a standard set at 90%.	3.1
Support the improved data governance and governance processes which support the delivery of safe and effective therapy	3.2; 3.6
Acknowledge the service improvements made to date and the ongoing service improvement programme.	3.3
Support the focus on the delivery of five evidence based therapies by adult services and the clear rationale when other therapies are being used.	3,4
Recognise that demand for psychological therapies continues to outweigh current capacity.	3.5: 7.7
Support the strengthened delivery structures which will ensure ownership and local accountability.	3.6
Note that there is no non recurring or recurring funding in the financial plan for 2015-2016.	7.6
Note that consideration needs to be given to the best way of maximising the allocation to NHS Lothian through the recently announced Scottish Government allocation for mental health innovation as set out in section 7.9	7.9

Alex McMahon
Director of Strategic Planning, Performance Reporting & Information
18 March 2015

NHS LOTHIAN

Board Meeting
1 April 2015

Joint Director, West Lothian Community Health & Care Partnership/Director of Strategic Planning, Performance Reporting & Information

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

1. Purpose of the Report

1.1 The purpose of this report is to inform the Board of the current performance and the resources still required to enable delivery on the Psychological Therapies 18 week Referral to Treatment standard.

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

2. Recommendations

2.1 Acknowledge that only 36% of people in February (44% in January) were able to access psychological therapies within 18 weeks against a standard set at 90%.

2.2 Support the improved data governance and governance processes which support the delivery of safe and effective therapy

2.3 Acknowledge the service improvements made to date and the ongoing service improvement programme.

2.4 Support the focus on the delivery of five evidence based therapies by adult services and the clear rationale when other therapies are being used.

2.5 Recognise that demand for psychological therapies continues to outweigh current capacity.

2.6 Support the strengthened delivery structures which will ensure ownership and local accountability.

2.7 Note that there is no non recurring or recurring funding in the financial plan for 2015-2016.

2.8 Note that consideration needs to be given to the best way of maximising the allocation to NHS Lothian through the recently announced Scottish Government allocation for mental health innovation as set out in section 7.9

3. Current Issues

3.1 Performance

The trajectory (which was set in June 2014) and actual performance for Improving Access to Psychological Therapies is set out in Table A.

Table A – Psychological Therapies Performance Trend

	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
Revised Trajectory set in June 2014									
Percentage seen within 18 weeks	52%	52%	57%	60%	62%	64%	64%	Note1	
Total waiting at end of month	2,438	2,442	2,456	2,464	2,462	2,459	2,457		
Those waiting more than 18 weeks	800	802	816	814	822	819	817		
Actual Performance									
	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
Percentage seen within 18 weeks	52%	52%	32%	52%	37%	36%	35%	44%	36%
Total waiting at end of month	2,438	2,442	2,542	2,645	2,800	3,004	3,068	3,095	3,111
Those waiting more than 18 weeks	800	802	814	859	1,004	1,069	1,142	1,201	1.216

Note1: Trajectory set in June was set only to December 2014

The anticipated number of patients waiting more than 18 weeks in the trajectory was significantly under estimated. In December 2014 we had anticipated 817 patients, the actual number was 1,142. Further work to map out our future trajectory is currently being worked upon.

In February 36% of patients were seen for a first treatment within 18 weeks. The number of patients waiting over 18 weeks has continued to increase with 1,216 patients waiting over 18 weeks at the end of February.

3.2 Data Governance

3.2.1 A number of additional measures have been put in place to quality assure the data and ensure greater devolved ownership of the target:

:

- Development of additional error reports that are being distributed to a named clinical and management lead on a weekly and monthly cycle.
- A formal process to sign off data at Director Level has been agreed and was implemented from 1st March.
- A standard of a maximum 5 days from appointment date to arriving and outcoming being completed on TRAK has been agreed. The completion of which will be actively managed by Service Managers and Heads of Service.

3.2.2 A number of services' data has not yet been included in the monthly data submission. These include:

- Older Adult Behavioural Services for Behaviour that Challenges in Edinburgh, East and Midlothian
- Guided self help delivered by 3rd sector organisations governed by Service Level Agreements
- Therapies delivered within inpatient mental health settings
- Physical health settings where there is associated mental illness such as depression or anxiety

- Formal psychological therapies delivered with Child and Adolescent Mental Health Services

Amendments and additions to TRAK need to be made to enable these services to be able to report data. Submission is not likely to be possible until April 2015.

3.3 Service Improvements

3.3.1 A number of service improvements have been implemented to improve access and treatment options for psychological therapies. These have included:

- Interpersonal Psychotherapy for Acute Crisis (IPT-AC) delivery within A&E and the Mental Health Assessment Service.
- Cognitive Behavioural Analysis System of Psychotherapy for Chronic Depression (CBASP-Group) in East and Mid Lothian currently and will be developed as a Pan-Lothian Group service.
- .Development of Pan-Lothian approach to group work to improve efficiency of service delivery.

3.3.2 An electronic version of the mandatory data set has been developed for use in TRAK. Staff teams been trained to input the mandatory data set measures into TRAK and from April 2015 we will routinely report performance in relation to completion of measures and using outcomes data to inform future service planning and improvements.

3.4 Providing to evidenced Based treatment to increase productivity

3.4.1 The evidence base is derived from the results of key therapeutic research trials, and to deliver an 'evidence based' therapy we must be able to demonstrate that we are replicating the conditions operating within those trials as closely as possible. In practice this means having Psychological Therapists who are:

- Trained to recognised standards and having the competences necessary to deliver psychological interventions effectively
- Delivering a therapy which has a strong evidence base with respect to the **patient's diagnosis.**
- Delivering well-articulated therapy, and adhering to the appropriate model; and operating within a well-governed system which offers regular high quality, model-specific psychological therapies supervision, support and relevant Continuing Professional Development (CPD).

3.4.2 Different levels of intensity of therapy are described in the *Psychological Therapies Matrix (2013): A Guide to delivering evidence-based Psychological Therapies in Scotland.* (The Matrix) as follows:

Low Intensity' evidence-based treatments
These are aimed at mild/moderate mental health problems with little complexity, are time-limited and normally last between 2-6 sessions. Within Lothian these interventions are delivered in the main by Third Sector partners.

High Intensity' interventions-Psychological Therapies
These are normally based in secondary care mental health services and comprise traditional, standardised psychological therapies. In NHS Lothian the Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), Eye Movement

Desensitisation and Reprocessing (EMDR), Behavioural Family Therapy (BFT) and Dialectical Behavioural Therapy[1] (DBT) delivered to protocol. These therapies are aimed at moderate/severe common mental health problems with significant complexity and effect on functioning, and normally last between 6 and 16 sessions.

Specialist Psychological Therapies
These are most commonly accessed through secondary care and specialist services. Essentially they are standardised high intensity psychological therapies developed and modified for specific patient groups. They are delivered at the same level as 'High Intensity' therapies, but in a specialist context. Specialist therapies are aimed at moderate/severe mental health problems with significant complexity and effect on functioning e.g. substance misuse, eating disorders, bi-polar disorder and normally last between 10 and 20 sessions.

Highly Specialist Psychological Therapies and Interventions
Highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models and are normally accessed through secondary, tertiary and specialist services. These are aimed at service users with highly complex and/or enduring problems, and normally lasting 16 sessions and above.

3.4.3 Effectiveness and Cost-Effectiveness
It is widely recognised that the absence of robust evidence for any particular approach does not prove that the approach is ineffective-it may simply be that the evidence has not yet been collected. However, in an environment where resources are limited it is prudent to focus on where we can have the greatest confidence in the maximum return for our investment.

NHS Lothian has therefore concentrated on ensuring that we aim to provide the 5 highest rated evidenced based Psychological Therapies (as detailed in section 3.3.2). We are in the process of achieving this through an audit of who is trained in which specific therapy and creating an awareness of the current gaps to ensure that priority is given to those areas where a gap exists.

3.4.4 The level of training and qualifications required to deliver the therapies has been clearly defined and matched Job Descriptions for Psychological Therapists developed.

3.4.5 The **Applied Psychology** workforce in NHS Lothian are expected to govern the delivery of all therapies including these 5 highest rated evidenced-based psychological therapies (CBT, IPT, EMDR, BFT and DBT) through a robust training, supervision and research agenda. As with all other Health Service treatments, Psychological Therapies must, in line with the ambitions of the Quality Strategy, be delivered in a way which is safe, effective and efficient.

3.4.6 The outcomes from well-designed research trials would predict a response rate of around 60% for most evidence-based therapies, leaving 40% of patients who may well respond better to an alternative evidence-based approach. The aim in NHS Lothian is to try to match patients with the treatment which is most likely to be effective, and considerations of patient preference are important here. The Applied Psychology Workforce will deliver a range of therapies to the most complex presentations and be highly skilled and competent to create formulation driven interventions that will rely on more than one model of Psychological Therapy.

[1] Includes Mentalisation and Mindfulness

3.5 Demand and Capacity

3.5.1 Following the move to TRAK there is now 6 months of data which has been used to review demand and capacity for each team.

Initial calculations based on referral data, service capacity, average number of therapy sessions (based on an **average of 7.5 sessions**) and current waiting time data indicates the following:

- There is a significant shortfall of capacity in most services which will result in continuing increases in waiting lists and waiting time
- Even where demand is calculated as meeting capacity most services require additional resource to clear significant backlogs of patients waiting
- Previous capacity and demand work with services in East and Midlothian has identified a shortfall in the capacity to meet demand.

3.5.2 The additional capacity required to meet the current number of referrals offered psychological therapy is 21.5 WTE.

Table B
Additional capacity required to meet **current number** of referrals offered psychological therapy

Summary	Psychology (wte)	Nursing and AHP (wte)	DCAQ (Deficit) (WTE)	Total Capacity Required
Edinburgh	13	11.5	15.7	40.2
East	3.3	5.00	0.38	8.68
Mid	2.5	5.70	0.42	8.62
West	3.29	2.30	5	10.59
	22.09	**24.50**	**21.5**	**68.09**

3.5.3 Demand relates to those referrals received and accepted and those patients who opt-in.

The DCAQ work in East Lothian, which was a national exemplar pilot and completed in April 2014, demonstrated that 55 to 60% of all referrals to Adult Mental Health Services were offered evidenced based psychological therapies.
Currently, referrals to mental health services who are then offered formal psychological therapies ranges from 26% to 54%.

If we use East and Midlothian as the benchmark (reflecting equity and need) an additional 26.5 WTE staff would be required.

Table C
Additional capacity required to meet **60% of all referrals offered psychological therapy**

Summary	Psychology (wte)	Nursing (wte)	DCAQ (Deficit) (WTE)	Total Capacity Required
Edinburgh	13	11.5	19.7	44.2
East	3.3	5.00	0.38	8.68
Mid	2.5	5.70	0.42	8.62
West	3.29	2.30	6	11.59
	22.09	**24.50**	**26.5**	**73.09**

3.6 Delivery Structures and Skill Mix

3.6.1 As we move forwards with the integration of health and social care it is imperative that improving access to safe and effective delivery of psychological therapies is part of the partnerships' mental health and older people's services.

3.6.2 It is proposed that the delivery of psychological therapies is clearly visible at senior management levels within each partnership and that this is supported by pan –Lothian governance through Applied Psychology as set out earlier in section 3.4.5

3.6.3 The Head of Adult Mental Health Psychology has been conducting a comprehensive skill mix review which will significantly shift the balance of the workforce with more staff at levels 6 and 7 (Psychological Therapists) with senior psychology staff focusing on supervision and working with the most complex patients.

3.6.4 The DCAQ work and outcomes detailed in section 3.5 which has informed the identification of the additional resource required is predicated on a number of nursing and Allied Health Professionals staff who are trained in one or more the five evidence based therapies having agreed job plans to deliver the psychological therapies at the agreed capacity level.

4. Risk Register

Identified Risks	Planned actions
Data The accuracy of data recording and reporting for Adult Mental Health services which limits DCAQ activity and accuracy of reporting.	Additional resource has been identified to ensure accuracy of waiting lists following migration of patient records to TRAK. The additional functionality utilised within outcoming in TRAK will improve data recording. The reporting functionality within TRAK will ensure the routine reporting of DCAQ data to services to provide feedback on performance and actual activity/ capacity against expected.
Data Delays to the entry of clinical activity data in the system has meant inaccuracies in monthly reports and limits analysis and utility of data for DCAQ and performance management	Job plans that are being developed will include agreed time for completion of admin tasks, including clinical data entry. Funding is being sought for additional admin to support clinical staff with the specific remit for data entry.
Capacity The anticipated capacity is required to be achieved to meet demand	The expected capacity has been outlined with each of the teams. The capacity management cycle outlined allows the expected activity in each area to be closely monitored in order to identify variance. Job plans for all staff delivering psychological therapies are required to be developed and signed off by respective managers as a priority.
Increased waiting times	Secure recurring funding to meet the demand

5. Impact on Inequality, Including Health Inequalities

5.1 The Auditor General for Scotland and the Accounts Commission Report on Health Inequalities in Scotland (December, 2012) concluded that there are significant and longstanding health inequalities in Scotland. The public sector can make better use of its resources to address these challenges. The report recognises that whilst there have been long-term increase in average life expectancy in Scotland and considerable improvements in overall health there are still significant differences in life expectancy and health depending on deprivation, age, gender, where people live and ethnic group. Activity reports will include ethnicity, gender. locality and age as part of routine reporting. This will enable services to identify the under representation of any population groups.

6. Involving People

6.1 There has been wide engagement with staff in relation to both the specific HEAT targets and the wider issues related to delivery psychological therapies. There is a Stakeholders Reference Group which meets monthly. Additionally, as part of the A12 work plan, the team has met with each service to discuss the key issues in relation to meeting the target.

7. Resources

7.1 As set out in Table D additional staffing of 21.50 WTE is required to meet the current gap in demand; to increase access to 60%, 26.5 WTE are required.

Table D: Additional Clinical Staff

Post	**To meet Current Demand WTE**	**Cost £**	**Travel, Training Equipment**	**To meet additional demands (60%)**	**Cost £**	**Travel, Training Equipment**
Psychological Therapist Band 7	18.5	840,473	26,825	21.5	976,766	31,175
Clinical Psychologist 8a	3.00	171,207	4,350	5.00	285,345	7,250
Total	21.5	1,068,066	31,175	26.5	1,262,111	38,425
Grand total			**1,099,241**			**1,300,536**

7.2 To support the clinical delivery additional admin and clerical staff would be required - this includes the introduction of a waiting list manager across Lothian.

Table E: Additional Admin Staff

Post	**WTE**	**Cost**	**Travel, Training Equipment**
Wait List Manager	1.00	25,965	500
Admin Band 3	4.00	89,732	2,000
Admin Band 2	4.00	79,748	2,000
Total	**9.00**	**195,445**	**4,500**

7.3 Recurring funding of £1,519,390 would be required to meet the additional demand (60% of referrals receiving psychological therapies)

Table F – Summary of required funding

Post	**To meet Current Demand WTE**	**Cost £**	**To meet additional demands (60%)**	**Cost £**
Clinical	21.5	1,099,241	26.5	1,300,536
Admin	9.00	195,445	9.00	195,445
Total	**30.5**	**1,294,686**	**35.5**	**1,495,981**

7.4 The Financial Plan for 2015/16 does not currently take account of this. Non recurring funding was allocated in 2014-2015 to support up to 10.00 WTE Clinical Staff and 5.00 WTE Admin staff.

7.6 Contracts have been extended to December 2015.

7.7 The Scottish Government has announced the allocation of a mental health innovation fund of £15 million. On 16 March the Minster announced how this would be allocated over a three year period (£5 million per year). The criteria includes

- An allocation to NHS boards to support increased access to child and adolescent mental health services (CAMHS), and to develop new and innovative approaches to treatment
- Funding to NHS Education Scotland to further develop the quality of CAMHS through improved training
- Work with partners and Boards to develop better ways of helping people in distress – including those who are at risk of self harm or suicide
- Money to work with Boards and partners to develop new ways of working with people with mental health problems in primary care settings

There needs to be a clear demonstration of partnership development of any proposals submitted. The Joint Integrated Partnerships will be expected to play a key role in developing proposals. There may be some opportunity within this to address improving access to psychological therapies through new ways of working in primary care and helping those in distress. Equally this may refocus attention on people who are not referred to secondary mental health services

Linda Irvine
Strategic Programme Manager
Mental Health and Wellbeing

Dr Patricia Graham
Head of Applied Psychology
Adult Mental Health

Maureen McKenna
Consultant
Psychological Therapist

18 March 2015

NHS LOTHIAN

2.11

Board Meeting
1 April 2015

John P Iredale, Non-Executive Board Member

SUMMARY PAPER - IMPACT OF RESEARCH UNDERTAKEN BY NHS LOTHIAN & UNIVERISTY OF EDINBURGH STAFF (REF2014)

This paper aims to summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

- The Research Excellence Framework 2014 to which every UK university medical school had to make a submission has, for the first time, mandated the submission of examples of research impact. Impacts are worked up case studies describing how research undertaken since 1993 has a demonstrable impact on society. In the form of case studies, each of these impacts falls into one of four broad areas:

  1. Improving clinical practice case studies which are primarily about innovation, service redesign, patient outcomes, quality of care, changes to guidelines or clinical practice.

  2. Boosting the economy. Case studies which have a primary or strong focus on economic growth (e.g wealth creation through novel devices or partnership with industry, cheaper treatments).

  3. Benefits to society case studies which are focused on societal issues and/or public understanding of health issues

  4. Beyond borders. Case studies which are primarily about international and developing world health care.

Of the 35 case studies submitted across the medical disciplines by the University of Edinburgh, we have selected those for which NHS Lothian employees or honorary contract holders led or played a major role in developing. These studies provide a detailed snapshot of the extraordinary range of impacts from research activities which take place in our laboratories and hospitals. To give an overview, in the period 2008-2014 from the £1.99M of grant income which underpinned those studies with a measurable health economic impact *annual* cost savings for the NHS in the UK were generated of £294M representing an *annual* return on public funding of a minimum of £147 for every £1 of grant income awarded. University of Edinburgh impacts demonstrated reach to in excess of 100 countries world-wide in all continents of the world and affected millions of individuals. These examples demonstrate how UoE and NHSL staff have influenced and defined practice for a) those delivering patient care, b) health care delivery organisations, c) national governments and global bodies – including the World Health Organisation (WHO).

For ease of reading only the abstracts of each impact is presented in the

document (1.1) although a link to the full statements which will be placed on the intranet is also provided. Additionally a pdf of the document exemplifying impacts from each of the UK's Medical Schools "The Health of the Nation" is enclosed (1.2). The structure of the abstracts describes the nature of the impact, its significance, where possible defined by data, the attribution with respect to those individuals that developed and delivered the research, the users and the beneficiaries of the impact and the reach of the impact. Whilst this document is quite bald and telegraphic, I trust that colleagues will appreciate the aim is to provide a summary of the portfolio; I have no doubt that many of you will be interested in identifying specific impact case studies and wish to read about them in greater detail on the web based material. I will of course be happy to discuss further at the Board meeting or off line.	1.1 1.2

John P Iredale
Regius Professor of Medical Sciences
4 March 2015
John.iredale@ed.ac.uk

NHS LOTHIAN

Board Meeting
1 April 2015

John P Iredale, Non-Executive Board Member

IMPACT OF RESEARCH UNDERTAKEN BY NHS LOTHIAN & UNIVERISTY OF EDINBURGH STAFF (REF2014)

1 Purpose of the Report

1.1 The purpose of this report is to highlight for the Board the high quality impact of research conducted by NHS Lothian substantive or honorary contract holders working with the University of Edinburgh. In particular to note the world wide reach of the impacts and the significance of many of these examples for improved quality of care in the NHS setting. See narrative on summary paper below.

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

2 Recommendations

2.1 To note the world wide reach of the impacts and the significance of many of these examples for improved quality of care in the NHS setting.

3 Discussion of Key Issues

3.1 Professor Iredale will be happy to discuss briefly in the Board meeting and off line with any interested Board members.

John P Iredale
Regius Professor of Medical Science
4 March 2015
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List of Appendices

Appendix 1: Impact of Research Undertaken by NHS Lothian & University of Edinburgh Staff
Appendix 2: Health of the Nation - The Impact of UK Medical Schools' Research -available at http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx

1.1 Impact of Research Undertaken by NHS Lothian & University of Edinburgh Staff

Summary Abstracts

Title of case study: **The GRACE risk score: a reference standard for the management of acute coronary syndrome**
Impact: Health and welfare; the GRACE risk score (derived using data from 102,000 patients with acute coronary syndrome (ACS) in 30 countries) identifies high-risk ACS patients more effectively than do alternative methods. **Significance:** GRACE is now a reference standard and has resulted in international guideline changes. It is estimated to save 30–80 lives for every 10,000 patients presenting with non-ST elevation ACS. **Beneficiaries:** Patients with ACS; the NHS and healthcare delivery organisations. **Attribution:** All work was led by Fox (UoE) with co-chair Gore (University of Massachusetts) and was developed from Edinburgh-based studies. **Reach:** Worldwide: guidelines adopted in more than 55 countries; >10,000 downloads of app.
NHS staff: Keith Fox, Kathryn Carruthers, Donald Dunbar, Royal Infirmary of Edinburgh, Edinburgh; Lewis Starkey, Fiona Bett, Wendy Osborne, Western General Hospital, Edinburgh.

Title of case study: **Avoiding ineffective statin use in aortic stenosis**
Impact: Health and welfare; a clinical trial demonstrated that statin therapy is ineffective in aortic stenosis; this informed international guidelines and changed clinical practice. **Significance**: Unnecessary statin therapy is avoided in up to 500,000 people in the UK alone, saving the NHS £169M p.a. Known statin side-effects of myalgia or hepatic dysfunction are avoided in 30,000 patients. **Beneficiaries:** Patients with aortic stenosis; the NHS and healthcare delivery organisations, the economy. **Attribution:** Newby and Boon, UoE, undertook the first investigator-led randomised controlled trial of statin therapy in aortic stenosis: the SALTIRE trial. **Reach:** Aortic stenosis affects 2% of people over 65. The SALTIRE trial results informed European and N American guidelines and have impacted the treatment of millions of people globally.
NHS staff: David Newby, Nicholas Boon, S. Joanna Cowell, Peter Bloomfield, Michelle Chui, Mauritzio Panarelli, ES Houslay, Royal Infirmary of Edinburgh, Edinburgh; A. White, David Northridge, Western General Hospital, Edinburgh.

Title of case study: **Detailed analysis of trial of lapatinib in combination with capecitabine in advanced, HER2+ breast cancer leads to marketing authorisation worldwide**

Impact: Health and welfare; additional effective therapy for women with advanced, HER2+ breast cancer.
Significance: Allows approximately 10,000 patients a year, whose disease is no longer being controlled by trastuzumab, to receive a more effective therapy than chemotherapy with capecitabine alone.
Beneficiaries: Patients with incurable metastatic HER2+ subtype breast cancer; policy-makers; commerce.
Attribution: Cameron (UoE) was joint chief-investigator on the global pivotal registration trial that led to the marketing authorisation of the drug lapatinib in combination with capecitabine.
Reach: World-wide: the drug is approved in >100 countries and generated >£650M in sales for manufacturer GlaxoSmithKline.

NHS staff: David Cameron, Western General Hospital, Edinburgh.

Title of case study: **Preventing deaths from pesticide self-poisoning in rural Asia – pralidoxime is hazardous and banning organophosphorus insecticides is beneficial**

Impact: Health and welfare; public health studies in Sri Lanka and clinical trials in a cohort of 35,000 pesticide self-poisoning patients have led to the withdrawal of high-dose pralidoxime as a WHO-recommended treatment and bans of three toxic pesticides in Sri Lanka.
Significance: Resultant changes in clinical practice and pesticide regulation have saved 3000 lives in the last four years in Sri Lanka alone; in the rest of Asia many times this as local guidelines and practice have changed.
Beneficiaries: Patients and communities, healthcare providers, policy-makers.
Attribution: Studies designed and led, with international collaborators, by Michael Eddleston, UoE.
Reach: International, particularly Asia, changes in WHO and international guidelines on pesticide use.

NHS staff: Michael Eddleston, Royal Infirmary of Edinburgh, Edinburgh

Title of case study: **Uterine artery embolisation is superior to surgery in the short term, for the treatment of symptomatic uterine fibroids**

Impact: Health and welfare; a UK clinical trial of uterine artery embolisation (UAE), with five-year follow-up, defined the risk- and cost-benefit of UAE versus surgery.
Significance: The trial informed guidelines/recommendations internationally and changed clinical practice. Women worldwide can now make an informed choice about their treatment; economic factors have been quantitated.
Beneficiaries: Uterine fibroid patients, the NHS, healthcare providers.
Attribution: G. Murray, UoE, developed and delivered innovative trial methodology; clinical aspects led by University of Glasgow.
Reach: UK guidelines; worldwide (Australia, USA, Europe) effect on clinical practice that will impact up to 25%of women.

NHS staff: .Gordon Murray, I. Gillespie, C. West, Royal Infirmary of Edinburgh, Edinburgh; C. Tay, Eastern General Hospital, Edinburgh.

Title of case study: **By defining the minimum liver remnant required, volumetric analysis is now the pre-operative standard of care in liver cancer surgery worldwide**

Impact: UoE-developed techniques to determine liver volume and define, pre-operation, the minimum liver remnant required have transformed the viability and success of liver surgery and stimulated commercial development of imaging software/hardware.
Significance: Precise functional liver volume measurement prior to surgery is now the standard of care and, for example, renders 85% of patients previously deemed irresectable to be resectable with a perioperative mortality of 2–4%.
Beneficiaries: Patients with liver cancer; the NHS and healthcare delivery organisations; imaging software/hardware companies.
Attribution: Pivotal studies were led by Wigmore and Garden at UoE.
Reach: Worldwide; technique recommended in guidelines in Europe, N America, Asia, Australasia; deployed in the management of 3600 patients per annum in the UK alone; the use of open-source software increases accessibility in developing world.

NHS staff: Stephen Wigmore, James Garden, Kenneth Fearon, Doris Redhead, Xue Yan, John Casey, Krishnakumar Madharan, Martin Schindl, Royal Infirmary of Edinburgh, Edinburgh.

Title of case study: **Diagnosis from gene discovery – developmental disorders of eye, brain, nerve and skeleton**

Impact: Health and welfare; policy and guidelines; public engagement. The identification of >20 genes linked to human developmental and childhood degenerative disorders.
Significance: Definitive diagnosis is essential for genetic counselling, prenatal screening and postnatal management.
Beneficiaries: People with developmental disorders and their families, prospective parents, the NHS and healthcare delivery organisations; public understanding of genetic disorders.
Attribution: Researchers from UoE identified/characterised all the genes described, and their mutation in disease.
Reach: Worldwide: these developmental disorders affect thousands of people. Genetic tests established as a result of the research are provided for people from 35 countries on all continents.

NHS staff: David Fitzpatrick, Veronica van Heyningen, Andrew Jackson

Title of case study: **Ovarian cryopreservation can restore fertility in women following cancer treatment that would otherwise irreversibly deny them children**

Impact: Health and welfare; policy and guidelines. Anderson and colleagues demonstrated that cryopreservation of ovarian tissue could be used for preservation of fertility following cancer therapy. This step-change has been incorporated into guideline documents internationally and has been adopted into clinical practice world-wide.
Significance: Ovarian tissue has been preserved from many hundreds of women; this is now translating into a growing number of babies born worldwide (currently 24 in nine countries).
Beneficiaries: Women at risk of fertility loss including pre-pubertal girls newly diagnosed with cancer; clinicians; the NHS and healthcare delivery organisations.
Attribution: The underpinning research was performed entirely at UoE.
Reach: Worldwide: UK, Europe, US, Australia.

NHS staff: Richard Anderson, David Baird, W Hamish Wallace, Hilary Critchley, D Stewart Irvine, K Joo Thong, Royal Infirmary of Edinburgh, Edinburgh.

Title of case study: **Reducing blood transfusions in intensive care and surgery saves precious blood, reduces costs and decreases patient risk**

Impact: Health and wellbeing; translation of a clear evidence base for reducing red blood cell use in intensive care and surgery into guidelines and changed clinical practice.
Significance: A 20% reduction in overall UK red blood cell usage between 2002–2012, saving the NHS approximately £100M annually; 7000 fewer patients are exposed to red cell transfusion annually, saving 500 lives.
Beneficiaries: Patients in intensive care units; the NHS and healthcare delivery agencies.
Attribution: Studies were led by Walsh at UoE with NHS and Canadian collaborators.
Reach: 7000 patients per year, UK-wide; incorporation into international guidelines.

NHS staff: Timothy Walsh, SS Chohan, F McArdle, SJ McKenzie, CR McIver, AP Bateman, Royal Infirmary of Edinburgh.

Title of case study: **Elective delivery of pregnant women reduces perinatal mortality, particularly in mothers over 40 years of age**

Impact: Health and welfare; healthcare guidelines on elective induction of labour. The research showed that elective induction at time points from 37 weeks' gestation progressively reduces perinatal mortality. UK guidelines now recommend routine induction at 39 weeks in mothers >40 years of age.
Significance: Implementation of the guidelines for mothers >40 years of age is estimated to prevent the stillbirth of 17 babies per year in the UK.
Beneficiaries: Pregnant women, policy makers and healthcare providers.
Attribution: The work was led by Jane Norman with Sarah Stock at UoE, in collaboration with NHS Information Scotland.
Reach: UK, Europe, North America. Applies to all pregnant women, especially those over 40 years of age.

NHS staff: Jane Norman, Sarah Stock, Royal Infirmary of Edinburgh, Edinburgh; James Chalmers, Andrew Duffy, Carole Morris, NHS National Services Scotland, Edinburgh.

Title of case study: **Progesterone does not prevent preterm birth in twin pregnancy (STOPPIT study)**

Impact: Health and welfare; public policy; the work led to UK and international guidelines advising against progesterone use to prevent preterm birth in twin pregnancy.
Significance: Thousands of women now avoid this unpleasant procedure annually, with a saving to the NHS of £25M.
Beneficiaries: Pregnant women, policy-makers, the NHS and healthcare-providers.
Attribution: The work was initiated by a five-centre UK collaborative group including UoE. Data analysis, interpretation and translation into practice were led by Jane Norman, UoE.
Reach: The data are cited in guidelines and have changed clinical practice on three continents: Europe (NICE), North America and Australasia. Applies to 11,000 women annually in UK alone.

NHS staff: Jane Norman, Sarah Cooper, Andrew Calder, Royal Infirmary of Edinburgh, Edinburgh

Title of case study: **Pharmacological and interventional therapies for acute coronary syndromes improve patient outcome**

Impact*:* Health and welfare, policy and clinical practice; randomised trial evidence has changed the management and outcome of acute coronary syndromes (ACS) globally.
Significance*:* Advanced anti-platelet and revascularisation therapies have become standards of care worldwide. There have been large (10–50%) reductions in the death rate from coronary heart disease across Europe. Clopidogrel was the second best-selling drug in the USA in 2011.
Beneficiaries*:* Patients with ACS, clinical practitioners, NHS and healthcare delivery organisations, policy-makers, pharmaceutical companies.
Attribution: Building on prior studies, Fox (UoE) and colleagues led multicentre randomised controlled trials; international trials were co-chaired by Fox with international investigators.
Reach*:* Global; guideline changes in Europe and USA; applies to the up to 5% of the population who have ACS.

NHS staff: Keith Fox, Royal Infirmary of Edinburgh, Edinburgh; TRD Shaw, Western General Hospital, Edinburgh.

Title of case study: **Defining patient needs and delivering evidence-based palliative and end-of-life care for non-malignant disease, through services that can be delivered in developed and low-income countries**
Impact: Health and welfare; evidence-based palliative care for patients with non-malignant disease beyond cancer patients and in low-income countries; influencing policy; public engagement. **Significance:** Care quality-standard changes and targeted interventions: for example, up to 50% fewer unplanned hospital admissions from nursing homes. Palliative care service development/redesign internationally; clinical tools deployed internationally. **Beneficiaries:** Patients and their families/carers; NHS and healthcare providers; policymakers including UK and international governments; medical charities. **Attribution:** The work was performed by an international team led by S. Murray at UoE. **Reach:** International; policy changes and new guidelines/service structures in 11 countries (UK, Europe, N. America, Asia, sub-Saharan Africa); applicable to all those at end of life.
NHS staff: Scott Murray, T Fred Benton, St Columba's Hospice, Edinburgh; Aziz Sheikh, Kirsty Boyd, Royal Infirmary of Edinburgh, Edinburgh; Hans Clausen, Western General Hospital, Edinburgh.

Title of case study: **Detailed epidemiological studies of people with allergy have triggered policy developments and catalysed service innovations to enhance care**
Impact: Health and welfare, policy and services. By quantifying the high lifetime prevalence of allergy, high costs and sub-optimal NHS care, UoE researchers catalysed international policy change and UK service developments. **Significance:** Investment in expanded allergy services and improved standards of care, resulting in a significant drop in global allergy-related mortality rates. **Beneficiaries:** People with allergies; GPs and emergency care clinicians; policymakers and professional bodies. **Attribution:** The work was led by Sheikh (UoE) with collaborators for national surveys. **Reach:** International. 1 in 3 people in the UK have an allergy; World Allergy Organization anaphylaxis guidelines are used in 89 countries.
NHS staff: Aziz Sheikh, Mark Levy, Kirsty Rankin, Colin Simpson, Royal Infirmary of Edinburgh, Edinburgh.

Title of case study: **Accurate epidemiological pneumonia incidence and mortality estimates have influenced child health policy to reduce global child pneumonia mortality**

Impact: Health and welfare; raised awareness of childhood pneumonia as the largest single cause of global childhood mortality, which has led to increased investment and action. Global deaths have reduced from 2.01M (in 2002) to 1.58M (2008) and 1.26M (2011).
Significance: Global child pneumonia mortality (2008–2013) showed about 1M deaths fewer than if 2008 levels had persisted throughout this period.
Attribution: Campbell and Rudan (UoE) derived global pneumonia incidence and mortality estimates as the pneumonia technical experts for the WHO / UNICEF Child Health Epidemiology Reference Group.
Beneficiaries: Young children and families, international agencies, Ministries of Health.
Reach: Global (>170 countries on all continents, especially low- and middle-income countries).

NHS staff: Harry Campbell, Igor Rudan, Royal Infirmary of Edinburgh, Edinburgh.

Title of case study: **Progesterone receptor modulators are effective in emergency contraception and therapy of heavy menstrual bleeding/fibroids**

Impact: Health and wellbeing; commerce; studies and clinical trials of the effects of progesterone receptor modulators (PRMs) underpinned their application for the benefit of women of childbearing age.
Significance: UoE studies underpinned the application of PRMs as emergency contraception including over-the-counter availability and the treatment of heavy menstrual bleeding (HMB); changed clinical guidelines; influenced Pharma R&D.
Beneficiaries: Women of reproductive age; the NHS and healthcare delivery organisations; pharmaceutical companies.
Attribution: Studies were conducted by Critchley, Baird and colleagues (UoE).
Reach: Worldwide; annually 4M women seek emergency contraception in the USA, and in the UK 1M women seek help for HMB. Drugs targeting the PR are licenced in 67 countries. Multiple global Pharma are active in the field of PRM biology.

NHS staff: .Hilary Critchley, Alistair Williams, David Baird, Sharon Cameron, Anna Glasier, AE Gebbie, H Wang, Royal Infirmary of Edinburgh, Edinburgh.

Title of case study: **Reducing the global burden of stroke by using aspirin and avoiding heparin use in the treatment of acute stroke**

Impact: Health and welfare; saving lives by determining that aspirin is an effective treatment for acute stroke and that heparin anticoagulation is ineffective.
Significance: In the UK, treating all acute stroke patients with aspirin and avoiding heparin means 1800 people avoid death or disability each year; aspirin is also highly cost-effective.
Beneficiaries: Stroke patients, the NHS, the economy.
Attribution: Sandercock, UoE, designed, led and reported the International Stroke Trial, and was on the steering committee of the Chinese Acute Stroke Trial.
Reach: Up to 15M stroke patients annually affected by guideline changes worldwide, encompassing Europe, North America and Australasia; educational events by the World Stroke Academy promote aspirin use.

NHS staff: Peter Sandercock, Richard Lindley, Martin Dennis, Charles Warlow, Joanna Wardlaw, William Whiteley, Western General Hospital, Edinburgh.

Title of case study: **Graduated compression stockings do not reduce the risk of post-stroke deep vein thrombosis (DVT)**

Impact: Health and welfare: reducing morbidity; providing evidence to disinvest in an ineffective and damaging treatment; policy change.
Significance: Since 2009, applied clinical trial findings have resulted in approximately 6000 fewer complications (e.g., skin breaks) in the UK. Stocking use has decreased by 95%, which has saved the NHS in excess of £20M per annum.
Beneficiaries: Stroke patients worldwide, the NHS and healthcare delivery organisations, the economy.
Attribution: Trials were designed and led by Professor M Dennis, UoE.
Reach: Changed national guidelines in at least seven countries worldwide (Europe, N America, South Africa, Singapore).

NHS staff: Martin Dennis, Peter Sandercock, J Reid, Western General Hospital, Edinburgh.

Title of case study: **Immediate computed tomography scanning in acute stroke improves outcomes for patients and is very cost effective, whereas arteriography and magnetic resonance scanning are not cost-effective in secondary prevention**

Impact: Health and welfare; Wardlaw's work on diagnostic imaging in stroke prevention and treatment has effected changes to clinical guidelines worldwide, prevented thousands of strokes and decreased disability.
Significance: In the UK, changes in stroke treatment consequent upon effective imaging result in 6000 more quality-adjusted life-years and save ~£300M per year. Improved stroke prevention averts 1760 strokes and saves the NHS £30M per year.
Beneficiaries: Stroke patients, the NHS and healthcare providers in other countries
Attribution: The research took place entirely at UoE.
Reach: UK, Europe, N. America, Australasia.

NHS staff: .Joanna Wardlaw, Martin Dennis, Peter Sandercock, Sarah Keir, Jonathan Best, Western General Hospital, Edinburgh.

Title of case study: **The FOOD trials: feeding policies in hospitalised stroke patients influence patient outcomes**

Impact: Health and wellbeing; improvement in mortality and morbidity; changes in policy and guidelines.
Significance: Clinical trial findings have led to 1160 fewer deaths and 780 fewer severely disabled patients each year in the UK; rationalising feeding policies saves over £12M annually.
Beneficiaries: Stroke patients, the NHS and healthcare delivery organisations, the economy.
Attribution: Trials were designed and led by Professor M Dennis, UoE.
Reach: Worldwide: revised national guidelines in UK, Europe, North America, South Africa, Singapore, Australasia.

NHS staff: Martin Dennis, Peter Sandercock, Charles Warlow, G Cranswick, Western General Hospital, Edinburgh.

Title of case study: **Evidence-based identification and cost-effective treatment of depression in cancer patients**

Impact: Improved depression care for people with cancer.
Significance: Assessment of emotional distress and evidence-based intervention to manage depression has a direct effect on quality of life of cancer patients. It may also reduce suicide attempts among them.
Beneficiaries: Cancer patients, NHS and healthcare delivery organisations.
Attribution: The work was led by Sharpe (UoE), with UoE Cancer Research Centre colleagues and collaborators in Manchester and London.
Reach: International; this work directly affected NHS practices and clinical guidelines in Europe and North America. It also stimulated international debate and new research into psychological aspects of living with cancer.

NHS staff: Michael Sharpe, Vanessa Strong, Jane Walker, K Allen, Royal Edinburgh Hospital, Edinburgh; Lucy Wall, Dawn Storey, Marie Fallon, Ann Cull, Western General Hospital, Edinburgh

Title of case study: **Medically unexplained symptoms including chronic fatigue syndrome can be accurately identified and treated**

Impact: By showing the benefits of accurate identification and targeted treatment of chronic fatigue syndrome, UoE research has influenced worldwide medical practice and stimulated public and governmental debate.
Significance: Guidelines and policy debate have resulted in improved patient treatment, with associated economic benefit.
Beneficiaries: Patients with medically unexplained symptoms, policy-makers, clinicians.
Attribution: Work conducted at UoE in a team led by Carson and Sharpe.
Reach: The research affects the more than 25% of all GP presentations who have unexplained symptoms / chronic fatigue syndrome (40% in gastroenterology and neurology). Guidelines have been changed internationally including UK, USA, Australasia.

NHS staff: .Michael Sharpe, Alan Carson, Jane Walker, Brigitte Ringbauer, Royal Edinburgh Hospital, Edinburgh; Jon Stone, D Wilks, Lesley McKenzie, Charles Warlow, Western General Hospital, Edinburgh; David Weller, Royal Infirmary of Edinburgh, Edinburgh; S Smith, NHS Lothian, Edinburgh.

Title of case study: **Diagnostic criteria for human prion disease enable case ascertainment and underpin international policy on prion disease**

Impact: Health and welfare; policy in the form of national and international guidelines; diagnostic service; engagement with patient groups.
Significance: UoE-formulated diagnostic criteria adopted by the World Health Organisation (WHO), the European Centre for Disease Prevention and Control (ECDC) and US Centers for Disease Control and Prevention (CDC), enable reliable case ascertainment and longitudinal study of disease trends. The UoE Creutzfeldt-Jacob Disease Unit acts as an international reference centre for diagnosis. Case ascertainment has improved.
Beneficiaries: Patients with prion disease and their families, policy-makers, the NHS, charities.
Attribution: The UoE CJD Unit led the work with international collaborators.
Reach: Worldwide; diagnostic criteria are WHO-endorsed and have been adopted worldwide. Pooling of data across Europe has enabled assessment of 11,000 cases of sporadic CJD.

NHS staff: .Robert Will, James Ironside, Richard Knight, David Summers, Craig Heath, Gillian Stewart, Katy Murray, Western General Hospital, Edinburgh.

Title of case study: **Identification of transmission risk of variant Creutzfeldt-Jakob disease (vCJD) via blood and blood products defines critical changes to health policy**

Impact: Changed public health policy by quantifying the level of asymptomatic vCJD infection in the population and the mechanism of its transmission, and by identifying cases of human–human transmission of vCJD via blood products.
Significance: UoE work informed the public and policy-makers of the risk of vCJD transmission, which resulted in policy changes and the implementation of precautions to prevent vCJD transmission and to limit the chance of a self-sustaining blood- or tissue-contamination-related secondary epidemic.
Beneficiaries: Patients, the NHS and healthcare delivery organisations, government, policy-makers.
Attribution: The work was carried out at UoE in the National Creutzfeldt-Jakob Disease Research and Surveillance Unit (NCJDRSU) and the Roslin Institute UoE (Roslin) with UK collaborators.
Reach: International, particularly UK and North America.

NHS staff: James Ironside, Robert Will, Richard Knight, Nora Hunter, Western General Hospital, Edinburgh; Valerie Hornsey, Ian MacGregor, Christopher Prowse, Marc Turner, Scottish National Blood Transfusion service, Edinburgh.

Title of case study: **Thrombolysis for acute ischaemic stroke is effective for a wide range of patients, including those over 80 years, and improves long-term function and quality of life**

Impact: Health and welfare; a large randomised controlled trial (third International Stroke Trial (IST)-3) and meta-analysis determined that the thrombolytic agent recombinant tissue plasminogen activator alteplase is a long-term effective treatment for acute ischaemic stroke in a wide range of patients.
Significance: Thrombolysis would result in 1488 more stroke patients being alive and independent per year in the UK.
Beneficiaries: Stroke patients, the NHS and healthcare delivery organisations, the UK economy.
Attribution: The IST-3 trial was led from UoE (Sandercock), with UoE (Wardlaw, Dennis) and University of Sydney (Lindley) colleagues.
Reach: Worldwide. Applicable to 4 million stroke patients per year; guidelines changed in Europe, N America, Asia, Australia.

NHS staff: .Peter Sandercock, Joanna Wardlaw, Martin Dennis, William Whiteley, Rustam Al-Shahi Salman, Jon Stone, Charles Warlow, Geoff Cohen, Western General Hospital, Edinburgh.

Title of case study: **Invention and commercialisation of Saccadic Vector Optokinetic Perimetry: development of visual-field testing technology and its translation to clinical practice and the marketplace**

Impact: New business, intellectual property, employment and clinical diagnostic capability resulting from the invention, development, validation and manufacture of a peripheral vision-measuring device.
Significance: A new technology, Saccadic Vector Optokinetic Perimetry (SVOP) has been developed and commercialised. SVOP enables the testing of visual fields in patients who previously could not be tested. A spin-out company, i2eye Diagnostics Ltd., raised £900K to commercialise the technology, employs five people and has made sales internationally.
Beneficiaries: Commerce; ophthalmologists, opticians and optometrists; previously untestable patients.
Attribution: UoE team comprising Professor Bob Minns, Professor Brian Fleck, Dr Ian Murray and Dr Harry Brash are inventors on the granted patent for SVOP. The UoE BioQuarter commercialisation team formed the spin-out company and recruited the management team.
Reach: Worldwide: SVOP instruments are now in use in the US, EU and Australia. The technology is suitable for the 30% of patients worldwide whose visual field could previously not be measured.

NHS staff: Robert Minns, Brian Fleck, Lai Tan, Royal Hospital for Sick Children, Edinburgh; Mary MacRae, Princess Alexandra Eye Pavilion, Edinburgh.