BOARD MEETING

DATE: **WEDNESDAY 4 FEBRUARY 2015**

TIME: <u>**9:30 A.M. - 12:00 P.M.**</u>

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

<u>Agenda Item</u>		<u>Lead Member</u>	
	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 3 December 2014	**BH**	*
1.2.	Minutes of the Special Board Meeting held on 14 January 2015	**BH**	*
1.3.	Running Action Note	**BH**	*
1.4.	Performance Management	**AMcM**	*
1.5.	Corporate Risk Register	**DF**	*
1.6.	Committee Memberships	**BH**	*
1.7.	Audit & Risk Committee - Minutes of 8 December 2014	**JB**	*
1.8.	Healthcare Governance Committee - Minutes of 25 November 2014	**MB**	*
1.9.	Finance & Resources Committee - Minutes of 12 November 2014	**GW**	*
1.10.	Strategic Planning Committee - Minutes of 13 November & 11 December 2014	**BH**	*
1.11.	East Lothian Health & Social Care Partnership Shadow Board- Minutes of 6 November 2014	**MA**	*
1.12.	Edinburgh Health & Social Care Partnership Shadow Board - Minutes of 18 July 2014	**RH**	*
1.13.	Midlothian Health & Social Care Partnership Shadow Board Minutes of 23 October 2014	**PJ**	*
1.14.	West Lothian Health & Care Partnership Sub-Committee - Minutes of 18 December 2014	**FT**	*
1.15.	West Lothian Health & Care Partnership Board - Minutes of 9 December 2014	**FT**	*

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

For further information please contact Peter Reith,☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk

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

2.1.	Healthcare Associated Infection Update	**MJ**	*
2.2.	Unscheduled Care & Winter Planning	**MJ**	*
2.3.	Consultant Vacancies	**AB**	*
2.4.	Waiting Times Performance, Progress and Elective Capacity Investment	**JC**	*
2.5.	Quality Report	**DF/MJ**	*
2.6.	Our Health Our Care Our Future 2014-2024	**AMcM**	*
2.7.	Financial Position to December 2014	**SG**	*

3. **Next Development Session:** Wednesday 4 March 2015 at 9:30 a.m. in the Boardroom, Waverley Gate.

4. **Next Board Meeting:** Special Meeting on Wednesday 4 March 2015 at 9:30 a.m. in the Boardroom, Waverley Gate, prior to the Development Session.

5. Resolution to take items in closed session

6. Minutes of the Private Meeting held on 3 December 2014   **BH** ®

7. Minutes of the Special Private Meeting held on 14 January 2015   **BH** ®

8. Matters Arising

9. **Items for Approval**

     9.1. Royal Edinburgh Hospital Phase 1 Addendum Full Business Case   **SG** ®

10. **Items for Discussion**

     10.1. Edinburgh BioQuarter   **SG** ®

11. Any Other Competent Business

Board Meetings in 2015	**Development Sessions in 2015**
4 March 2015 *(Special Meeting)*	4 March 2015
1 April 2015	6 May 2015
24 June 2015*	15 July 2015
5 August 2015	2 September 2015
7 October 2015	4 November 2015
2 December 2015	

1.1

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 3 December 2014, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

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

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: Dr M Douglas (Consultant in Public Health Medicine for item 68) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mrs K Blair 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.

57.   Welcome and Introduction

57.1   The Chairman welcomed members of the public to the meeting. He also welcomed students from Edinburgh Napier University. It was noted one of their modules was on clinical governance and previous students attending the meeting had found it useful to experience the strategic approach adopted by the Board.

58.   Agenda reordering

58.1   It was agreed to reorder the agenda to discuss the Vale of Leven Report alongside the quality report.

59. Chairman's Opening Comments

59.1 The Chairman read out a statement from Mrs Blair, Non Executive Board Member who was unable to attend the meeting. She had commented that she felt the Board had reached a critical time in terms of scrutiny and decision making. She felt whilst over the past few years the Board had been given some well argued assessments of the problems and challenges facing the organisation she felt the Board now had to step up and raise its game. She believed there was a need to make more radical decisions to effect change however unpalatable this might be to some stakeholders. Mrs Blair felt the Board should not keep repeating the same old rhetoric or accept the same reasons for non improvement. Nor should the Board accept the exercise of writing repeated reports with insufficient actions.

59.2 The Chairman commented he also wanted to make some opening remarks. He advised the Board were already aware of the tightening conditions under which health, social and community care systems were operating under. There had been a growing trend in demand and demographics through a principally aging population and the ability as a nation to simply fund that demand using the same system models as had evolved over the last 20 years was no longer appropriate.

59.3 The Chairman felt that the body of evidence for this was now accumulating rapidly from Mid Staffordshire, Francis and Keogh etc and more recently the need for investigations into performance shortcomings in Lanarkshire, Grampian and then more historically the Vale of Leven Report the findings from which would be considered by the Board later in the day. The Chairman felt more importantly perhaps that at an overall system level the last few months had seen authoritative comment and reports from the Head of the NHS in England, the Eve Commission, Audit Scotland and others which had made visible the pressures being faced within NHS Lothian. At the current meeting these issues would be discussed in terms of actions that needed to be considered against a position where the Board could not currently balance its books with other demands over the next few years.

59.4 The Board would in private session discuss in more detail further processes to enable it to reshape the healthcare system to meet these challenges. It was stressed that NHS Lothian was not alone in this endeavour.

59.5 The Chairman commented one benefit of the welter of comment in reports in recent times was that everyone in the NHS Scotland family as well as colleagues in Scottish Government, local authorities and other partners as well as politicians were working together to produce solutions. The recent announcement from the Chancellor of the Exchequer about additional resources was a manifestation of the position across the UK. The Chairman felt the current tough times might be the catalyst needed to make much more fundamental change and was therefore an opportunity to be seized upon and used to secure a better model for the future.

60. Items for Approval

60.1 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.

60.2   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.

60.3   <u>Minutes of the previous Board meeting held on 1 October 2014</u> – Approved.

60.4   <u>Performance Management</u> – The Board received the update report on the existing performance against current 2014/15 HEAT targets and other relevant standards. It approved that performance would be presented against the all Scotland position where available using published ISD data. The Board would receive performance details where information was available by partnership from 2015. The Board also agreed to replace the previous performance reporting template with focussed information as positioned within the circulated paper.

60.5   <u>Corporate Risk Register</u> – The Board agreed to use the updated NHS Lothian corporate risk register, highlights of which were contained in section 3.2.1 and summarised in appendix 1, to inform Healthcare Governance assurance requirements.

60.6   <u>Committee Membership and Terms of Reference</u> - The Board agreed to appoint Elaine Duncan, Clinical Director at St Johns Hospital to the West Lothian Community Health and Care Partnership Board to replace James McCallum. The Board also agreed to agree an amendment to the terms of reference of the Staff Governance Committee.

60.7   <u>Partnership Centre Bundle – Full Business Case</u> – The Board noted that the Finance and Resources Committee of 12 November 2014 had scrutinised and approved the full business case (FBC) for submission to the Board. The Board therefore approved the submission of the FBC to the Scottish Government Health and Social Care Directorate Capital Investment Group. It was further agreed that subject to the approval of the FBC by Scottish Government, the approval of the final terms of the project agreement and associated contract documentation be delegated to the Chief Executive and the Director of Finance for NHS Lothian or another nominated person from the Finance and Resources Committee. Additionally it was agreed that subject to the approval of the final terms of the project agreement the signing of the project agreement at financial close be delegated to the Chief Executive or the Director of Finance for NHS Lothian. <u>The draft minute of approval for delegated authority is attached as an appendix to the Board minute</u>.

60.8   <u>The Third Joint Health Protection Plan 2014/16</u> – The Board supported the implementation of the Third Joint Health Protection Plan 2014/16, in collaboration with local authorities as required by the 2008 Public Health (Scotland) Act.

60.9   <u>Healthcare Associated Infection Update</u> – The Board acknowledge receipt of the Healthcare Associated Infection reporting template for October 2014 (appendix 1). It was noted that NHS Lothian's staphylococcus aureus bacteraemia March 2015 target was a rate of 0.24 per 1000 bed days (≤184 incidences). The current rate was 0.33 (152 Incidences). Multidisciplinary effort was required if progress towards the target was to be sustained.

60.9.1 The Board further noted NHS Lothian's clostridium difficile infection target by March 2015 was to achieve a rate of 0.32 per 1000 bed days (≤ 262 incidences). The current rate was 0.51 (245 incidences). NHS Lothian was currently off trajectory therefore a pan Lothian multidisciplinary effort was essential if the target was to be delivered.

60.9.2 The Board noted the publication of the report of the Vale of Leven inquiry on 24 November 2014 which would be discussed in further detail later in the meeting. The Board supported the antimicrobial team activities in relation to the antimicrobial prescribing review and the reduction of antimicrobials associated with clostridium difficile.

60.9.3 In conclusion the Board supported the delivery of the actions outlined in the report and action plan provided to the Corporate Management Team in relation to clostridium difficile.

60.10 <u>Audit and Risk Committee – Minutes of 29 September 2014</u> – Adopted.

60.11 <u>Finance and Resources Committee - Minutes of 27 August and 27 October 2014</u> – Adopted.

60.12 <u>Healthcare Governance Committee – Minutes of 23 September 2014</u> – Adopted.

60.13 <u>Strategic Planning Committee – Minutes of 9 October 2014</u> – Adopted.

60.14 <u>East Lothian Community Health Partnership Subcommittee – Minutes of 13 August 2014</u> – Adopted.

60.15 <u>East Lothian Health and Social Care Partnership Shadow Board – Minutes of 4 September 2014</u> – Adopted.

60.16 <u>Edinburgh Community Health Partnership Subcommittee – Minutes of 13 August 2014</u> – Adopted.

60.17 <u>West Lothian Health and Care Partnership Subcommittee – Minutes of 9 October 2014</u> – Adopted.

60.18 <u>West Lothian Health and Care Partnership Board – Minutes of 7 October 2014</u> – Adopted.

61. Items for Discussion

62. Unscheduled Care and Winter Planning

62.1 The Board noted that unscheduled care performance against the 4 hour standard for the month of October had been 92.62%. The November position had reached 94% with the current performance being almost 95%. It was noted there had been increased attendance since August 2014 and this continued to be sustained despite the festival being over. This however had not translated into a corresponding increase in admissions. It was noted that the 94% performance level for November had been positive given the background of patient flow and

delayed discharges. It was noted that the circulated report detailed the work being undertaken with local authorities and other partners to mitigate the delayed discharge position.

62.2   The Board were reminded of a previous request for more information around 12 hour breaches and the reasons for these. This information was provided in the circulated paper with it being noted a specific workshop session was being held in December to look at how to improve the position.

62.3   In terms of winter planning it was noted a winter plan was produced each year to reflect increased attendance and admissions in January / February and March largely from respiratory and orthopaedic trauma patients. Each year beds were added to increase bed capacity to cope with winter demand and the details of these were provided in the appendix to the Board papers. It was noted over the course of the year that beds had closed in Corstorphine and the Astley Ainslie Hospitals and had moved to better accommodation at the Royal Victoria Hospital. There remained a significant number of open but unfunded beds within the system. The net position was that there were more beds in the system than had been the case in the previous year. The Board noted although there were some additional beds available at the Astley Ainslie Hospital that these would only be opened in extremis as a backstop position and on the authority of an Executive Director. It was felt the system was better placed than had been the case in the previous year.

62.4   The Hospital at Home and Discharge to Assess Model was welcomed although assurance was sought that packages of care had appropriate safety elements embedded within them. The Board were advised the number of packages of care were increasing and were starting to show benefits in providing improved flow within the acute sector. It was stressed patient safety was of paramount importance and that public health colleagues were engaged in providing training and support. It was pointed out however that hospital to home only provided a short term solution with there being difficulty in passing patients onto appropriate care settings and this caused reablement and rehabilitation services to get silted up. The chronic problem was the availability of mainstream capacity particularly within Edinburgh and work was continuing with local authorities to address this.

62.5   The point was made there was a need for a rigorous evaluation of the interventions that could be undertaken to stop people being admitted to the acute sector. This would provide details of effective interventions that could be focussed upon. There was also a need to consider the effectiveness of national campaigns. The Chief Executive concurred advising that he and other colleagues had met with the Chair of the GP Subcommittee about primary care input into the January 2015 Board Development Session. He commented on the need to increase community care capacity to avoid admission to the acute sector and facilitate discharge. A key issue would be to consider how to get rapid deployment of carers into the community setting especially out of hours to avoid people being admitted into hospital in the first instance.

62.6   The question was raised in respect of nursing home availability whether this related to capacity or funding. It was noted the fundamental issue was that the model was around reablement. There was rapid deployment of council staff for initial intensive care. However there were capacity issues downstream in terms of the ability to recruit staff as well as local authorities having the ability to fund the capacity in any event. There was a possibility of closing beds and poor facilities and deploying

some of this resource to community processes with the residue being used to support the bottom line in financial terms.

62.7   The Board were advised in respect of home care provision within the City of Edinburgh Council that the previous administration had taken the decision to move from a 50% inhouse 50% outsource model to a 25% inhouse 75% outsource model partly with a view to reducing costs. It was noted the 75% provision was largely provided by commercial organisations with terms and conditions of workers having been driven down to the minimum wage and this was leading to the current recruitment problem. The council had taken a decision in the current year to increase payment to outsourcing organisations to £15 p/h rising to £15.50 p/h if capacity could be increased. There was evidence this approach was working although progress was slower than would be wanted. There was an additional issue in getting care workers to go to some parts of the city because they did not receive travel expenses.

62.8   Discussion ensued around the risk appetite in respect of the winter plan given funding and the availability of open beds within the system. The point was made there were currently unfunded beds open within the acute sector to maintain patient flow. Other beds were open and funded until the end of March 2015 at which point it was planned that they would close although in previous years this had proved to be difficult to execute. It was noted however plans and improvements would be made over the next few months to ease the closure process. In the meantime in order to protect patient safety when there were more patients than available capacity the decisions about opening additional beds without funding would be escalated to Executive Director level.

62.9   There was some disappointment expressed about the need for a winter plan with there being a view there should be a long term strategy to address spikes in activity in conjunction with the integration proposals and local authorities. The Board were advised plans for in-year surge capacity were being discussed and would in part be around how acute beds would need to be remodelled in future as some of the big surge events happened outwith winter.

62.10   The proposal to put resource and capacity into the community rather than acute beds was welcomed although detail was sought around the timescale for this to happen given it went to the heart of issues around patient flow and cancellation of electives. It would be important however not to close beds before community capacity was established in the primary care and third sector.

62.11   The Chief Executive commented in relation to the previous point that one of the key reasons for the establishment of Integration Joint Boards (IJBs) was to drive locally focussed fundamental change. Current demographic issues required acute beds to operate between 40 and 50% more effectively. In many instances there was little prospect of closing acute beds and transferring resources and in reality there was probably a need for more beds. The focus would therefore have to be on rationalising the estate to move to a more radical model of discharge to home for reablement and assessment with support workers being provided on a peripatetic basis into peoples home. If this type of model was successful this would release resource for investment elsewhere which would still be dependant on the ability to recruit staff in primary, community and social care. It was noted over the next few years the development of capacity would remain a challenge because of the increase in costs in the acute sector and the need to make financial savings.

62.12 In conclusion it was felt that the challenges were not bridgeable by radical redesign alone and would require additional investment as referenced by the Chancellor of the Exchequer statement around extra resources. The point was made although it was not possible to control the availability of additional investment it was possible to start work on the radical redesign process. It was noted the position was not solvable solely by the NHS Board and would need input and engagement from the IJBs.

62.13 The Board were advised of the Cosla care for the elderly report which focussed on the development of carer pathways and community investment in step up / down beds. It was noted that at the Cosla leaders meeting the previous week commitment had been made to a delayed discharge target of 72 hours for patients after they were fit to leave hospital as the benefits of this were evidence based. It was noted that both national and local government recognised that service provision could not continue in the same mode and would need radical decisions. It was suggested that IJBs needed to come up with the radical decisions and the challenge for national and local government would be around the funding of these proposals.

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

63.   Workforce Risk Assessment

63.1 It was noted that the recruitment challenges detailed in the circulated paper were not new and the Board noted that the Scottish Government had written to all Boards detailing a proposal for training fellowships which could be used to help sustain the medical workforce. It was noted that NHS Lothian had submitted 15 applications for a range of specialties and if successful these posts would support the out of hours service and enable trainees to acquire additional skills. It was noted that the outcome of the application process would not be know until the new year.

63.2 The Board noted that the Lothian Medical Workforce Group continued to meet with a continued focus on ensuring and demonstrating safe and appropriate staffing levels. The Director General of NHS Scotland had written to Boards to ensure that junior doctor hours of working were both European working time compliant and represented a safe working pattern.

63.3 Reference was made to a recent British Medical Association (BMA) comment that 1 in 10 consultant posts were vacant. It was noted that a paper was being prepared for the Board in terms of vacancies and recruitment. It was noted within Lothian there were 1200 trained medical staff with 44 vacancies although this might be an understatement given that the deployment of long term locums was not identified. In terms of trainees there were 30 vacancies out of around 1000 posts.

63.4 The Board noted within medicine of the elderly that efforts were continuing to recruit to training grade and career grade staff across all sites. Emergency medicine was no longer regarded as a specialty at risk and that the production of an internal website had been successful in assisting both recruitment and the delivery of good care to patients.

63.5 The point was made that the long term planning for medical staff remained a concern with it being felt that the use of 6 locums was a significant number. The point was made that there appeared to be a fundamental issue in the planning process in respect of the fact that recruitment to medicine of the elderly was less than optimal. The Board noted that this was a national issue and not specific to NHS Lothian.

63.6 The Board were reminded that the number of medical trainees in total and within specialties was capped by government and was therefore outwith the control of individual health systems. The point was made that 90% of care was delivered within the primary care sector and that the Board had yet to have sight of a primary care workforce risk assessment with there being a feeling that there was a need for this to come forward in similar vein to the acute papers. The point was made that the securing of information to produce such a paper was difficult. Reference was made to a recent article from the BMA which had stressed that the crisis in GP recruitment must be tackled to ensure patients received the care they needed. The BMA felt that UK medical schools needed to recruit more students with an interest in following a career in general practice as currently little more than 1 in 10 students entering medical school wanted to become GPs.

63.7 The Medical Director whilst acknowledging that the availability of information was difficult would consider how best to bring back a paper to the Board to address the fundamental capacity issue in primary care.

63.8 The Board were reminded the solution was not always around creating additional training posts as currently the health system was unable to fill all posts available to it. It was pointed out that a different medical workforce was emerging with new trainees being reluctant to apply for jobs in hard pressed specialties which operated on a 24/7 basis or specialties that had a heavy front door workload. There were now more female doctors resulting in more maternity leave with a future prediction of less full time working with a subsequent need to employ more doctors to make up for the trend towards less than full time working. The Board noted that the implementation of the Greenaway Report on the shape of training would pick up on these issues and would promote a larger cohort of generalist doctors to work in the community. It was noted in respect of the Greenaway Report that a series of scoping groups had been established to consider the implementation of the conclusions of the report which would lead to a new model of post graduate training.

63.9 The Board noted that the paediatrics rota at St John's Hospital was covered for December although it continued to be heavily reliant on a small number of staff doing additional night and weekend shifts to cover rota gaps. The Board noted in respect of overseas trainees that once they had undertaken their initial training the expectation was that they would move back to their home countries.

63.10 The Board noted that sustainability of services in the future would also include the requirement for changes in the skill mix of the wider workforce to develop roles that could be covered by non medical staff through appropriate training. It was noted that conversations were already being held with service areas in respect of developing alternative models of staffing.

63.11 The Board noted that due to the recruitment of 17 A & E medical consultants that this specialty was no longer regarded as at risk. The point was made however that

within obstetrics there was a need to appoint an extra 10 consultants at a cost of £1.5m to achieve a sustainable rota with no other additional service benefits. The acute sector therefore was requiring extra resources to simply achieve a standstill position. The need to regularise the terms and conditions within rotas across NHS Lothian was discussed.

63.12   The Board noted the recommendations contained within the circulated paper.

64.   Waiting Times Performance, Progress and Elective Capacity Investment

64.1   The Board noted that the paper in front of them was in similar format to previous submissions. It was noted that difficulties in cystoscopy capacity relating to consultant availability was responsible for the majority of those waiting for key diagnostic tests at the end of October with 710 scope patients waiting more than 6 weeks. Steps were in place through the use of junior doctors and a nurse cystoscopist to attempt to mitigate this position.

64.2   The Board noted that the position in respect of outpatient waits was as a direct result of a refocus earlier in the year on electives. It was anticipated that this position would stabilise towards the March target.

64.3   The Board were advised that TTG compliance would not be achieved by the end of December although assurance was provided to the Board that the trend was a reducing one.

64.4   The Board noted there were 2 significant reasons for the unscheduled care adverse performance. It was noted in terms of unscheduled care that performance had been impacted upon by the ability to admit patients on the day of surgery as a result of people arriving at the front door of the service for treatment. It was noted that the previous Delivering For Patients plan had not recognised the subsequent impact on patients scheduled for elective care. In some instances people had been cancelled on 2 or 3 occasions. An algorithm was being developed to categorise the risk around patients arriving at the front door and elective surgery and work continued on this. It would be important in future to ensure patients were discharged from surgical beds. The issue would be addressed further at a forthcoming Healthcare Governance meeting.

64.5   The Board noted that the success in a series of recruitment initiatives over the previous 8 months had been compromised by either not attracting applicants as was the case in gastroenterology or not being able to identify suitable candidates to shortlist as had been the case in orthopaedics, ophthalmology and plastics. In addition where appointments had been made there was a long lag time until individuals became available in post (anaesthetics and ENT).

64.6   The Board noted that it had been further to this analysis and the impact of the most recent capacity losses that had resulted in NHS Lothian advising the Scottish Government that the Board would not meet the TTG target in December.

64.7   The Board noted that as a consequence of the inability to create internal capacity that there had been a requirement to shift activity to the independent sector, engage the use of locums and agency staff as well as creating waiting time initiatives in order to sustain the position. In terms of the financial position it was

noted that if current trends were to continue then based on month 6 figures this would result in a £4m deficit to the end of March 2015. It was noted in particular that the £2.5m cost of cancelled electives had not been included in the delivering for patients plan and this was a key driver in respect of the £4m deficit. It was noted if the £4m was not available then this would result in a deterioration of the 12 week position with the core team currently considering how to minimise this.

64.8   The Board noted that these issues had been subject to extraneous processes of management and clinical engagement to deal with the 2 issues which had not been categorised in the delivering for patients plan. It was still felt however that the process was sound and that if the additional investment could be obtained then the downward trend previously experienced could be continued. It was noted that the issue of the additional £4m investment would be discussed later on the agenda as part of the finance paper.

64.9   The Board were advised in respect of a question about contact with the Scottish Government that they had been notified of the inability to meet the TTG target by the end of December although it was clear that there were no resources held by the Scottish Government that had not been previously issued for delivering for patient purposes.

64.10   The Chairman commented that underlying performance and funding issues were now being openly discussed with Scottish Government colleagues. The point was made by a Non Executive Board member that given that TTG was a legally binding target that there might be some financial leverage available with the Scottish Government.

64.11   The Board welcomed the open description of the problem and noted that during the patient safety walkabout process that participants had heard from patients and staff about the significant distress caused by the impact of elective cancellations. It was noted that the senior oncology nurse had volunteered to participate in a review of the front door process to assist in freeing up beds. It was recognised that distress and frustration amongst both patients and staff was tangible and that that there was a clear willingness for people to engage in order to do things differently. It was reported that other models of care were being worked on to reduce workload to allow medical staff to focus on the issues that only they could undertake.

64.12   The point was made that the paper clearly demonstrated difficulties in meeting the target and the requirement for an additional £20m worth of investment. It was noted however that there was also a requirement for £20m to build capacity in primary care premises. The point was therefore made whether NHS Lothian had £40m available to deliver against these targets. The Chairman commented that this referred back to his introductory comments about this being the opportune time to deliver plans to resolve these dilemmas.

64.13   The Board noted that it had been useful to receive the forecast of timescales to reduce the tail of waiting lists although the question was raised whether there was the available capacity to deliver on the target. It was pointed out that the purpose of the delivering for patients plan had been to create core capacity with the intention being that by October this would have been enhanced to deliver activity. The extenuating circumstances around cancelling electives and recruitment difficulties had been largely unexpected and had impacted on the overall position.

64.14 The Board were advised that the delivering for patients plan would allow the Board to deliver down to 12 weeks. The suggestion was made that in order to be confident about delivery to the 12 week level that performance really required to be focussed around 10 and 11 weeks and the system was not currently resourced to achieve this. The point was made that the key issue was not just about TTG delivery but the lack of sufficient core capacity. It was reported that if the additional investment was not provided then this had the consequence of building up a backlog of referral patients. The Board noted that there were around 3000 elective patients processed each week and that the backlog of 400 required to be seen within the context of an annual throughput of 150,000. It was recalled that at the beginning of the process the backlog had peaked at 2000 patients waiting more than 12 weeks with the position having reduced down to around 400. The point was therefore made that if the £4m was not invested then the system would move back to the same position as it had started from. The Board were reminded that even if no additional investment was available then the patients would still require to be treated.

64.15 The point was raised in respect of the pilot of evening list work at St Johns Hospital in general surgery about whether other initiatives were being offered to existing consultants to take on additional clinical sessions. It was noted there was a discrepancy with some post holders having 12 sessions available whilst newer recruits only had 10 sessions available. It was reported that the introduction of evening lists had been to address an ambition to use fixed assets more flexibly. The limiting factor was the availability of resources although the pilot had been carried out to test the theory. To formalise this approach would require changes in both consultant job plans and theatre dynamics. An attempt had also been made to bring into use modular capacity. The Board were also advised of work in progress around the provision of plastic surgery and oral maxillofacial surgery. The Board noted consideration was being given to expanding job plans in some specialties although there still remained issues about anaesthetic availability.

64.16 The Board noted if the £4m of investment was agreed following discussion under the finance paper then this would be utilised largely in the independent sector and by the delivery of additional waiting list initiatives.

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

65. Quality Report and Vale of Leven Report

65.1 The Board agreed to subsume the discussion around the quality report and the Vale of Leven report into a single topic.

65.2 The Board noted that a number of the issues reflected in the quality report were also covered elsewhere in the consent agenda with particular reference being made to the c-difficile position in relation to the Vale of Leven report.

65.3 The Board noted that the position around medical readmissions to St John's Hospital was no longer an outlier based on the last 2 quarters of data from the Information Services Division (ISD). It was noted that the West Lothian Pathways Collaborative were supporting patients at home. Other successful initiatives were being undertaken within the hospital environment to improve the interface between hospitals and primary care and the need to support people in the community.

65.4   The Board noted that the NHS Lothian length of stay was shorter than the rest of Scotland. NHS Lothian appeared to be an outlier for surgical readmission for both 7 and 28 days. The two hospitals contributing to this were the Western General Hospital and the Royal Infirmary of Edinburgh. It was advised that when looking at this data over time there were no underlying trend changes in the data although the Royal Infirmary of Edinburgh for the quarter January to March 2014 was a statistical outlier for both 7 and 28 days.

65.5   The Board noted that the number of formal complaints remained stable although a subset of these were prison service related and accounted for a large number of the overall complaints. The Board noted that a review of the internal complaints process was under review.

65.6   The Board were advised in respect of older people in acute care that the Health Improvement Scotland approach had changed and they were now reviewing their inspection process with a view to being seen much more as enablers to ensure that inspections were for the sustained improvement of the service.

65.7   In respect of patient complaints the question was raised whether the Board could have sight of the nature of complaints in order to improve understanding. The Board were advised that a review of the complaints function 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. An update was provided in respect of the availability of information around patient experience work which would report to a forthcoming meeting of the Healthcare Governance Committee.

65.8   In terms of the Vale of Leven report it was noted there were no specific recommendations for the Board at this point. Reference was made however to the Health Care Associated Infection Update Report in the consent agenda and in particular NHS Lothian's c-difficile performance as discussed at previous Board meetings and the Health Care Governance Committee. It was noted that NHS Lothian would fail to meet its target.

65.9   The Board noted that the Vale of Leven report had been published on 24 November 2014 in relation to incidents that had occurred in 2007/08. It was noted there had been a significant outbreak of c-difficile with 34 patients having this identified as a cause of effect on their death certificate. It was noted that the substantive report as well as an executive summary had been circulated with the Board papers.

65.10 The Board noted that although some of the key recommendations in the Vale of Leven report required national changes the vast majority related to Health Boards in particular. It was noted that progress in respect of addressing the Lothian position around c-difficile had commenced in advance of the Vale of Leven report having been issued with the current focus being around a change in the antimicrobial prescribing policy. The Vale of Leven report was being scrutinised in detail in order to identify issues that required to be addressed by NHS Lothian. An update report would be provided to the Health Care Governance Committee in January and thereafter to the Board in February with if appropriate a detailed report on how to improve the position in Lothian.

65.11 The Board noted that there would be issues around the Vale of Leven report in respect of the estate and assets and this would need to align with work on the reconfiguration of beds with an important aspect being how the system would respond to these outcomes. Work was also underway in respect of the chain of governance primarily in order to provide assurance of appropriate escalation procedures as this had been an issue raised in the Vale of Leven Report.

65.12 The Board noted that in recent months the Chief Executive had chaired an internal Patient Safety Experience Action Group which met every fortnight to focus on specific issues like complaints and c-difficile. In addition the Corporate Management Team also explicitly focussed on patient safety and the importance of addressing any emerging issues.

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

66. Financial Position 2014/15 and Forward Look to 2015/16

66.1 The Board noted there had been significant media coverage around the NHS UK financial position. In preparing the finance paper there had been an awareness that there might be an announcement of additional resources by the Chancellor of the Exchequer. However the Director of Finance did not think that this would fundamentally change the financial position that NHS Lothian faced.

66.2 The Board noted Lothian staffing levels and the use of bank and agency staff were higher than the rest of NHS Scotland because of the paramount requirement to protect patient safety thereby requiring recruitment to ward areas. It was noted that Lothian was also in a position where it was able to recruit staff whereas other parts of the NHS had more difficulty in doing so and this reflected in their more positive financial position. It was noted that Lothian in addition to staffing issues also had to develop staff capacity to deliver waiting time targets and to address the lack of physical infrastructure. It was noted that until appropriate theatre capacity was in place then there would be a requirement to pay premium rates in the independent sector and this was also a disproportionate cost that NHS Lothian had to bear in comparison to other health systems. To compound the position further NHS Lothian also had a higher level of delayed discharges and this represented and reflected itself in the number of temporary beds open which also had an impact on the financial performance of the system. There was also an increased difficulty in delivering recurrent Local Reinvestment Plan (LRP) as well as pressures on drug costs.

66.3 The Board noted that in looking at the financial pressures across the system that these were demonstrating a significant impact for financial year 2016/17 largely as a consequence of the level of uplift from the Scottish Government at 1.8% as well as the impact of the National Resource Allocation Committee (NRAC) formula changes and the uplift required in employers pensions costs. It was noted that at the previous months Finance and Resources Committee it had been reported that the financial plan was not in balance. It was noted that normal practice would be to report back to a further meeting of the Finance and Resources Committee before coming forward to the Board with details of the financial plan. In this current year however it had been felt by the Finance and Resources Committee given the nature of the position that the details around the financial plan should be reported

as soon as possible to the full Board.   The Board noted therefore that the paper before it encapsulated the totality of the financial position.

66.4   It was reported that through the midyear financial review process and prior to the month 7 outcomes becoming available there had been reasonable confidence that NHS Lothian would deliver a breakeven financial position based on a number of actions around additional reserves and a rates rebate around which a letter of comfort had been issued by advisors. It was noted however the month 7 financial position had been extremely adverse with a movement in month of £2.7m after feeding in non recurrent support. This therefore made the current years position fragile and this had been discussed with the Scottish Government. It was noted that the introduction of a single new hepatitis C drug would cost the NHS Lothian system £5m this year alone.

66.5   The financial position had been discussed in detail at the Corporate Management Team meeting where a number of actions to slow down the trend of expenditure without paralysing the system had been discussed and this included a risk assessed approach to future recruitment.

66.6   It was noted that in the financial plan cognisance had been taken off unscheduled care and winter planning requirements although such capacity had used up significant resource. It would be important therefore for the system to close beds to timescales previously agreed. It was felt that issues around the previously referred to waiting times investment of £4m were different as there was an element of choice. Therefore given the lack of confidence around delivering financial balance it was proposed to pause this investment until the month 8 figures had been analysed before deciding how much if any of the £4m could be released. The Board noted that the ambition still remained to achieve financial breakeven if the spend rate in the system could be slowed sufficiently.

66.7   The Board noted that the draft 2015/16 financial plan was based on estimated numbers and was therefore subject to change although it was felt to represent a reasonable assessment of the position. It was noted that the system would carry forward a much larger recurrent deficit than desirable and there was a need to find out how much of the overspend was recurrent. It was felt that £26m was a reasonable assessment of what the carry forward would be into the following financial year. It was noted the system had no choice other than to meet the additional costs associated with pension changes, pay uplifts, drugs and inflation.

66.8   It was noted that under normal circumstances the gap between income and expenditure would be covered through the LRP process. It was not considered credible to adopt this approach for a sum potentially in the region of £73m and in that regard it had not been possible to advise the Finance and Resources Committee that the system would produce a balanced financial position. The Board were reassured that the financial outcome would not be at the quantum previously reported as the system would generate efficiency saving at a level currently assumed at £25m.   In addition there would be non recurrent resource benefits possibly of around £15m although this still left a gap of around £30m to be addressed. The statement from the Chancellor of the Exchequer around additional resources would provide some benefit although it was not yet possible to understand how this would translate recurrently and non recurrently. In addition it was thought that there might be some benefit around the pension position. The Board were advised that even if financial sustainability was delivered in the

following year this would mean that NHS Lothian would be one of the Boards moving out of recurrent balance and this had the potential to destabilise the system. It was stressed to the Board that currently a sustainable balanced financial plan was not available.

66.9 The Board noted that it would be important to establish IJBs to start to deliver the changes that would be needed in order to generate savings as there were no quick wins left. The only option was to make more broader more innovative redesign savings.

66.10 The Board noted the intention to undertake a diagnostic review to determine the efficiency of the system. It was noted that NHS Lothian had a lot of data but not a lot of information. It was noted that the diagnostic review work was proposed to be co-sponsored with the Scottish Government with the focus being to undertake an intensive review within 1 or 2 areas. One such area was to review cancer services prior to progressing to an expensive new capital build solution. It was noted that the process of diagnostic review had been discussed with clinical colleagues who were happy to support the process. Discussion had also been held about the establishment of a Clinical Change Cabinet to help to support and deliver the necessary change required to sustain the service and the financial position moving forward. It was reported that work continued through the Efficiency and Productivity Group as it was still felt that there was further work that could produce savings around issues like production kitchens, drugs and waste.

66.11 The Board noted that the immediate challenge was how to deliver the 2015/16 LDP that was designed to deliver both patient quality and financial balance as well as reaching other national targets. It was felt there was further work needed on scenario planning without compromising patient safety and national targets.

66.12 The Chairman commented that the private session would contain more specific debate.

66.13 The point was made by a Non Executive Board member that this paper in addition to a number of other papers discussed at the current meeting represented an ever worsening situation both in financial and performance terms. The question was raised about whether the message was that the system was no longer able to run a quality heath service with the finances available to it. The Director of Finance commented that the key issue was that the service could not be delivered in the same way as it had been in the past and that there was a need for significant and radical redesign. The Board noted that the UK and Barnett consequentials would have an impact on the financial position. It was noted that analysis in NHS England had stated that there was a need for radical reform and additional investment and that this was not a neither nor solution. Reference was made back to the obstetrics position where an additional 10 extra consultants were required for the system to stay still therefore demonstrating the requirement for additional money to maintain the status quo. It was noted that the National Institute for Clinical Excellence had undertaken a review of evidence around the safety of planned home births which had concluded that it was safe for significantly more home births to be undertaken and this represented significant service redesign over the current model of provision. The point was made that the main costs for NHS Lothian were around staff, buildings and drugs. Therefore the only safe way to reduce expenditure was to reduce spend in these key areas.

66.14   It was reported that during a primary care leadership walkaround event the previous day that the comment had been made that it was difficult to know where to get support in primary care to progress ideas and suggestions around innovation. The point was made it would be important to ensure that processes were put in place in order to receive these innovations and deal with the system in a connected manner.

66.15   The Chair of the Finance and Resources Committee advised that normally the paper before the Board would not come until the following calendar year. However following discussion at the Finance and Resources Committee there had been sufficient concern about the financial position and a view that it required to be discussed on the full Board agenda as the current position was not sustainable. It was felt that the solution required a combination of redesign and efficiencies and investment and the Finance and Resources Committee felt it required to send that message to the Board.

66.16   The Board noted that the Finance and Resources Committee had discussed the availability of internal resources and skill to support the redesign process. The view had been reached not withstanding the financial position that there was perhaps a need to engage some limited external support for clinical and management teams. In particular dedicated project support to drive proposals through the system was felt to be important. The Finance and Resources Committee had been of the view that there was a need to carve out both funding and other resources to allow the challenge to be unlocked and to support redesign through leadership. In terms of the request for £4m of additional investment for unscheduled care it was felt that the system might be at the point where it had to accept that it would not meet the target because the additional funding was required elsewhere.

66.17   The point was made as had previously been the case that the level of unmet LRP had increased year on year to the point where some people felt that it could not be delivered.   The question was posed about whether there would be benefit in adopting a segregated LRP approach as happened elsewhere.

66.18   The Board noted that the Finance and Resources Committee had taken the information it had received around the financial position seriously. The point was made by a Non Executive Board member who was also a member of the Finance and Resources Committee that in respect of the £4m investment requested for unscheduled care that he was personally less concerned abut the specifics of the delivering for patient programme as he was about the issues it demonstrated in terms of patient safety. He commented that he felt it was unacceptable that people were having their operations cancelled and that therefore the £4m worth of investment should be provided. He commented that he did not feel that the Board would achieve financial balance this year nor the next year and that there was a need therefore to make this point to the Scottish Government. The Chief Executive advised that at civil service level there continued to be debate with the Scottish Government about the ongoing financial performance. He reminded the Board that there were only 2 legal statutory requirements placed upon the Board the first was to achieve financial break even and the second was the legal requirement to treat patients within 12 weeks.

66.19   The Chief Executive commented given the above there was a need to discuss the £4m investment sought for the delivery of waiting times. He stressed the issue was not about spending this sum to deliver and hit the target as the system was

currently not meeting the target nor had it done so in the past. He stressed there were around 400 – 500 patients per month who were not treated within target. Therefore in order to maintain the position at 400 – 500 patients over the next few months there would be a need to treat around 1400 patients who without the additional investment would go untreated. This would result in an unsustainable backlog being created of patients who would still require in any event to be treated. The investment of £4m was therefore about avoiding a backlog.

66.20   The Board noted that the City of Edinburgh Council Health and Social Care budget was predicting a £5.3m overspend for a number of reasons including pressures on home care. The Finance Committee had demanded that this position be brought back in line and this would require stopping areas of work that would have an impact on the NHS.

66.21   The Board requested that the Chair should write to the Cabinet Secretary to ask her to take on board the concerns raised by the Board. It was noted in terms of the investment required that the Scottish Government now had the ability to borrow which it had not previously had and the idea should be floated that this would be one of the projects that would benefit from this type of borrowing investment. The Chief Executive and Chair would discuss how best to progress this communication.

66.22   The point was made that the Board had already received an advance of £10m of brokerage from the Scottish Government to deal with the waiting times backlog and this had largely been spent in the independent sector. It now transpired an additional £4m was required with the question being raised about what this would buy in NHS Lothian's own wards. The question was posed about whether it would be possible to incentify NHS Lothian's own staff. The Board was advised that around £14m was being spent currently in the independent sector. The reason for this spend was that the internal system did not have sufficient capacity to deal with the current activity levels. The delivering for patients plan had been intended to deliver capacity and this had ultimately been comprised by the inability to recruit and build capacity. It was noted the paper discussed under the waiting times performance, progress and elective capacity investment part of the agenda had categorised the impact of reduced levels of investment. It was recognised the position was complex and only once a decision had been made around the investment would it be possible to map the real consequences to the system.

66.23   The suggestion was made by a Non Executive Board member that there was a need to send a message to the Cabinet Secretary that it was not sustainable to keep spending money in the independent sector. The Chief Executive stressed that the £10m of bridging was an upfront payment of money that NHS Lothian would have received in any event.

66.24   The Chairman commented that the detailed debate had raised a number of points which would be debated further in the private session.

66.25   The Board agreed the recommendations contained in the circulated paper with the exception of recommendation 2.2. It was noted given the caveats and questions raised that there was a need for a process to be agreed around the release or otherwise of the £4m investment following the month 8 financial result being posted. The Board agreed given the risk of delaying a decision which would lead to a backlog of patients that the decision on the investment would be delegated for consideration to the CMT.

67.   Local Access Policy Audits

67.1   The Board were reminded that following the April 2014 paper which had changed the local access policy it had been agreed that the Board would receive an audit specifically around the change of a reasonable offer period from 14 to 7 days.

67.2   The Board noted that audits had been conducted around mail delivery times, telephone call activity, period of notice provided on written offers and patient satisfaction on notice period provided.

67.3   It was noted that improving communication to patients had also been reviewed in terms of information provided on outpatient letters and leaflets as well as information provided to patients with additional needs.

67.4   The Board noted that the review of progress by access, performance and governance had concluded that ongoing oversight was required in the above areas to be assured that patients received the necessary information clearly and in good time.   It would therefore remain a topic at monthly management meetings and progress in these areas would subsequently be discussed at the Acute Hospitals Committee.

67.5   Specifically it was noted that performance on mail delivery had been around 80% although 9% of letters had not arrived and discussions were ongoing with mail providers in this regard.   The internet capacity was being augmented to inform patients that they had a message that was ready to be picked up.   Consideration was also being given to electronic transmissions of information to patients building on proof of concept work undertaken 18 months previously.   A national project was underway and NHS Lothian would be at the frontend of that process.   It was noted if adopted in full this would reduce the correspondence transmission time to zero.

67.6   It was noted that the Director of Scheduled Care would chair a project team to drive forward initiatives over the next 18 months with the anticipation that it would take 2 years to full implementation.

67.7   The Board noted that the contents of the telephone protocol had been examined particularly in respect of concerns around delayed calls.   It was noted the Royal Hospital for Sick Children had been identified as an outlier and once this had been examined a technical issue had been identified which had now been resolved.

67.8   It was reported given that written offers relied upon the postal system, the Access, Performance and Governance Group had agreed that written offers should not be sent to patients less than 10 days in advance.   There had been 312 outpatients whose letter was printed less than 10 days prior to their appointment date and this was now being addressed in the governance arrangements. The respective patient surveys had provided positive feedback.

67.9   The Board noted that the content of the offer letter was complex and a reduced size of letter had been produced and would be sense checked with users. In terms of patients with additional needs work had been undertaken to ensure that people could read the letter in terms of its font size and also to ensure that the language was clear, understandable and appropriate.

67.10   It was noted that the performance around this aspect of work was being monitored by the Access, Performance and Governance Group and this would allow ongoing calibration of processes as and when issues emerged.

67.11   The Vice Chair commented that she had initially expressed concern about the proposals and was heartened to read the positive reports. It was noted that telephone access was an issue that was discussed in other committees and in that regard there were ongoing opportunities to learn lessons. She reminded colleagues that the issue in respect of people with additional needs had in part been around frail elderly people who relied on other people to read their mail and it would be important to include a cohort of these people in the next iteration of the policy.

67.12   It was agreed consideration would be given to the use and inclusion of symbols in future communications to assist people with learning difficulties and that this would be built into future work and business cases.

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

68.   NHS Lothian Health Inequality Strategy

68.1   The Board noted that the Health Inequality Strategy had been discussed at the Strategic Planning Committee on 13 November 2014 and agreed for onward transmission to the Board for approval. It was noted that the NHS was not able to resolve all issues and would require input from Community Planning Partnerships and others. The strategy however focussed on the issues that NHS Lothian could progress.

68.2   The Board noted that the strategy identified that tackling health inequalities required commitment across NHS Lothian. This included actions that used the potential of the NHS as a large employer and through procurement; ensuring services were available and accessible to all and delivered proportionate to need, to reverse the 'inverse care law'; increasing the priority given to primary and community services, early years and preventative interventions relative, as the most disadvantage groups benefit most from these; addressing the social issues that impact on patients health and ability to use health were; developing partnerships with the voluntary sector; raising awareness of underlying causes that advocating for policies in intervention that reduce inequalities in income, wealth and power.

68.3   The Board noted that a detailed action plan had been developed for the next 3 years that identified actions relating to procurement, NHS as an employer, clinical services, partnership and monitoring.

68.4   The Board noted in response to a question about the cost associated with the implementation of the strategy that it had been designed without the requirement for significant additional cost and was about using existing resources differently. The point was made that the key issue was about building the detail of the strategy into future plans.

68.5   The point was made that it would be useful for Non Executive Board members to have access to a single page set of guidelines to discuss with staff at regular

interactions to ensure that issues were addressed through the various Board committee structures and that appropriate assurances could be received. Dr Douglas would consider how best to progress this.

68.6   The Board noted that the GP Subcommittee had endorsed the strategy and were content with its proposal.

68.7   The Board approved the Health Inequality Strategy and action plan.

69.   Better Cancer Outcomes in Lothian – A Strategy for Cancer 2015 – 2020

69.1   The Board noted that the cancer strategy 2015 – 2020 had been discussed at the Strategic Planning Committee meeting on 13 November 2014 and agreed for onward transmission to the Board for approval. It was noted that this particular strategy did not have a cost or financial plan sitting behind it.

69.2   The Board noted the majority of respondents to the consultation were supportive of the strategy with earlier detection, prevention, support for a new regional cancer centre and affordability being key issues raised.

69.3   It was noted that affordability and resourcing issues required to be considered as part of taking forward the overall strategy 'our health, our care, our future'. The point was raised however that there was a proposition that the deep dive process would look at all aspects of cancer care provision. This proposal had been supported by the South East and Tayside Planning Group who had agreed to consider pathways of care, innovation and how change could be radically delivered. It was anticipated that the outcome of this proposal might produce an alternative to a bricks and mortar solution.

69.4   The Board noted that the cancer strategy had been considered by the GP Sub-committee who were happy to support it.

69.5   The Board approved Lothian's cancer strategy, better cancer outcomes in Lothian – a strategy for cancer 2015/20.

70.   Date and Time of Next Meeting

70.1   It was agreed to extend the January Board Development Session to include a formal meeting of Lothian NHS Board to be held between 8.30 – 9.30am to discuss and approve Integration of Health and Social Care: Integration Schemes. The actual Board Development Session to be held between 9.30am – 12.30pm would pick up a significant amount of the business discussed at the current Board meeting.

71.   Invoking Standing Order 4.8

71.1   The Chairman sought permission to invoke standing order 4.8 to allow a meeting of Lothian NHS Board to be held in private. The Board agreed to invoke standing order 4.8.

LOTHIAN HEALTH BOARD

**Extract of Minutes of a Meeting of Lothian Health Board
held in Edinburgh
on 3 December 2014 at 9.30 a.m.**

PRESENT

Mr B Houston (in the Chair)
Mrs S Allan (Vice Chair)
Mr M Ash
Mr J Brettell
Dr M Bryce
Councillor D Grant
Councillor R Henderson
Professor J Iredale
Mr P Johnston
Councillor C Johnstone
Mr A Joyce (Employee Director)
Mrs J McDowell
Mrs A Meiklejohn
Mrs A Mitchell
Councillor F Toner
Mr G Walker
Dr R Williams
Mr R Wilson.
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)
Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information).

IN ATTENDANCE

Dr M Douglas (Consultant in Public Health Medicine for item 68)
Mr D Weir (Corporate Services Manager).

1. **APOLOGIES**

   Apologies for absence were received from Mrs K Blair and Mr G Warner.

2. **DECLARATION OF INTERESTS**

   No declaration(s) of interest(s) were raised in relation to any of the matters to be discussed.

3. **PARTNERSHIP CENTRE BUNDLE (the "Project")**

> There was submitted by the Chief Executive of the Board the "Partnership Centre Bundle Approval Submission dated October 2014" outlining the hub project to be entered into by the Board on or around 30 January 2015 (or such other date as may subsequently be approved by those persons identified in paragraph 4(v)) together with a brief report (i) advising members of the proposed hub project, the hub design and build, finance maintenance agreement (**"DBFM"**) and ancillary documents as listed in paragraph 4(v) of these minutes, particularly those to which the Board is to be a party; (ii) seeking formal approval for the appropriate officer to negotiate, agree, finalise (in liaison with Campbell Kerr, Senior Project Manager), execute and deliver the DBFM and ancillary documents as listed in paragraph 4(v) of these minutes (the **"Project Documents"**) on behalf of the Board; and (iii) seeking formal approval for the Board to inject 23.4% of the subordinated debt (being a sum of £497,000.00) into the Project via LBP Sub-hubco Limited (the **"Injection of Subordinated Debt"**).

AFTER DISCUSSION AND DUE CONSIDERATION THE BOARD AGREED THAT:

i. The Board has statutory powers to enter into the Project Documents and effect the Injection of Subordinated Debt. The Project Documents and the Injection of Subordinated Debt are calculated to facilitate and to procure facilities as incidental to the discharge of the Board's function as Health Board for the promotion of the improvement of the physical and mental health of the people of Scotland, and the statutory provision conferring this function is Section 2A of the National Health Service (Scotland) Act 1978 as modified by the National Health Service Reform (Scotland) Act 2004, as amended;

ii. The Board is satisfied that the Project meets with its internal approvals, policies, procedures, constraints and requirements, including its Standing Orders, current Scheme of Delegation and Standing Financial Instructions;

iii. The Board confirms that it has obtained all consents, authorisations and approvals necessary for their authorisation of the Project to be effective and for the Project Documents to be enforceable against the Board all in accordance with its Standing Orders, current Scheme of Delegation and Standing Financial Instructions;

iv. The Board approve the terms and contents of the "Partnership Centre Bundle, Stage 2 Approval Submission dated October 2014" and the brief report referred to in Paragraph 3 above;

v. The Board authorises Tim Davidson, Chief Executive, or in his absence Susan Goldsmith, Director of Finance, whose specimen signatures shall be set out in a certificate in the form annexed hereto, to negotiate, agree, finalise (in liaison with Campbell Kerr, Senior Project Manager), execute and deliver the DBFM together with the following Project Documents (each as defined in the DBFM) for the Project and documents on behalf of the Board provided that such authorised signatories are satisfied that due process has been followed and

that the terms of the relevant documents reflect those approved by the Board subject to any amendments agreed pursuant to paragraph vi below:

   a. the Funders' Direct Agreement;

   b. the Contractor's Collateral Agreement;

   c. the Service Providers Collateral Agreement;

   d. the Key Subcontractor Collateral Agreements;

   e. the Independent Tester Contract;

   f. the Insurance Proceeds Account Agreement;

and, subject to paragraph vi, any other additional or ancillary documents to be signed by the Board in connection with the Project;

vi.   The Board authorises those persons identified in paragraph 4(v) to consider and agree (having considered the advice of the Board's external advisors) any amendments proposed to the Project Documents after the date of this meeting and to consider and agree the terms of any further additional or ancillary documents required in connection with the Project;

vii.   The Board authorises the performance of the DBFM and Project Documents by it following the finalisation, execution and delivery of the same;

viii.   The Board authorises the Chief Executive or his nominated representative to provide a certificate to whomsoever it may concern setting out the names and specimen signatures of the Chief Executive and Director of Finance who are authorised by paragraph 4(v) to execute and deliver the DBFM and the Project Documents on behalf of the Board by virtue of paragraph 4(v);

ix.   The Board authorises the Chief Executive or his nominated representative, to provide to whosoever it may concern certified copies of the Board's current:

   a. current Scheme of Delegation;

   b. Standing Orders; and

   c. Standing Financial Instructions.

x.   The Board approves the Injection of Subordinated Debt.

<div align="center">**APPENDIX**</div>

<div align="center">[To be typed on to be typed on headed paper of Board]</div>

[To be completed so as to satisfy paragraph 3 of part 2 to Schedule Part 2 of the DBFM]

TO WHOM IT MAY CONCERN

Date: [●]

Dear Sirs

Partnership Centre Bundle (the "Project")

I refer to the hub design and build, finance maintenance agreement (**"DBFM"**) and the ancillary documents relating to the above Project shortly to be entered into by the Board.

I confirm that the following persons have been authorised by the Board to execute the DBFM and the Project Documents (as set out in paragraph 4(v) of the Minutes of the Meeting of Lothian Health Board dated 3 December 2014) and to consider and agree any amendments proposed to the Project Documents after the date of the meeting and to consider and agree the terms of any further ancillary documents required in connection with the Project:

Full Name	Position	Specimen Signature
Tim Davison	Chief Executive	
Susan Goldsmith	Director of Finance	

[Insert any other authorised signatory for the purposes of the joint insurance account going forward (if not the same as the person signing the agreement)]

I confirm that the specimen signatures set opposite the names of the persons are the true signatures of the persons referred to.

Yours faithfully,

For and on Behalf of Lothian Health Board

....

Insert Full Name: Tim Davison

[Chief Executive]

LOTHIAN NHS BOARD

Minutes of a Special Meeting of Lothian NHS Board held at 8.30am on Wednesday 14 January 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); Mr M Ash; Mr J Brettell; Dr M Bryce; Councillor D Grant; Professor J Iredale; Mr P Johnston; Councillor C Johnstone; Mr A Joyce (Employee Director); Mrs J McDowell; 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); 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 J Forrest (Joint Director, West Lothian Health and Social Care Partnership); Mr P Gabbitas (Joint Director, City of Edinburgh Council Health and Social Care Partnership); Mr M Hill (Consultant); Ms E McHugh (Joint Director, Midlothian Health and Social Care Partnership); Mr D A Small (Joint Director, East Lothian Health and Social Care Partnership) Mrs L Tait (Associate Director of Strategic Planning) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mrs K Blair, Councillor R Henderson 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.

72.   Welcome and Introduction

72.1   The Chairman welcomed members of the public to the meeting.

73   <u>Mr Robert Wilson</u>

73.1   The Chairman advised that Mr Robert Wilson had resigned from the Board as he had been concerned about his continuing ability to contribute on a limited capacity because of his ongoing health difficulties. The Chairman advised he had asked Mr Wilson to consider over the festive period other ways of inputting into Board

meetings. However following this period of further reflection Mr Wilson had still decided to resign from the Board. The Chairman commented whilst he had reluctantly accepted Mr Wilson's resignation he would keep in contact with him in order to obtain his challenging views on the Board. He advised there would be a more formal opportunity to recognise Mr Wilson's contribution to the Board.

74. Programme for the Day

74.1   The Chairman advised as all of the items on the agenda were for discussion the normal consent agenda would not apply. He reminded colleagues that the day was split into 3 separate sessions. The first was the Public Board meeting followed by a Private Session. This would conclude the formal Board business and the remainder of the day would be turned over to the pre-planned Board Development Session.

75. Integration of Health and Social Care; Integration Schemes

75.1   The Board were advised that they were being asked to approve for consultation 2 of the 4 Integration Schemes required in Lothian to establish the Integration Joint Boards. The Board were reminded that they had received and approved for consultation the Midlothian and East Lothian Integration Schemes in December 2014. Therefore at the current meeting approval for public consultation was being sought for the: -

- West Lothian Draft Integration Scheme
- Edinburgh Draft Integration Scheme

75.2   It was noted if the Draft Integration Schemes were approved this would allow a short period of time for consultation. The consultation process would provide an opportunity to make final changes to the 4 draft schemes.

75.3   The Board received an update on the proposed treatment of Mental Health Services with it being explained the approach was covered later in the Private Board paper on the revised organisational arrangements for the management of Lothian Acute Hospital Services. It was noted there was still a need to obtain total clarity about the operational role of Integration Joint Boards and it was hoped this would be resolved during the consultation period. The Edinburgh Leadership Group had however taken the practical and prudent decision that NHS Lothian would retain operational management of Mental Health Services for the period of the redevelopment of the Royal Edinburgh Hospital. Responsibility for strategic planning of Mental Health Services would be devolved to the Integration Joint Boards. It had been agreed at the Edinburgh Leadership Group to produce a paper on Mental Health Services and this would be shared with the Board.

75.4   The Board approved for public consultation the: -

- The West Lothian Draft Integration Scheme
- Edinburgh Draft Integration Scheme

75.5   The Board also noted and agreed the consultation period.

76. The Disestablishment of the Community Health (and Care) Partnerships

76.1 The Board were advised that the purpose of the report was to explain the impact of the Public Bodies (Joint Working) (Scotland) Act 2014 on the existing Community Health Partnerships, and the governance architecture of Lothian NHS Board (the Board). The report set out a proposal for a new committee structure for the Board, in the light of CH(C)P Subcommittees no longer existing, and Integration Joint Boards being established.

76.2 The report also set out the proposed nominees of the Board for the voting membership of the 4 new Integration Joint Boards.

76.3 In addition the report set out the arrangements for the governance of Children's Services.

76.4 The Board agreed to continue to convene the CHP Subcommittees and the CHCP Board until the Integration Joint Boards were established (as per option 1 set out in the paper)

76.5 The Board also agreed that the other committees of the Board should start the development work required to ensure that they could provide adequate operational governance oversight to the NHS functions and services that were currently overseen by the CHP Subcommittees and the CHCP Board.

76.6 The Board also approved its nominations to the four Integration Joint Boards.

77. Date and Time of Next Meeting

77.1 The next Board meeting would be held on Wednesday 4 February 2015 at 9.30am in the boardroom, Waverley Gate, Edinburgh.

78. Resolution to Take Items in Closed Session

78.1 The Chairman sought and received permission to invoke Standing Order 4.8 to allow a meeting of Lothian NHS Board to be held in private.

Action Required	Lead	Due Date	Action Taken	Outcome
Renewing NHS Values (24/07/13)				
• Arrange engagement sessions for service teams.	**AB**	TBC	*The Associate Director of Workforce is leading on this process.*	**In progress**
• Development of the Implementation Plan to be included as a separate Board seminar.	**AB**	TBC	*The Associate Director of Workforce is leading on this process.*	**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**
Scottish Public Services Ombudsman Case 201200092 (23/10/13)				
• Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance.	**SRW**	Ongoing	*A quarterly Customer Relations and Feedback Quality Report now goes to the Healthcare Governance Committee and the Board. This report goes into detail about complaints, trends and actions. It has been agreed that an external expert will now drive forward the review into how NHS Lothian handles all feedback and how it uses that feedback for quality improvement and service delivery purposes. There will also be a complete review of the role and function of the Customer Relations and Feedback Team. A report on the options available will be produced by the end of January 2015.*	**In progress**

Action Required	Lead	Due Date	Action Taken	Outcome
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 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.	**AB**	TBC	*A paper is being considered at the February Board meeting.*	**Completed**
• 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*	**December Board**

Action Required	Lead	Due Date	Action Taken	Outcome
			and others on delegation of functions.	
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 between May & July 2014.	**AMcM**	July 2014	*Paused whilst the review of the model of integration in Edinburgh is complete, but work has been done and we can go to consult quickly post decision re adult services.*	**Paper to 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	*Paper on the agenda.*	**Update to**

Action Required	Lead	Due Date	Action Taken	Outcome
		2014		**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.*	
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.	**AB**		*The complaints review is ongoing and on scheduled. The report is due at the end of January 2015. progress has been reported to the Healthcare Governance Committee. Workshops have been organised for February. This work is on target for the April Board meeting.*	**In Progress**
Vale of Leven Report (03/12/2014)				
• An update report would be provided to the Healthcare	**MJ**			**An update**

Action Required	Lead	Due Date	Action Taken	Outcome
Governance Committee in January and thereafter to the Board in February.				**will be provided at the next meeting.**

NHS LOTHIAN

Board Meeting
4 February 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.

Summary of NHS Lothian's current achievements against targets are captured within table 3.1 of the performance management paper	3.1
Since the last reporting period the status of Heat id H6.1;Smoking Cessation, has changed from green to red	4.1
Green status has been maintained within the following HEAT and 2014 – 15 Heat National Standards, H11.1Early Access to Antenatal Care, E 8.2 Energy Efficiency and Cancer 31& 62 day performance	4.2,4.3, 4.9

Julie Drysdale
Strategic Programme Manager
Strategic Planning, Business Continuity
Resilience and Public Records
7 January 2015
Julie.Drysdale@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning,
Performance Reporting & Information

Alex.McMahon@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 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. 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 targets, with a more detailed description of these being provided under item 4 of the paper, key risks and area's 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
A12.2	Psychological Therapies	Red	JF
A12.1	Child and Adolescent Mental Health	Red	JF
T15.1	Delayed Discharge	Red	MJ
T12.1	Reduction in Emergency Bed Days	Red	MJ
T11.2	Clostridium difficile Infection (CDI) and Staphylococcus aureus Bacteraemia (SAB)	Red	MJ
2014 –15 HEAT NATIONAL STANDARD			
Cancer 31 day performance		Green	MJ/JC
Cancer 62 day performance		Green	MJ/JC
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 December 2014 Ranking of performance by Health Board Lothian positioned 5 out 14** (Responsible Director: Director of Public Health and Health Policy)

The latest data published by ISD on Smoking Cessation covers up to 30/06/2014 and shows that the Board's performance was 249 successful quits against a target of 440. This was 43.4% below target, placing NHS Lothian 5th out of the 14 Boards monitored. The all Scotland performance on this indicator was 53% below target.

4.2   **Heat id H11.1; Early Access to Antenatal Care Last updated December 2014 Ranking of performance by Health Board Lothian positioned 4 out 14** (Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

The latest data published by ISD covers up to 30/06/2013 and shows that the Board's performance was 84% against a target of 74%. This was 13.5% above target (the all Scotland figure being 9.8% above target), placing NHS Lothian 4th out of the 14 Boards.

The performance in November 2014 was 92.60% 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** (Responsible Director: Director of Human Resources and Organisational Development)

NHS Lothian completed a two year energy investment programme at end of March 2014, with total investment of £1.5 million. The completion of boiler decentralisation at Astley Ainslie, removal of theatre humidification at RIE, variable speed drives in WGH ventilation plant and various other projects has helped NHSL towards achieving HEAT target but further and more major investment such as CEF for St John's boiler replacement is essential. In addition, for the future, we need to design low energy new buildings and our efforts with new RHSC and REH are meeting with difficulty where derogation on BREEAM Excellent has been granted following agreement with HFS and Scottish Government, "affordability" is the key issue and contrasts with requirements of the Climate Change Act.

Reduction of CO_2 is -6.93% against a target required of 11.47% and is therefore worse than target

Reduction of energy is -5.41% against a target required of -3.94% and is therefore better than target

ACCESS TO SERVICE

4.4 **Heat id A12.2; Psychological Therapies Last updated December 2014 Ranking of performance by Health Board Lothian positioned 13 out 13** (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

The latest data published by ISD on Psychological Therapies covers up to 30/09/2014 and shows that the Board's performance was 43.1% against a target of 90%. This was 52.1% below target (the all Scotland figure being 4.8% below target), placing NHS Lothian 13th out of the 13 Boards for which figures are available.

Following a gap in reporting since migration to TRAK in June, the board submitted unadjusted data only for August and September. The unadjusted figure for July-September for patients seen within 18 weeks was 43.1%, placing NHS Lothian 13th out of the 13 Boards for which figures are available. It should be noted however that the continued differences in the scope and methods for calculating and reporting wait times means, as stated in the ISD publication, that NHS Boards figures may not be directly comparable. It should also be noted, that as the capacity for delivering psychological therapies is targeted at patients with the longest wait times the Boards performance against the 18 week standard will remain poor in the coming quarter.

There are continuing issues with data quality following migration to TRAK. These are being addressed.

There is on-going support and guidance for clinical staff to ensure the efficient and effective use of the TRAK system to allow accurate reporting of wait times. This work continues to be supported by the A12 Team.

Further work in relation to demand and capacity is to be completed following the cleansing of the TRAK data and service re-design activity is on-going with services across Lothian to increase capacity and improve access to psychological therapies.

4.5 **Heat id A12.1; Child and Adolescent Mental Health Last updated December 2014 Ranking of performance by Health Board Lothian positioned 10 out 12** (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

The latest data published by ISD on CAMHS covers up to 30/09/2014 and shows that the Board's performance was 67.1% against a target of 88%. This was 23.8% under target (the all Scotland figure being 13.8% under target), placing NHS Lothian 10th out of the 12 Boards for which figures are available.

There are continuing issues with data quality following migration to TRAK. These are being addressed and it is planned that these will be resolved by mid-December.

There is on-going support and guidance for clinical staff to ensure the efficient and effective use of the TRAK system to allow accurate reporting of wait times. This work continues to be supported by the A12 Team.

The additional 10 WTE non-recurring CAMHS posts have been recruited to. This additional capacity has been agreed as part of the planned trajectory to meet the 18 week target by May 2015.

It should be noted however, that as the capacity for delivering new patient treatment appointments is targeted at patients with the longest wait times, the Boards performance against the 18 week RTT standard will remain poor in the coming quarter.

TREATMENT APPROPRIATE TO INDIVIDUALS

4.6   **Heat id T15.1; Delayed Discharge Last updated December 2014 Ranking of performance by Health Board Lothian positioned 10 out 14** (Responsible Director: Director of Nursing, AHPs and Unscheduled Care)

The latest data published by ISD on Delayed Discharge covers up to 15/10/2014 and shows that the Board's performance was 111 patients waiting more than 2 weeks against a target of 13. This was 753.8% above target, placing NHS Lothian 10th out of the 14 Boards monitored. Performance across Scotland was 401.7% above target.

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 and the situation is 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.

There was a slight improvement in the performance in November compared to the previous four months

In November the break down was:
- 164 delays after X codes removed (195 Oct, 179 Sept, 210 Aug,177 July)
- 230 overall including X codes (254 Oct, 238 Sept, 265 Aug, 240 July)
- 63 patients delayed >4 wks (63 Oct, 74 Sept, 84 Aug,83 July)
- 31 days is the average length of stay (31 Oct, 38 Sept, Aug 33, 37July)
- 2 Non-Lothian delays (2 Oct, 3 Sept, 7 Aug, 2 July)
- 66 X codes (59 Oct, Sept, 55 Aug, 63 July)
- 436 Overall number of patients held on the DD data base (Oct 436, Sept 434, Aug 459)

4.7   **Heat id T12.1;Reduction in Emergency Bed Days Last updated December 2014 Ranking of performance by Health Board Lothian positioned 4 out 14** (Responsible Director: Director of Nursing)

The latest data published by ISD on rate of occupied bed days per 1000 population (75+) covers up to 31/07/2014 and shows that the Board's performance was 4,835 against a target of 4,821. This was 0.3% above target (the all Scotland figure being

2.8% below target), placing NHS Lothian 4th highest out of the 14 Boards monitored. However, NHSL performance continues to improve month-on-month.

The HEAT target reduces month-on-month by 0.3% with the aim of reducing by 8.7% to 4,709 between April'11 and March'15. Currently the monthly target is at 4,821 (July'14). The revised target for Lothian from April 2014 (an increase from 4,799 to 4,867) has meant an overall reduction in divergence with Lothian reporting 0.3% above target (March'14: 13.5%). The latest published figures (ISD, December 2014) show that for the previous rolling year (July'13-July'14) NHS Lothian has seen an overall decrease of 12.3% (interim) in bed days. The reduction in bed days may show the impact of various Change Fund and other initiatives across Health & Social Care designed to increase prevention and prevent admission. Also the introduction of Hospital at Home/Compass+ initiatives.

	NHSL	EL	ML	CEC	WL
July'13	5512	5811	5543	5806	4247
July'14	4835	4967	4923	4979	4182
	-12.3%	-14.5%	-11.2%	-14.2%	-1.5%

		NHSL	EL	ML	CEC	WL
		Reduction in target trajectory from April'15 (stretch target removed) gives same line of travel as other Board areas in Scotland.	Rising since Aug'11; Oct.'13 highest CHP against target. Marked reduction since then.	now second lowest CHP in Lothian. Few changes against monthly returns suggest stable LoS.	Reducing from high point July'12. Figures suggest increased stability and reduced LoS.	Rising since Dec'12. Recent months showed a more flatline profile and numbers are now declining. Remains only Partnership exceeding

Difference between Lothian figure and milestone:
-5.7% July'11
0.3% July'14 (interim)

All areas now report a reduction against the same month previous year, with City of Edinburgh and East Lothian Partnership areas showing the largest drop in activity across the rolling year. West Lothian, following a period of fairly level performance, has now resumed a decrease in emergency bed days. It is hoped NHSL will drop below its target within the next few months.

4.8 **Heat id T11.2; Clostridium difficile Infection (CDI) and *Staphylococcus aureus* Bacteraemia (SAB) Last updated October 2014 Ranking of performance by Health Board Lothian positioned 14 out 15** (Responsible Director: Nurse Director of Healthcare Associated Infection)

The latest data published by ISD on rate of C. difficile Infections in Ages 15+ per 1,000 total occupied bed days covers up to 30/06/2014 and shows that the Board's

performance was 0.52 against a target of 0.37. This was 40.5% above target, placing NHS Lothian 14th out of the 15 Boards monitored. Performance across Scotland was exactly on target for this indicator.

NHS Lothian's SAB 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 0.33.

NHS Lothian continues to exceed the HEAT target for CDI. 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 0.50. Response to SGHD on the Vale of Levens Inquiry Reports 65 Health Board Level Recommendations by 19 January 2015. Following the initial review of the Vale of Leven Inquiry Report the key priorities for NHS Lothian are those reflected in the Corporate Action Plan, these are:

- Antimicrobial Prescribing
- Environmental Standards and Cleaning
- Reliable use and monitoring of Standard Infection Control Precautions and Transmission Based Precautions
- Governance Structure and Management Culture
- Reliability of Care

2014 –15 HEAT NATIONAL STANDARDS

4.9 **Cancer 31 and 62 day performance** (Responsible Director: Director of Scheduled Care/ Director of Unscheduled Care)

95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment with 62 days of receipt of arrival.

Our monthly management information report for August 2014 shows that we are exceeding the 95% standard expected for 31-day cancer performance, with August performance at 98.5% (July 96.3%).

Our 62-day cancer performance level decreased in August to slightly under the target level of 95%, with performance in August standing at 94.8% (July, 96.5%). The lung, colorectal, and urology teams meet with the Director – WGH to review performance, assess progress, and troubleshoot issues weekly.

The latest Cancer Waiting Times publication was released by ISD Scotland on the 30th of September 2014. This report covers performance in the period April – June 2014 (quarter-2). NHS Lothian achieved both of the waiting times standards. Our 62-day performance was 95.2%. NHS Lothian was one of only 5 NHS Boards to meet the 62-day target in the period. For Scotland 92.9% of patients met the target. Our 31-day performance was 96.6%. This compared to 96.3% across Scotland.

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

Lothian's performance against the bundle: August 50%, September 48.4% and October 35.7%. Local Delivery Plan stroke bundle target to be met by April 2015: 65%.

During financial year 2014/15, stroke performance will be 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 August to October 2014, performance in each of the four elements changed as follows;

a) Access to a stroke unit by the day after admission – increased from 57% to 62.5% [August - 57%, September – 64%, October - 62.5%] (local target = 85%)

b) Imaging undertaken within 24 hours – remains stable and above the national target [August – 97.9%, September – 96.7%, October 97.3%] (national target = 90%)

c) Swallow screen – decreased from 79.2% to 63.4% [August – 79.2%, September – 65.9%, October - 63.4%] (local target = 90%)

d) Aspirin – increased from 81.7% to 89.4% [August – 81.7%, September – 77.4%, October - 89.4%] (local target = 90%)

Our agreed local target for bundle performance is 65%, and overall performance against the bundle has continued to decrease over the last few months - from 50% in August to 35.7% in October 2014. Although aspirin treatment improved significantly in October, both access to the stroke unit and swallow screening have proved disappointing with decreases in performance. The outreach nurse service has been instrumental in improving performance in these standards over the last year, but with no funded posts at RIE and SJH it has proved difficult to sustain improvement.

Action plans specifically for swallow screening were drawn up by each site at the request of the Chief Executive and these are being implemented on each site. It is recognised that if swallow screening improved then this would result in bundle performance improvement due to the numbers of patients who 'fail' to meet the bundle only due to the omission of a swallow assessment.

5   Risk Register

5.1   Responsible Directors have been asked to ensure that any risks associated with their targets have been clearly identified within the risk register. Risks are escalated to the corporate risk register as appropriate i.e. delayed discharges.

6   Impact on Inequality, Including Health Inequalities

6.1   As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall.

7 Involving People

7.1 This paper does not propose any strategy / policy or service change.

8 Resource Implications

8.1 There are no resource implications relating directly to the provision of this report. Financial implications are reported as appropriately to the Board, CMT and other committees.

Julie Drysdale
Strategic Programme Manager
Strategic Planning, Business Continuity
Resilience and Public Records
7 January 2015
Julie.Drysdale@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning, Performance Reporting & Information

Alex.McMahon@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
<u>4 February 2015</u>

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
• This report sets out the Quarter 2 position which was previously reported to the Dec 2014 Board. It provides a summary of the corporate risks and movement in risk grading over the last 4 quarters and illustrates minimal movement in risk grading.	3.2 & Table 1
• The top risks for NHS Lothian are all at High (16) and are as follows:- - Health and Social Care Integration - Patient Safety - Healthcare Acquired Infection - Maintenance Backlog - Medical Workforce Sustainability The adequacy of controls to mitigate these risks are set after review at adequate but partially effective.	3.2.1
• The Risk Management Steering Group are reviewing in January 2015, the Corporate Risk Register to ensure it remains fit for purpose. Any recommendations from the review will be made to the Audit & Risk Committee.	3.2.2
• Table 2 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

<u>Jo Bennett</u>
<u>Clinical Governance & Risk Manager</u>
<u>13 January 2015</u>
<u>Jo.bennett@nhslothian.scot.nhs.uk</u>

NHS LOTHIAN

Board Meeting
4 February 2015

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1   Purpose of the Report

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

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

2   Recommendations

2.1   Use the NHS Lothian Corporate Risk Register, highlights of which are contained in section 3.2.1 and summarised in Appendix 1, to inform healthcare governance assurance requirements

3   Discussion of Key Issues

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

3.2   This report sets out the Quarter 2 position. Table 1 below provides a summary of the corporate risks and movement in risk grading over last 4 quarters. Appendix 1 provides additional details of each individual risk with September 2014 updates. When a risk's adequacy of control is inadequate or uncertain, the rationale is stated on the individual risk.

3.2.1   The top risks for NHS Lothian are all at High (16) and are as follows:-

        • Health and Social Care Integration
        • Patient Safety
        • Healthcare Acquired Infection
        • Maintenance Backlog
        • Medical Workforce Sustainability

        The adequacy of controls to mitigate these risks are set at adequate but partially effective.

3.2.2   The Risk Management Steering Group are reviewing in January 2015, the Corporate Risk Register to ensure it remains fit for purpose. Any recommendations from the review will be made to the Audit & Risk Committee.

3.2.3 If you have an electronic version of this report, links to each risk in the appendix have been embedded in the below table (please click on individual Datix risk number in the table). This table illustrates that there has been minimal movement in risk grading over the last year. The Healthcare Associated Infection risk (1076) has been upgraded from Medium 9 to High 16 to reflect the current position.

Table 1

Datix ID	Risk Title	Initial Risk Level	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014
NHS Lothian Board Risks						
3567	Health & Social Care Integration	High 16	Date opened 16/01/2014	High 16	High 16	High 16
3211	Achievement of National Waiting Times Targets (Standing Board Agenda item under Performance Report)	High 12	High 12	High 12	High 12	High 12
Healthcare Governance Committee Risks						
3480	Patient Safety (Safety Measures in monthly Quality Report SPSP reported January & June 2013 to Board)	High 16	High 16	High 16	High 16	High 16
1085	Public Protection (Child, Adult, MAPPA) (Standing item on HCG Committee. Reported to Board via Minutes)	High 16	High 15	High 15	High 15	High 15
3454	Patient Experience (Complaints reporting and National Person-Centred Programme reported to Board March 2013)	High 12	High 12	High 12	High 12	High 12
3486	Data Quality	High 12	High 12	High 12	High 12	High 12
1076	Healthcare Associated Infection (Standing item on Board Agenda)	Medium 16	High 12	High 12	Medium 9	High 16
2812	Data Protection Act 1998 Compliance (Reported to HCG Committee and to Board via Minutes)	Medium 9	Medium 9	Medium 9	Medium 9	Medium 9
1966	Preparedness in Emergency Planning (Reported via HCG Committee Minutes to Board)	Medium 12	Medium 4	Medium 4	Medium 4	Medium 8
Finance & Resources Committee Risks						
3189	Maintenance Backlog (Reported through Finance & Resources Committee via Minutes)	High 15	High 16	High 16	High 16	High 16
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	High 12	Date opened April 23/04/2014	High 12	High 12	High 12
3203	Unscheduled Care (Title changed from Delay Discharges Jan 2013) (On Board agenda under Performance	High 10	High 10	High 10	High 10	High 10

Datix ID	Risk Title	Initial Risk Level	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014	Jul-Sept 2014
	Management)					
Staff Governance Committee Risks						
3527	Medical Workforce Sustainability - which replaces/incorporates: ID 1103 Paediatric Services at St John's Hospital, now closed	High 16	High 16	High 16	High 16	High 16
3455	Health & Safety (Reported at H&S Committee, via Staff Governance Committee Minutes)	Medium 9	High 15	High 15	High 15	High 15
3328	Roadway / Traffic Management (Risk escalated from UHD 06/03/2013) (Reported at H&S Committee, via Staff Governance Committee Minutes)	High 12	High 12	High 12	High 12	High 12
3531	Lack of Management Capacity	High 15	Medium 9	Medium 9	Medium 9	Medium 9

3.3 Articulating Risk Appetite

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

Table 2

	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	12.6%	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	198 (as at Dec 2014)	Quality Report (Graph 12)
• Achieve 262 or fewer C.Diff by March 2015 with a tolerance of 95% against target. n=275-262	Red	311 (as at Dec 2014)	Quality Report (Graph 11)
• 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%	Red	91%	Inpatient Survey August 2014 reported in October Quality Report

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

	Current Status	Current Position	Data Report
• 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	4.8%	Quality Report (Graph 6)

Corporate Objective 3 – Improving the way we deliver Scheduled Care. **Low Risk Appetite**

	Current Status	Current Position	Data Report
• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Green	85.9%	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**

	Current Status	Current Position	Data Report
• 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%	Green	93%	Quality Report (Graph 17)
• 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	128	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	71	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	74%	Quality Report (Graphs 19-21)

Corporate Objective 6 – Protect and Improve Health in Lothian for all. **Medium Risk Appetite**

	Current Status	Current Position	Data Report
• 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.	Red	43.4% below target	Performance Report
• 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**

	Current Status	Current Position	Data Report
• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Red	£148k overspend at period 8 (inc. unachieved LRP), equating to 0.1%	Period 8 Finance Report
• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%	Red	£6,522k overspend for the year-to-date (inc. unachieved LRP) equating to 0.8%	Period 8 Finance Report

3.3.1 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.

3.4 Review of Risk Registers - Update

In June 2014, the Audit & Risk Committee agreed a proposal to carry out a self-assessment of the Risk Management System using the Audit Scotland Best Value Toolkit for Risk Management and highlight areas for improvement at a corporate and service level.

Sample risk registers have now been reviewed and meetings taken place with:

- The senior management team for Scheduled Care
- REAS
- Edinburgh CHP
- Facilities

These sessions have proved useful and improvements have been agreed and beginning to be implemented. These are principally around updating and refining risk register documentation and re-establishing routine review mechanisms following organisational change. Technical support is being provided as required by the Clinical Governance and Risk Management Support Team.

Sessions have been arranged for November/December 2014 with the Unscheduled care management team, RIE site management team and the diagnostics clinical management team.

4   Key Risks

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

5   Risk Register

5.1 Not applicable.

6   Impact on Health Inequalities

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

7   Resource Implications

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

Jo Bennett
Clinical Governance & Risk Manager
13 January 2015
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Summary of Corporate Risk Register

NHS Lothian Corporate Risk Register

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3480	1:Improving Patient Safety	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	• 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.	October 2014: Risk Reviewed, control in place and notepad updated. Established a single system medicines reconciliation group. Mapping current process on three acute sites and RHSC. To inform improvement Plan. Review of Executive walkrounds complete. HIS review of all four work streams taken place included engagement with frontline staff and Executive team. Reviewing HSMR plan in light of recent data and priorities. Risk grade/rating remains unchanged High/16	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	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	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 been 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.	November 2014: Risk Reviewed, controls and notepad updated. Following successful recruitment of Clinical Fellows, additional Consultant staff and the introduction of Advanced Nurse Practitioners to support the middle grade doctor rota, the level of risk within Emergency Medicine has reduced and is no longer considered a high risk. The other areas identified however remain areas of high risk. A refresh of the medical workforce risk assessments will be undertaken over November 2014 to January 2015. Evidence will be provided to the UK Migration Advisory Group to support the additional of an expanded range of specialties onto the shortage occupation list, which males overseas recruitment easier. 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	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	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. • Board will approve draft Integration Schemes for East, Mid and Edinburgh in December. It is unclear if the West Lothian Integration Scheme will be submitted. If not it is very likely that the ministerial deadline will not be achieved • 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 **Rationale for Adequacy of Controls:** The Scottish Government have issue the final regulations and orders in relation to health and social care integration. Set 2 of the regulations will be released in November in advance of submitting the draft Integration Schemes to the Board and Council and in advance of the requirement for public consultation on the Schemes.	Oct 2014: Risk Reviewed and Controls Updated. Adequacy of controls remain as inadequate. Potential that risk is now higher in West Lothian than other areas Risk grade/rating remains High/16	Inadequate: control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Low 3	Alex McMahon	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3189	7:Ensure the Delivery of a Sustainable Financial Framework	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.	•The revised backlog maintenance sum has been reported at circa. £65.8 million. The Property Asset Management Strategy (PAMS) describes how this figure will be reduced by disposals and Reprovision Programme. •The financial plan has allowed for a further £5m BLM allocation for 2014/15 and 2015/16, thereafter the allocation has been reduced to £2.5m. Programmes of works are being confirmed for the next three financial years. •The capital plan for 2014/15 has a number of capital projects which will improve the physical condition of the estate and reduce backlog maintenance. For example, investment in ARAU of the WGH, Royal Victoria Hospital. •The programme of works will continue to address high and significant risks. The programme continues into the financial year 2013/14. •A procurement and implementation strategy was approved in early November 2012, which described how this funding would safely expended. •An update of the PAMS each year will log the affect upon the backlog maintenance and compliance figure. •A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance. •A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years.	October 2014: Risk Reviewed, controls updated. The backlog maintenance programme of works for 2014/15 is currently being undertaken – this will see a further improvement to the estates. A number of disposals have been concluded since April 2014 which will impact on BLM. Risk Grade Rating remains High/16	Adequate but partially effective: control is properly designed but not being implemented properly	High 16	Medium 4	Alan Boyter	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
1085	6:Protect and Improve Health in Lothian for All	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.	.• A revised structure for Public Protection following a review in 2011 is now firmly embedded across NHS Lothian. • Designated leads for child and adult protection as well as the Multiagency Arrangements for Public Protection (MAPPA) are in place reporting directly by the Assistant Director for Public Protection to the Executive Director for Public Protection (Public Protection Framework attached). • The Public Protection arrangements are supported by range of robust policies, procedures and guidelines both interagency and health. • A comprehensive Public Protection training strategy is in place. • The governance arrangements for public protection are monitored by the Executive Lead through the relevant public protection action group. • There are interagency structures in place across Lothian to ensure effective partnership working at operational and strategic level. • Processes are in place with health and interagency to investigate significant incidents and disseminate learning.	October 2014: Risk Reviewed and updated The Clinical Director for Learning Disabilities Dr Tracey Sanderson has taken on the role of Lead Consultant for Adult Protection and commenced in September 2014. Dr Sanderson will work with Anne Neilson Assistant Director Public Protection and the Public Protection Team to strengthen arrangements for Adult Support & Protection. The Clinical Nurse Manager for Child Protection has recently retired and a new Clinical Nurse Manager for Public Protection has been appointed. The post holder will take up post on 13th October. The Designated Doctor for Child Protection is now established in post, however there are some challenges with giving her adequate time to undertake the role as attempts to recruit a paediatrician to backfill her post has to date been unsuccessful. A consultant lead for child protection in now in place across each CHP/CHCP area. Cover for health input to IRD in West Lothian is very stretched and fragile following two resignations and inability to recruit. Consultant cover is being reviewed with a view to moving to a Lothian wide IRD service. Risk grading/rating remains unchanged - High/15	Satisfactory; controls adequately designed to manage risk and working as intended	High 15	Medium 9	Melanie Johnson	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3455	1:Improving Patient Safety	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 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.	October 2014 - Risk reviewed, Controls in place and Notepad updated formally by the NHS Lothian Health and Safety Committee on 21 October 2014. Despite significant activity in relation to the ROSPA audit and manual revision, it was agreed that the risk should remain at the level of the previous review. Risk grading/rating remains unchanged High/15	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	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3211	3:Improve the way we deliver Scheduled Care	Achievement of National Waiting Times Targets	There is a risk of: Not achieving 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.	October 2014: Risk Reviewed – Controls and Action Progress updated Risk Grade/Rating remains High/12	Satisfactory; controls adequately designed to manage risk and working as intended	High 12	Low 1	Jim Crombie	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance

3328	1:Improving Patient Safety	Roadways / Traffic Management	There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites	• Traffic surveys have been conducted across all hospital sites, and action plans have been prepared. Higher risks have been prioritised and actions taken where funding has permitted.
				• Actions include:
				  o segregation of vehicle and pedestrian traffic where possible;
				  o risk assessing and controlling reversing manoeuvres for drivers and vehicles under NHSL control
				  o creation of protected walk ways where possible;
				  o development and use of one way systems where possible
				  o use of barriers and entry systems to control traffic where possible
				  o drop-off areas and disabled spaces;
				  o additional parking attendants.
				• Interim measures have been put in place to prevent illegal and inappropriate parking including temporary barriers and bollards.
				• RIE Site Campus Group has been put in place to co-ordinate the re-provision of DCN & RHSC, including impact on activity on traffic management. Action plans have been revisited on a number of hospital sites and has resulted in additional high risk works being undertaken
				• Banks man arrangements in place on high volume high risk delivery areas,
				• Risk assessments and procedures are being developed and reviewed all areas where risk has been identified – a more robust risk assessment process has been developed
				• NHSL fleet vehicles fitted with reversing cameras and audible alarms.
				• Traffic Management training in place along with regular refreshers.
				• Work Place Transport policy available and reviewed within agreed time scales.
				• Escalation process in place should congestion become an issue
				• Site traffic management groups to review all sites established.
				• Action plans developed from the above groups and implemented monitored and reviewed by Traffic Management Review Groups
				• Capital proposals to introduce engineered solutions for in-patient sites.
				• High Risk Capital proposals funded.
				• Reviews regularly carried out as to effectiveness of plans and operational procedures
				• Site walk rounds in place conducted by site stakeholders
				• Improved monitoring systems in place – formally recorded
				• Known areas of people v vehicle conflict segregation measures put in place to avoid risk of injury due to contact where reasonable and practicable to do so
				
				Rationale for Adequacy of Controls:
				There are ongoing issues with traffic management and potential for pedestrians to stray into Facilities type areas. Proposals have been prepared and costed for each site. These will have to be approved before works can commence. The plans have been provided to capital to incorporate into master plans and this is reflected in the Adequacy of Controls
				
				Local TM Groups will continue to apply simple and low cost actions and repairs/improvements where approvals and budgets allow.
					October 2014 – Risk Reviewed. Controls and notepad updated.
					
					The Pan Lothian TM Plan is being updated monthly and tabled quarterly at each Heads of Service Meeting. This details the risks, controls and further actions required at each site.
					
					A draft monitoring tool has been developed to ensure the TM Groups are carrying out formal and effective monitoring, findings will be discussed at each TMG and issues escalated to the Pan Lothian Plan as required.
					
					A review of all TM Risk Assessments in currently underway using an improved process and linked in to the monitoring activities (above) and will be reviewed at each TMG as they are updated
					
					A programme of Traffic Management Risk Assessment training will commence at the end of October to upskill those carrying out the TM Risk Assessments.
					
					Risk grade/rating remains unchanged - High/12
						Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 8	Alan Boyter	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3454	2:Improve Patient and Staff Experience	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.	The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care. • 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. • 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, these lists have been reviewed and discussions are ongoing as to how we further strengthen the linkages between all aspects and tie back to the person-centred agenda October 14. • 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 Hub has been established as a resource for staff (primarily nursing) but where appropriate, other disciplines. • As part of the improving care to vulnerable patient's the rollout of a support manual with detailed information inclusive of a rapid patient essential care check sheet has been implemented within acute and community In patient facilities. Review of the usefulness of this tool has indicated that staff have found it helpful and wish to retain. • 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 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 95% achieved. A local collaborative will take place in December 2014 and will link patient and staff experience to develop a 'person centred culture' across our organisation. Following a visit to Northumbria we will be testing their questionnaire in a number of different in-patient areas across NHS Lothian. We will also be testing 'Shadowing' the patient journey and will involve clinical and non clinical staff following patients through out system. • A review of Tell us Ten Things will take place during November 2014 to ensure the questions are mapped 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. • Funding to support this for 2014/15 has been confirmed by Scot Gov, NB does not cover all costs. Rationale for Adequacy of Controls through the newly developed quality management group discussions are ongoing re: • agreement on final question/media format • PC test site work - Oct 2014 • Agreement required to re setting questions in 'Tell us Ten things' - Oct / Nov 2014 • Agreement required on reporting measures and process • Agreement required as to what else will be included in the measures • Submission to govt 30/6 re bid for 14/15 to support this work.	October 2014: Risk Reviewed The DBC hub now established on the WGH site has secured further funding for 15/16, Discussions are ongoing to agree how this future funding will be allocated. The vulnerable Patients Quality Improvement Framework has been revisited in light of the OPAC September 14 self assessment. The framework is a live document however at UHS May CMG it was agreed that the e document required refining to make more user friendly and a driver diagram is currently being consulted on this will be reported back to CMG in October 14. 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 December 2014. The patient Quality Indicator tool (PQI) has been reviewed and now also incorporates Person centred questions. Adequacy of controls changed to Inadequate following discussion at Risk Management Steering Group. Risk Grade/Rating remains unchanged - High/12	Inadequate: control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 6	Melanie Johnson	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3486	1:Improving Patient Safety	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.	A Data Quality Steering Group has been established to identify and address risks associated with poor quality. It has been accepted by the CMT that issues that cannot be resolve through the group, which includes operational elements of the service, will be escalated to the Corporate Management Team. Minutes of the meeting with a covering report if necessary, are provided to the JMT for meeting. Given the number of issues to address the group has opted focus on the area of beds at this current time, investigating discrepancies in local and national reporting as well as information shared through site and capacity discussions operationally. Some issues around the reporting of elective care were outlined to the Acute Hospitals Committee in September 2014.	September 2014: Risk Reviewed - Controls updated. Risk Grade/Rating remains unchanged - High/12	Adequate but partially effective; control is properly designed but not being implemented properly	High 12	Medium 9	Alex McMahon	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	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. 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. Further work is required to address the strategic financial challenge, and this can include: • The best way to identify the actual effect of reducing resources on the provision of services. • The best way to avoid an unacceptable impact on services as a result of reducing resources. Identifying how best to support the organisation in implementing its strategies and policies whilst remaining within the financial envelope • How to step up the necessity for re-design in all activities. • Whether there are opportunities to revisit the implementation of current strategies and policies, so as to deliver the same objectives in the context of reducing resources. • Whether there are any activities/ policy objectives which need to be scaled back in the context of reducing resources. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressur which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested. As this is a new risk an action plan is still to be developed.	November 2014 – Risk Reviewed - actions added and actions updated. Risk Grade/Rating remains unchanged - High/12	Inadequate: control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 6	Susan Goldsmith	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3203	4: Improve the way we deliver Unscheduled Care	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 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.	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 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.	September 2014: Risk Reviewed. Controls updated. Increasing pressures on patient flow due to number of delayed discharges continues to hamper performance. Additional winter beds to be opened to deal with anticipated heightened demand. LUCAP 2 approved by Scottish Government July 2014. Quarterly updates due at September, December and March. Strategic workshops for unscheduled Care held during May and June '14 have gathered significant data and have supported a range of service redesign initiatives. A further strategic development day is planned for 6th November '14. Specific work to review patient flow across all 3 adult acute sites taking place during October in the form of Flowpoly. Risk grade/rating remains at High/10	Adequate but partially effective; control is properly designed but not being implemented properly	High 10	Low 1	Melanie Johnson	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
2812	1:Improving Patient Safety	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. Consequence of inappropriate disclosure are; distress to individuals, reputational damage to organisation, legal action or financial penalty up to £500,000.	1.Annual reporting to the Healthcare Governance Committee. 2.Information Governance Assurance Board committee 1/4ly review 3.Information Governance Working Group1/4ly meeting 4.Audit & Risk Committee commission internal audits and monitor recommendations and management actions 5.Incident reporting procedures and controls on further escalation established 6.Information Governance, Data protection and IT Security Policy and procedures are in place, and are review and update in line with any incidents. 7.Staff Mandatory training and education in place, and ongoing awareness raising exercises	October 2014: Risk Reviewed and updated

Information Governance Assurance Board committee reviewed status of Data Protection Act Compliance as a Corporate Risk 22nd July 2014. The decision was not to reclassify to a lower level. Action relating to staff communications ongoing. Letter issues to all staff, payslip message and leaflet enclosed with payslips and at induction Next committee date 28th October 2014.

Risk grade/rating remains unchanged - Medium/9 | Adequate but partially effective; control is properly designed but not being implemented properly | Medium 9 | Low 1 | Alison McCallum | Healthcare Governance Committee |

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	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 if any recommendations. Systems are in place to escalate investigations. HAI Matrix utilised to identify reporting level HAIORT. Communications provide support to manage public release of information as required. •Packages of audits are in place to monitor standards and are 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.	September 2014: Risk reviewed and updated Grading has been increased as the HPS will be publishing a quarterly report where trend analysis in patients aged 15-64 years comparing the year-ending June 2013 with the year-ending June 2014 indicates there has been a statistically significant increase in NHS Lothian. Actions reviewed and updated to reflect current situation Risk Grade/Rating increased at High/16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Sarah Ballard-Smith	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
3531	8:Ensure the Delivery of a Sustainable Workforce Framework	Lack of Management 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 objectives are not met.	• Board reports on delivery of organisational objectives, risks and response. • Annual appraisals and mid-year reviews. • Review of organisational development needs including visible leadership at points of care. • Articulate organisational priorities to focus management efforts and identify areas of risk the organisation can tolerate in areas, particularly around internal audit recommendations. • Audit & Risk Committee commission internal audits and monitor recommendations and management actions. • Staff Governance Committee to lead on management capacity and capability from a governance perspective.	October 2014: Risk Reviewed Site management arrangements are in place for RIE, WGH and SJH for Unscheduled Care. Appointments have also been made in Scheduled Care. Joint Directors are also in place for each of the 4 Partnerships. Further changes in structure are planned which should further strengthen the management capacity. Proposed that the Risk grade/rating is reduced to Low Risk grade/rating remains at Medium/9	Adequate but partially effective; control is properly designed but not being implemented properly	Medium 9	Low 3	Tim Davison	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Owner	Assurance
1966	6:Protect and Improve Health in Lothian for All	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 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 prepared-ness is given in Scottish Government Preparing Scotland and in Preparing for Emergencies – Guidance for Health Boards in Scotland | • There is a Resilience website on the NHS Lothian intranet to provide easily accessible information about resilience to all staff.
• The NHS Lothian has established an executive led Resilience Committee to provide leadership, governance for emergency preparedness and resilience work, as recommended in Scottish Government guidance. This is chaired jointly by the Director of Public Health and Health Policy and the Director of Strategic Planning. It
• NHS Emergency Planning matters are also reported at several other key meetings, including JMT, HG&RM and EPSAG..
• NHS Lothian is represented by the Director of Public Health and Health Policy on the strategic, multi-agency, Regional Resilience Partnership and by the Emergency Planning Officer on the Local Resilience Partnership, NHSScotland Resilience Forum and other tactical and operational groups. The Emergency Planning Officer is also a member of several RRF work stream groups.
• Structured debriefs are held after major and other significant incidents so that lessons can be identified and resilience strengthened, by improving plans, procedures and skills.
• NHS Lothian staff regularly take part in emergency planning training and exercises at local, regional and national levels. | October 2014: Risk Reviewed, notepad updated

Recently published plans:
• NHS Lothian Tactical Incident Management Plan part 1 & 2
• Persons of Interest to Media and Security (PIMS) protocol – replacing the VIP policy
Training and exercises in last 6 months:
• Leonard's workshop (jointly with Scottish Resilience Development Service chairing incident management teams & rapid briefing)
• Ex. Sheldon, (28 May) main NHS Lothian annual resilience exercise, whole day, over 100 tactical and strategic staff up to and including the Chief Executive.
• Ex Falcon (Sept), full day, real-time, multi-agency exercise; live play element including media management (200+ participants)
• Forthcoming (Oct): Port Health Exercise of response to ebola case on aeroplane.
Debriefing: Lessons identified from several significant incidents (bomb threats, attack on patient leading to multiple site lock downs) are being followed up.

Multi-agency: The PH Resilience Lead leads regional groups on mass casualties and mass fatalities and has drafted the national mass casualties mutual aid agreement.

Staffing: One full time member of resilience staff has retired and the BC Lead has taken on several non-resilience duties.

Learning and Improving: Some external risks have increased (ebola, terrorism threat) and exercise and incidents have identified areas for improvement (e.g. communications with staff during emergencies) and but our improved awareness of these is allowing them to be addressed.

Risk Grade/Rating increase Medium/8 | Satisfactory; controls adequately designed to manage risk and working as intended | Medium 8 | Low 2 | Alison McCallum | Healthcare Governance Committee |

NHS LOTHIAN

Board Meeting
<u>4 February 2015</u>

Chairman

1.6

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 Julie McDowell to replace Jeremy Brettell as Chair of the Audit & Risk Committee and Ian Buchanan to replace John Richardson as Public Partnership Representation on the West Lothian Community Health & Care Sub-Committee. Ian is the current Chair of the West Lothian Public Partnership Forum.

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

2   Recommendations

2.1   To appoint Julie McDowell as Chair of the Audit & Risk Committee.

2.2   To appoint Ian Buchanan, Chair of the West Lothian Public Partnership Forum, to the West Lothian Community Health & Care Sub-Committee

3   Discussion of Key Issues

3.1   Jeremy Brettell leaves the Board at the end of February and Julie McDowell has agreed to serve as Chair of the Audit & Risk Committee.

3.2   The proposed appointment of Ian Buchanan has gone through the appropriate process and has been signed off by the CHCP Chair, Frank Toner

4   Key Risk

4.1   If appointments are not made to these Committees there may be problems in achieving appropriate representation and in some cases 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.

<u>Peter Reith</u>
<u>Secretariat Manager</u>
<u>19 January 2015</u>
<u>peter.reith@nhslothian.scot.nhs.uk</u>

Report To: NHS Lothian Board

From: Jeremy Brettell, Chairman, Audit & Risk Committee

Re: Committee Meeting: December 2014
              (Next Meeting Scheduled 16 February 2015)

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

Other items for noting by the Board in this report are:

Internal Audit – Resourcing
Ms Berry from Scott Moncrieff joined the meeting as the interim Head of Internal Audit, and very positive and constructive work is currently in hand

Internal Audits

- The Committee agreed to accept the revised and updated report on Complaints

Jeremy Brettell

Committee Chairman: January 2015.

DRAFT

NHS LOTHIAN

AUDIT & RISK COMMITTEE

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 8 December 2014 in Meeting Room 7, 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); Mr M Ash; Mrs M Bryce; Councillor D Grant; Councillor R Henderson; Councillor C Johnstone and Ms J McDowell.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Ms H Berry (Interim Chief Internal Auditor); Ms D Howard (Head of Financial Control); Ms M Johnson (for item 32); Mr C Marriott (Deputy Director of Finance); Mr D McConnell (Audit Scotland); Mr A Payne (Corporate Governance Manager); Mr D Proudfoot (Deputy Chief Internal Auditor); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr Davison and Mrs Goldsmith.

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.

31   Minutes of the Previous Meeting

31.1   Minutes of the previous meeting held on 29 September 2014– The Committee approved the circulated minutes as a correct record subject to the inclusion of Mrs Bryce's apologies.

32   Medicines Management – Safe Handling and Security of the Medicines within the Clinical Area

32.1   Ms Johnson explained that the report updated members on the actions taken following the internal audit of medicines management. The key risks associated with this work are the loss or theft or misuse of drugs. She gave a brief overview of the extensive work to review all 146 clinical areas that handle and store medicines within NHS Lothian and the subsequent action taken.

32.2   Ms Johnson advised that good progress had been made against all actions; though there was still significant work to be done. She was confident that the actions and the work of the short life working group could be completed by March 2015.

32.3   The Committee was assured that there is a plan in place and that progress is being made, however felt that at this point it cannot be assured that there are systems of control in place that are operating as intended.   The Committee asked for a further update to be presented to its meeting in February 2015 as an update on progress of the action plan, and that update should provide a

status report that is reconciled to the original audit points and their agreed implementation dates. If a particular point has not been completed there should be a clear indication as to when management anticipate them being completed.

MJ

32.4   The Chair proposed that Ms Johnson consider using the support of the Internal Audit Team as the actions progress leading up to the deadline in March.

32.5   The Committee agreed to accept the report and Ms Johnson left the meeting.

33   Matters Arising

33.1   <u>Matters Arising from the Meeting of 29 September 2014</u> – the Committee received the paper detailing the matters arising from the Audit & Risk Committee meeting held on 29 September 2014, together with the action taken and the outcomes.

33.2   The Committee noted that they were content with the response from the Staff Governance Committee in relation to ownership of risks that appeared under the Staff Governance Committee on the Risk Register.

33.3   Following a detailed discussion regarding the Board being sighted on and responding to the risk appetite at its bi-monthly meetings, Mr Brettell agreed to write to the Chief Executive and Chairman. He agreed to copy the letter to Ms Berry, Ms Bennett, Mr Payne and Mrs Goldsmith for information.

JMB

33.4   The Committee accepted the Running Action Note.

34   Risk Management

34.1   <u>NHS Lothian Corporate Risk Register Update</u>

34.1.1 Ms Bennett gave a detailed overview of the report. She drew the Committee's attention to the changes made to date, and advised that a review of the totality of risk on the corporate risk register was ongoing. She also advised that the acute services risk register was being fundamentally reviewed.

34.1.2 The Committee discussed the scoring of several of the risks on the corporate risk register, and the register's effectiveness in articulating the relative significance of the various issues. Ms Bennett agreed to examine the extent that the scores of four and five are awarded terms of risk likelihood, i.e. "strong possibility that this could occur – likely to occur" and "this is expected to occur frequently/ in most circumstances – more likely to occur than not."

JB

34.1.3 The Chair asked that the grading system within risk appetite be reviewed.   It was suggested that an "amber" grading be applied where performance is within risk tolerance but below the target that has been set by the Board.

JB

34.1.4 The Chair asked that future reports clearly state the date on which the risks were produced.

JB

35   Internal Audit Reports

35.1   Internal Audit - Progress Report December 2014

35.1.1 Ms Berry gave a brief overview of her role.   She is working with the team to deliver the remainder of the 2014/15 internal audit plan. She will work with the corporate management team to develop the 2015/16 internal audit plan, and part of that work will be to review the Audit Universe.

35.1.2 In terms of developing the service, the team will now have close out meetings with the relevant executive director at the end of each audit.   There will no longer be an overall grading given to each audit, but rather the focus will be on the grading of each control objective covered by the audit.   However in terms of determining which audit reports should be presented in full to future committee meetings, the previously agreed scoring system will be applied.

35.1.3 Ms Berry advised that she is developing Key Performance Indicators (KPIs) which will be used in the future to assess the effectiveness of the function, and updates will be included in the regular progress report. She will engage the corporate management team as part of this work, in order to determine what kind of service they want. Generally Ms Berry will build relationships with management so that the general relationship with internal audit is improved.

35.1.4 Ms Berry advised that she intended to develop the follow-up system, and that this will in the future be presented as a separate report to the committee.

35.1.5 The Chair commented that the presentation of the follow-up results showed that there is a number of recommendations that are not moving, and there could be a range of reasons as to why this is happening. Ms Berry advised that it is important that future audit reports make it much clearer why a control is important, and how it relates to the management of risk.

Councillor Henderson entered the meeting.

35.1.6 Members agreed that for all management actions outstanding for a period of 3 months, the relevant manager should provide internal audit with a narrative highlighting the barriers to progress. Internal audit may consider reviewing the deadline should they consider this appropriate. In the event that an audit action has been outstanding for 6 months or more, without supporting rationale, then the Audit and Risk Committee will expect the manager to attend a committee meeting to provide an update.   **HB**

35.1.7 The Committee accepted the Internal Audit Progress Report – December 2014.

35.2   Internal Audit – Complaints June 2014

35.2.1 Ms Berry drew the Committees attention to the revised wording surrounding Issue 1. The Committee agreed to accept the changes to issue 1 and agreed

the report was finalised. However the Committee's concerns surrounding the complaints process remain.

35.2.2 The Committee noted that a review of the complaints process was about to start and agreed that it would be helpful if the non-executives (through the Committee Chairs meeting in January 2015) had sight of the scope of the review. It was also agreed that the Committee should receive a report at its next meeting on the outcome of the review   **HB**.

35.2.3 The Committee agreed to accept the report.

36.1 <u>Counter Fraud Services – Referrals and Operations December 2014</u>

36.1.1 Mr Proudfoot introduced the summary of CFS referrals and operations as at November 2014. He advised that 3 referrals and 5 operations were currently open. He went on to highlight the ongoing work with overseas patients and fraud risk management.

36.1.2 Mr Brettell requested that Mr Proudfoot remove operation names in all future reports to avoid confusion where it might be thought they are actual names   **DP**.

36.1.3 The Committee accepted the CFS – Referrals & Operations report.

37.   General Corporate Governance

37.1 <u>Write–Off for Overseas Debt</u>

37.1.1 The Committee approved the referral to write off the losses of £40,186 and £61,134.42 to the Scottish Government Health & Social Directorate on behalf of the Board as the sum was over Board's delegated authority.

37.1.2 Mrs Bryce requested that Mrs Howard contact the communications team to request that pamphlets and posters be located within Edinburgh Airport to raise awareness with overseas patient whom fly into the city.   **DH**

37.2 <u>Royal Bank of Scotland Bulk Cash Service</u>

37.2.1 The Committee agreed to recommend that the Board approve the use of the Royal Bank of Scotland bulk cash service subject to the following matters being clarified and presented to the Board:

- Are there any limits to the authority to be given by the Board to individuals?
- What liabilities or increased exposure fall to the Board as a result of entering into this agreement?
- It needs to be made clear that this arrangement is associated with the operation of the Board's bank account.

DH

38. **Any Other Competent Business**

38.1 There were no other items of competent business.

39. **Date of Next Meeting**

39.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 16 February 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.

Summary of Healthcare Governance Committee Meeting of 25 November 2014   **1.8**

1.0   Key Issues Discussed

1.1   Mandatory Training

The Committee received a report on Mandatory Training from the Staff Governance Committee which indicated the ongoing challenges of obtaining valid and reliable data on staff compliance with mandatory training. The Committee received limited assurance that the vast majority of staff were compliant with mandatory training and will seek further assurance from the Staff Governance Committee in 2015. The data challenges reflect national issues and work is ongoing with NHS Education Scotland to reach a robust solution to the problems.

1.2   Vale of Leven Inquiry

The Vale of Leven Inquiry report was discussed. It was noted in the Healthcare Associated Infection Update report that NHS Lothian was not on track to achieve the HEAT target for *Clostridium difficile*.

1.3   National Health and Care Experience Survey

The Committee received reports from each of the Integrated Joint Boards on the survey and some of the challenges facing primary care. Among the themes that emerged were the increasing demands on primary care services and the shortage of GPs and resources to meet this rising demand.

Dr Morag Bryce
Chair of the Healthcare Governance Committee
20 January 2015

NHS LOTHIAN

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 am on Tuesday 25 November 2014 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 P. Eccles, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Mr A. Joyce, Employee Director, 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; Dr L. Bream, Consultant in Public Health Medicine (item 40.2); Ms M. Christie, Head of Health, West Lothian Community Health Care Partnership; Dr B. Cook, Associate Medical Director; Dr E. Duncan, GP, West Lothian Community Health Care Partnership; Dr D. Farquharson, Medical Director; Ms M. Fraser, Complaints Manager; Ms A. Henderson, Scottish Patient Safety Programme Facilitator (item 40.1); Ms M. Johnson, Director of Unscheduled Care; Ms A. Malone, Strategic Programme Manager; Dr N. Maran, Clinical Lead, Scottish Patient Safety Programme (item 40.1); Professor A. McMahon, Director of Strategic Planning; Ms B. Pillath, Committee Administrator (minutes); Ms E. Reid, National Programme Lead for Emergency Care Pathways, Scottish Government (observing); Mr D. White, General Manager, Edinburgh Community Health Partnership; Mr S. Wilson, Director of Communications.

Apologies: Mr T. Davison, Chief Executive; Mr J. Forrest, West Lothian Community Health Care Partnership; Ms C. Garrod, Patient and Public Representative; Mr B. Houston, Board Chairman; Professor A. McCallum, Director of Public Health and Health Policy; Mr D. Small, Joint Health and Social Care Integration Manager, East Lothian Community Health Partnership; Professor A. Timoney, Director of Pharmacy; Councillor F. Toner, Non-Executive Board Member; Mr G. Warner, 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 Scott Macfarlane had retired from her role as Public Representative on the Committee and thanked her for her 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.

34. Patient Story

34.1 Ms Johnson read out a letter from a patient about a very positive experience at Ellen's Glen Hospital.

35. **Committee Cumulative Action Note and Minutes from Previous Meeting (23 September 2014)**

35.1   The previously circulated updated cumulative action note was noted.

35.2   The minutes from the meeting held on 23 September 2014 were approved as a correct record.

36. **Matters Arising**

36.1   Mandatory Training Update Report

36.1.1   A paper had been previously circulated. Mr Joyce noted that training compliance is likely to be significantly higher than was currently shown in the data due to problems with the way data was collected. The data did not show that mandatory education had been completed. The improvement of data collection on Mandatory Training was now a standing item on the Staff Governance Committee and there had be discussion at the Risk Management Steering Group. National work was also in progress through NHS Education Scotland which was working on a 'Scottish Passport' system which would make training and data systems compatible throughout Scotland to allow easier movement of staff.

36.1.2   Other problems with recording of compliance were noted, including: staff booked onto training but unable to attend due to clinical pressures; those undertaking advanced training were not required to undertake core training, but records showed that they were non-compliant; leadership was required for staff to understand how important training was for patient and staff safety. It was noted that Fire Safety training was statutory as well as mandatory; policies on training had been approved without systems being put in place to allow compliance; access to computers and the locality of training venues was not optimal especially for staff in community facilities.

36.1.3   Ms Meiklejohn stated that assurance was required on when an improved data collecting system would be available, as it was not clear what compliance there was in mandatory training until this was achieved. Ms Johnson agreed that the lack of data was unacceptable and that local data did not give adequate assurance that training was taking place.

36.1.4   Mr Joyce advised that an improvement plan was being discussed and was expected to be in place and presented to the Staff Governance Committee in February 2015. A report could then be made to the Healthcare Governance Committee at its meeting in March 2015.

37. **Emerging Issues**

37.1   Vale of Leven Inquiry Report

37.1.1   Ms Johnson noted that the Inquiry had reported on 24 November 2014 giving 75 recommendations. Work was being done to determine where NHS Lothian met these recommendations and would be reported back to the Committee at a future meeting.   **MJ**

37.2   Healthcare Environment Inspectorate Visit to Western General Hospital

37.2.1   Ms Johnson noted that there had been an unannounced HEI inspection at the Western General Hospital on 18 and 19 November 2014. The full report would be available in the next month.

37.3   Draft Health and Social Care Integration Schemes

37.3.1   Professor McMahon advised that the draft integration schemes for each Community Health Partnership would be submitted to the Board in December 2014, and would be presented at the Healthcare Governance Committee at the meeting in January 2015, including a covering paper highlighting areas of importance for clinical governance.   **AMcM**

38.   Corporate Risk Register

38.1   The updated risk register had been previously circulated. Dr Farquharson noted that Healthcare Associated Infection had been moved from a medium to a high risk.

39.   Person Centred Care

39.1   Customer Relations and Feedback Team Report

39.1.1   A report had been previously circulated. Ms Fraser noted that the quarterly complaints report was also available for quarter 2. These reports would be included on the Healthcare Governance Committee agenda in future meetings.

39.1.2   Ms Fraser noted that the trends in complaints data had remained the same for some time. A report on the review of the structure of the Customer Relations and Feedback Team would be submitted to the next meeting.   **SW**

39.1.3   Ms Meiklejohn noted that the number of complaints about staff attitude was high and wondered if complaints were being sufficiently linked to training needs. Ms Fraser advised that the high number in this category was partly due to recording processes; a number of different complaints were covered by the category 'staff attitude'. This should improve when logging of complaints moved onto the datix system, which would allow more accurate categorisation.

39.1.4   Ms Johnson noted that the person centred culture report would be ready early in 2015 and that this covered the link between staff and patient experience and work on the causes and issues around complaints and compliments. Ms Fraser noted that compliments and positive feedback were also received by the complaints team but that these figures were not reported anywhere.

39.1.5   Ms Johnson advised that one of the areas of person centred culture work was to share person centred culture data with the public in an accessible way. Ms Gormley expressed interest in being part of this working group.

39.1.6   Ms Christie noted that responding to patient feedback still needed to be more in real time. Ms Fraser agreed that she would like to spend more time with staff explaining the process and the importance of comprehensive responses to the patient and their relatives.

39.1.7   Ms Meiklejohn noted that the number of complaints received was small in comparison with the number of patients treated but Ms Allan suggested that patients were vulnerable and would not always complain; raising concerns could be a better way to receive feedback. Ms Bennett agreed that a system was needed that allowed fewer formal complaints and better resolution of concerns raised in real time. Work on person centred culture would improve this.

39.2   General Practice Health and Care Experience Survey

39.2.1   A paper had been received from each Community Health Partnership giving a response to the findings of the General Practice Health and Care Experience Survey.

39.2.2   Mr White spoke to the paper from Edinburgh Community Health Partnership. He noted that survey results had a number of positive points, especially as the survey was taken at a time when there were a number of concerns in general practice. Work was in progress to try and improve the referral process. The patient access scheme was in pilot in all four local authority areas and the feedback from doctors and patients was positive. Work was in progress on improving the patient journey for patients with conditions such as diabetes, to reduce the number of unnecessary visits to the GP. Mr White noted that progress in deprived areas was more challenging with up to 10% of the population contacting the practice each week. There had been some small scale initiatives in social prescribing which had been successful and there were plans to increase the scale of this. More funding would be made available shortly which would be an opportunity for a more profound redesign for improvement in use of resources and patient access.

39.2.3   Mr White noted that the staff attitude results in the survey were good with 95% of patients rating GPs as good at listening to patients across the system; this was what confidence in the healthcare systems was founded on and it was good to confirm that standards were still high.

39.2.4   Dr Bryce noted that the question about how mistakes were dealt with had got a low rating in Lothian. Ms Bennett noted that this was a new question and that there may have been some interpretation problems. Only 121 of 2,000 patients had responded to this question.

39.2.5   Dr Williams noted that he was pleased that primary care work was coming to the Committee and suggested that some timescales for improvement be put in place and a further report back to the Committee in future. He also noted that the Committee could not dismiss the fact that there were challenges in resources in primary care including staff and premises. He noted that 90% of all consultations took place in primary care, with only 8% of the budget allocated. Ms Meiklejohn noted that the pressures being experienced by primary care were not on the risk register. Ms Bennett advised that this had been discussed at the Risk Management Steering Group and any action to be taken was being discussed.

39.2.6   Dr Bryce noted that other clinical groups could be used to make use of resources more efficient, for instance practice nurses. Dr Williams noted that third sector colleagues could be more use, but that it was difficult for a GP to be aware of which organisations were available for referrals.

40.   Safe Care

40.1   <u>Scottish Patient Safety Programme Reports, Acute and Primary Care</u>

40.1.1   Dr Bryce welcomed Dr Maran and Ms Henderson to the meeting. Ms Henderson spoke to the previously circulated paper which outlined the second phase of the Scottish Patient Safety Programme which would expand on the building process of the first phase.

40.1.2   The second phase would focus on ensuring that work in all areas was sustainable and not person dependent, making improvements when required. Charge nurses were working on improving processes and encouraging multi-disciplinary working in groups and teams. Ms Henderson was confident that processes would be more sustainable in the next year.

40.1.3   Dr Williams wondered whether data could also be used to show any improvements made, for instance the significant reduction in cardiac arrests and increased survival rate. Ms Bennett noted that a review on pressure ulcers and falls was likely to show improvements. This data would be submitted to the Committee in March 2014.   **JB**

40.1.4   Ms Meiklejohn noted that it was important that any success was shared so that good practice was used across the organisation. This required good leadership. Ms Bennett noted that the Human Factors work was very important in this area and in engaging front line staff.

40.1.5   Dr Maran advised that work was being done on improving medical staff engagement in the Scottish Patient Safety Programme and suggested that a lack of engagement in the past could have been due to a lack of understanding of why changes to practice had been made. There was a need to discuss changes with clinicians in the service area and put them into context. Improvement work had included learning and awareness, including human factors training and collaborative sessions focused on the role of medical staff in reducing patient harm and deterioration.

40.1.6   Dr Maran had been working with quality clinical leads and liaising with the Medical Director and other improvement leads in identifying areas for improvement. An increased interest from medical staff in improving quality improvement skills had been apparent. A multi-professional training programme on quality improvement had been developed along with more specialised training for staff showing a particular interest in this area. There were also fourteen medical staff undertaking the NHS Education Scotland course on quality improvement.

40.1.7   Ms Bennett advised that much of the additional work described by Dr Maran had been made possible through short term funding which would continue for one more

year. The funding had been used to provide three quality improvement clinical leads working in different areas to support clinical engagement, and had been key to improvements made.

40.1.8   Dr Bryce suggested that non-executive Board members could also support engagement work by attending any events held. Ms Allan agreed to discuss this with Mr Houston.

40.1.9   Ms Fairgrieve highlighted the fact that improvements made under the Scottish Patient Safety Programme often had a direct effect on staffing, for instance one to one nursing required to prevent falls.

40.1.10   Dr Williams noted that some excellent improvements had been achieved through the patient safety programme and that these should be recognised, perhaps through nominations to the Health Awards.

40.2   Overview of *Clostridium difficile* Infection (CDI) Data

40.2.1   Dr Bryce welcomed Dr Bream to the meeting. Dr Bream introduced herself as Consultant in Public Health Medicine who had been asked to be clinical lead on the improvement programme for CDI and gave a presentation on the current CDI data for NHS Lothian and the position against other Boards.

40.2.2   With reference to Dr Bream's explanation of a change made by NHS Greater Glasgow and Clyde to their hospital antibiotic policy which appeared to have reduced the incidence of CDI over 6 months, Dr Cook confirmed that it had been unanimously agreed at the Acute Hospitals Committee that NHS Lothian's prescribing policy would be changed to reflect the new policy used by Greater Glasgow and Clyde. The new Lothian policy was in draft form but implementation, training and support was required to put it into use. Dr Cook also noted that the alternative medicines recommended in the new policy were sometimes more problematic than those associated with CDI, for instance, effective use of gentamicin required monitoring of levels of the drug in the blood using laboratory testing.

40.2.3   Dr Williams noted that the current antimicrobial prescribing policy was evidence based and data showed that compliance in both primary and secondary care was good. He noted that Lothian initially had the lowest prescribing of broad spectrum antibiotics in Scotland, but had not been successful at reducing this further as other Boards had.

40.2.4   Ms Gormley noted that if prescribing policies were being changed, the communication of this change to patients currently on antibiotics was important as patients may not have been aware that antibiotic treatment put them at risk of developing CDI. Ms Johnson confirmed that this was being considered and was part of the recommendations from the Vale of Leven Inquiry Report.

40.2.5   Ms Johnson noted that the CDI action plan circulated in the papers for information was important for tracking improvements made.

40.3   Healthcare Associated Infection Update

40.3.1   A paper had been previously circulated. Ms Johnson noted that the paper did not include an update on Ebola, and explained that work was ongoing to ensure that NHS Lothian was ready for a patient with Ebola. In this instance the focus would be on the transfer of the patient to a specialist unit in Glasgow or London. Measures in Lothian included staff training, particularly in the Infectious Diseases Unit. Public Health was leading work on putting systems in place for contact tracing. A formal update would be part of the Board HAI paper in December 2014.

40.3.2   Mr Joyce noted that a protocol had just been completed for staff traveling to African countries to help deal with Ebola, and what measures should be taken on their return.

40.3.3   Dr Williams noted that protective equipment had been purchased by GP practices.

40.3.4   Ms Johnson noted that upgrading work had been completed in the Infectious Diseases Unit and that there were arrangements in place with the Scottish Ambulance Service, Edinburgh Airport, Port Authorities, NHS 24 and Health Protection Scotland regarding screening patients and there would be communication with specialist units in Glasgow and London if required.

40.4   Public Protection Update

40.4.1   A paper had been previously circulated. Ms Johnson noted that all aspects of public protection were currently busy with high activity. Some good work had been done on meeting the requirements of CEL 16 on looked after children, and there had been some new funding from the Board for a revised staffing structure. Not all looked after children were yet having health screening as required to comply with CEL 16, but this was improving.

40.4.2   There had been ongoing problems with recruiting medical staff specialising in child protection and some patients have had to have their consultations transferred between Community Health Partnership areas.

40.4.3   Ms Johnson clarified that funding was being withdrawn from the MAPPA Serious Offenders Liaison office for violent offenders only, and not for sex offenders. Funding may be raised from within the Public Protection Team in Lothian to continue to work with violent offenders, but Police Scotland were likely to withdraw their part.

40.4.4   The annual Adult Support and Protection Conference had taken place in November 2014 with 100 inter agency attendees, and had been very successful. There was a focus on learning disabilities.

40.4.5   The Patient Safety Experience Action Group, membership of which included the Medical Director, Nurse Director, Board Chairman, Chief Executive, Director of Finance and Director of Human Resources, considered more detailed reports from the Public Protection Team.

41.   Effective Care

41.1 <u>Quality Report</u>

41.1.1 The paper had been previously circulated. Ms Bennett highlighted that the data showed that NHS Lothian was no longer an outlier for surgical re-admission numbers at St John's Hospital following some good work done.

41.1.2 Complaints were now separated in the report between prison healthcare and other healthcare complaints. This showed that complaints about prison healthcare had increased in number but that hospital complaints had remained at the same number. This change in number of prison complaints was due to a change in process. Many complaints were about mental health and substance misuse; work was in progress in HMP Edinburgh to improve this service.

41.1.3 Ms Bennett noted that areas for improvement highlighted in the report included anticipatory care plans and end of life care. Pressure ulcers and falls management were being considered as part of older people's care to ensure that the different areas of concern in older people's care were considered together.

41.2 <u>Medical Revalidation Update</u>

41.2.1 A paper had been previously circulated. Dr Farquharson noted that this was the second year that revalidation of medical staff had been required by the General Medical Council. Dr Farquharson could recommend staff for revalidation, defer revalidation, or refer for non-engagement. Processes were in place to ensure that permanent medical staff received regular appraisal; locum and retired doctors also needed to be included. It would become mandatory from 2015 that all doctors have NHS Education Scotland approved appraisals; sufficient numbers of staff needed to be trained to give this type of appraisal.

41.2.2 Ms Gormley noted that under the 'Involving People' part of the paper submitted, 'not applicable' was noted, and felt that as patient feedback was involved in the appraisal process, this should be highlighted here.

41.3 <u>Homeopathy Equality and Diversity Impact Assessment</u>

41.3.1 The paper had been previously circulated. Dr Bryce tabled an email from Dr Caragh Morrish in which a number of concerns were raised. Dr Morrish had been Homeopathic Practitioner representative on the group carrying out the impact assessment but had asked to be withdrawn from process once the assessment had been completed, due to these concerns.

41.3.2 Professor McMahon noted that a rapid impact assessment was carried out at the time of the agreement to cease providing homeopathy services. Having made the recommendations, as good practice, a further impact assessment was carried out by a group of relevant staff including Dr Morrish.

41.3.3 The impact assessment had found that there would be no significant detriment to patient care or increase in access to GP services or other services as a result of the withdrawal of homeopathy services. Complaints related to the withdrawal of the services were being monitored; one complaint had been received and a number of

concerns had been raised. Dr Williams noted that no GPs had expressed concern about increased contact from homeopathy patients.

41.3.4 A court case regarding withdrawal of homeopathy services was in process with the hearing expected in February 2015.

41.3.5 Dr Williams noted that it had been planned that savings made by withdrawal of the service would be reinvested into areas such as chronic pain and fatigue. Professor McMahon confirmed that short term funding had been received for a pain fatigue rehabilitation service, and there had also been work on redesign of the pain service.

41.3.6 Ms Gormley observed that Dr Morrish's concerns were regarding a group of patients whom she felt would adversely affected by the withdrawal of services; the rapid impact assessment showed that with recommendations for actions, this group of patients would not be adversely affected. Dr Morrish had withdrawn from this process.

41.3.7 The Committee agreed that due process had been followed, and Dr Morrish's views had been taken into account along with other members of the group carrying out the rapid impact assessment, and they supported the findings of the rapid impact assessment.

41.4 Role of Healthcare Clinical Support Workers in Patient Medication

41.4.1 A paper had been previously circulated. Ms Johnson advised that the plan outlined in the paper sought to formalise a practice which was already used in all areas. This would allow Healthcare Support Workers to be able to help more in administering medication to patients assisting patients in taking medication. The paper described the governance processes to be put in place including training and supervision. This would not remove the accountability of registered nursing staff and would only take place in specific situations where it could be properly controlled.

41.4.2 Dr Williams confirmed that the recommendations in this paper had been scrutinised by the Area Drug and Therapeutics Committee which was happy to support them. The Healthcare Governance Committee also supported the recommendations made.

41.4.3 Ms Johnson noted that an impact assessment had now been completed on this process with a positive outcome.

42. Exception Reporting Only

42.1 Organ Donation Annual Report

42.1.1 Dr Williams highlighted the successes described in the Organ Donation Annual Report and noted that the percentage of Lothian's population on the organ donation register was the highest in Scotland and in the UK.

42.2 Members noted the following items for information:

42.2.1   Respiratory Managed Clinical Network Annual Report;
42.2.2   Diabetes Managed Clinical Network Survey and Action Plan;
42.2.3   Scottish Intercollegiate Guidelines Network Annual Report;
42.2.4   Heart Disease Strategy Programme Board Annual Report;
42.2.5   Scottish Intensive Care Society Audit Group (SICSAG) Annual Report;
42.2.6   Unannounced Inspection Report, Marie Curie Hospice Edinburgh, July 2014;
42.2.7   Resilience Committee Update;
42.2.8   Letter re: Secure Mental Health Placements for Adolescents;
42.2.9   Area Drug and Therapeutics Committee Revised Constitution;
42.2.10   Reducing Health Inequalities, NHS Health Scotland;
42.2.11   Scottish Public Services Ombudsman Complaints Report;
42.2.12   Improving Management and System Learning from Adverse Events;
42.2.13   Scottish Trauma Audit Group Quality Indicators Feedback Report to Royal Infirmary of Edinburgh Emergency Department 2013.

43.   Other Minutes: Exception Reporting

Members noted the minutes from the following meetings for information:

43.1   Area Drug and Therapeutics Committee, 3 October 2014;
43.2   Clinical Management Group, 9 September, 14 October 2014;
43.3   Lothian Infection Control Advisory Committee, 9 September 2014;
43.4   Health and Safety Committee, 29 April, 29 July 2014;
43.5   Public Protection Action Group, 20 August 2014.

44.   Date of Next Meeting

44.1   The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 27 January 2014** in **Meeting Room 7, Second Floor, Waverley Gate**.

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

NHS LOTHIAN

1.9

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9.00am on Wednesday 12 November 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Ms K Blair; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Ms M Johnson and Mr J Brettell.

In Attendance: Mr J Crombie (Director of Scheduled Care); Mr B Currie (Project Director, Royal Hospital for Sick Children / Department of Clinical Neurosciences); Mr I Graham (Director of Capital Planning and Projects); Mr C Kerr (Senior Project Manager); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager); Mr D A Small (Joint Director of Health & Social Care, East Lothian); Professor A Timoney (Director of Pharmacy) and Mr D White (Assistant General Manager).

Apologies for absence were received from Mr T Davison; Mr B Houston; Professor J Iredale and Mr P Johnston.

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.

Councillor Henderson declared a non-financial interest in Agenda Item 5.4, Primary Care Investment Summary, as he was the Councillor for Ratho which was served by the proposed GP Surgery in Ratho.

41.   Minutes of Previous Meetings

41.1   <u>Minutes of the Meeting held on 27 August 2014</u> – Minutes of the meeting held on 27 August 2014 were approved subject to an amendment to the 2nd sentence of the Minute 32.4 to read "Mr Brettell felt that he was unable to support the approval of the recommendation to the Board in respect of the ongoing revenue implications, however, conceded that the report would go forward as all other members present had agreed to approve the recommendation".

41.2   <u>Minutes of the Meeting held on 27 October 2014</u> – the previously circulated Minutes of the meeting held on 27 October 2014 were approved.

42.   Matters Arising

42.1   <u>Western General Hospital Front Door Services Development Project</u> – Ms Johnson advised the Committee that work was in progress to obtain the additional information concerning potential improvement to outcomes, efficiencies, benefits, savings and

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42.   Matters Arising

42.1   <u>Western General Hospital Front Door Services Development Project</u> – Ms Johnson advised the Committee that work was in progress to obtain the additional information concerning potential improvement to outcomes, efficiencies, benefits, savings and

funding sources. A progress report would be given to the next meeting of the Committee.   **MJ**

43. **Running Action Note**

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

43.2 Mrs Goldsmith advised the Committee that the Royal Hospital for Sick Children and Department of Clinical Neurosciences financial close was on the agenda and that guidance on due diligence in respect of the integration process was still awaited from the Scottish Government. A report would be brought to a future meeting of the Committee to provide appropriate assurances. Mrs Goldsmith commented that the guidance referred to costs rather than budgets which did not reflect how NHS funding worked. The Committee noted the position.

44. **Prescribing in NHS Lothian**

44.1 Professor Timoney introduced a previously circulated report describing the steps being taken to improve the management of prescribing in NHS Lothian.

44.2 It was noted that more work was being done on acute prescribing with a £1.67m savings target for the Local Reinvestment Plan. Price reductions were being obtained using the national scheme.

44.3 Professor Timoney was hopeful that following the appointment of a new medicines management pharmacist there would greater engagement and involvement at operational level.

44.4 The Committee noted that, whilst the focus of work for the next 18 months would be prescribing in the acute sector, work would continue in primary care with additional investment around prescription for excellence. This would develop more prescribing pharmacists working to address poly-pharmacy issues and an invest to save project involving pharmacy technicians to improve repeat prescribing. This approach had delivered high quality cost effective prescribing in primary care and would continue to be supported.

44.5 Professor Timoney cited the example of a new drug for the treatment for Hepatitis C which could effect a complete cure at a cost of £400 per tablet with a course of treatment of 1 tablet per day for between 12 and 24 weeks. The drug had been approved by the Scottish Medicines Consortium as it could be cost effective with patients no longer having to undergo other expensive treatment including liver transplant. The treatment regime was administered under strict guidelines and was likely to be administered on a daily basis through community pharmacy to ensure adherence to the treatment regime.

44.6 The Committee noted that the Acute Prescribing Board prioritised the work of the medicines management team determining where their involvement would be of the greatest benefit. In terms of reducing the cost of prescribing, it was more important that medicines were prescribed according to the formulary than doctors or junior doctors being aware of the costs of medicines.

44.7 It was noted that a major contribution to the overspend in General Practice prescribing was the significant shortfall in supply of medicines. Manufacturers were concerned at the possibility of prescribed medicines being re-exported to other countries in the European Union because of the difference between the exchange rates for the pound and euro. This issue had been raised nationally and at Westminster as patients were having to wait for drugs and Health Boards were having to pay a premium in order to have special supplies provided by manufacturers.

44.8 The Committee noted the approach being taken on prescribing in NHS Lothian and the reporting arrangements in place.

44.9 The Chair thanked Professor Timoney for her contribution.

45. Draft Financial Plan 2015/16

45.1 Mrs Goldsmith introduced a previous circulated report giving an overview of the Scottish Government's draft budget for 2015/16 and the financial implications for NHS Lothian.

45.2 Mrs Goldsmith reminded the Committee that NHS Lothian's very challenging financial position had been outlined at the Development Day and Mr Marriott and his Team had now brought together a Mid Year Review forecast.

45.3 The Committee noted that, in spite of the 1.8% increase of £21.4m in the recurring baseline funding from 1 April 2015, an additional £7m of NRAC funding and an integration fund allocation of £4.2m, the uplift for 2015/16 would be £18.4m less than the previous year which would bring greater financial challenges. The recurring carry forward of the Local Reinvestment Plan shortfall into 2015/16 was estimated at over £15.2m at the Mid Year Review and there were further issues relating to financial performance against total budget across NHS Lothian.

45.4 The Committee noted that the numbers were indicative at this stage, pending prioritisation and agreement of the detailed Local Reinvestment Plan schemes to be supported. Whilst the detailed implications for 2016/17 and beyond still required to be worked through in advance of the Board seminar at the end of November, the implications were that the system needed to plan to deliver annual efficiencies of 3-4% through service redesign.

45.5 Mr Brettell commented that whilst at the moment it was believed possible that breakeven could be achieved, there might be a shortfall at the end of the financial year. Actions taken to achieve financial balance in the current year might damage the following year's budget. He felt that the situation was now beyond accounting measures to resolve. It was now time to be clear about the position.

45.6 Mrs Blair commented on the increasing use of Bank and Agency staff and the substantial cost of providing services in this way and there was a need to change attitudes among staff.

45.7 Mr Crombie advised that the market was simply not providing the numbers of qualified specialists necessary to provide services without using Bank and Agency staff. He advised that other NHS Boards in Scotland and Health Authorities in NHS England were faced with similar difficulties.

45.8 The Committee noted that spending on the private sector in order to achieve waiting times targets was often required as a result of the difficulty in recruiting suitable specialist staff and that this was a national issue that could not be addressed locally.

45.9 It was accepted that any actions taken to achieve financial balance would inevitably impact on performance figures and it was vital that the position was discussed in depth at the December Board meeting. The increasing cost of delivering services to national targets because of the lack of specialist staff and pressure on beds because of delayed discharges was putting the achievement of financial balance in the current year at significant risk. This would exacerbate the already substantial anticipated shortfall in 2015/16. Delivery of Local Reinvestment Plan savings of the required magnitude could not be achieved without radical service redesign which could clearly not be delivered within such a short timescale.

45.10 The Committee agreed that this matter should be on the agenda at the December Board meeting and that there should be transparency about the challenges being faced. The public needed to be aware of the difficult choices that might have to be made. It was agreed that the concerns of Non-Executive Board members at the difficulties in achieving performance targets within the financial resources provided should be communicated to the Scottish Government along with the necessity for the Board to look at radical solutions as to how these could be funded.

45.11 It was agreed that those parts the strategic plan which supported radical service redesign proposals should be accelerated. These should be designed with an eye on both achieving cash savings in the shorter term along with longer-term efficiency and ensuring we deliver safe care in the best possible way from the most appropriate locations.

45.12 The committee noted that management and project capacity was very constrained and suggested that NHS Lothian must consider finding extra human resources and/or external expertise to assist in developing redesign and efficiency proposals.

45.13 It was agreed to recommend that NHS Lothian should immediately begin dialogue with the Scottish Government Health Directorates about these concerns which would need both financial support or support to look at significant service redesign.

45.14 The Chair undertook to discuss these concerns with the Board Chairman and Chief Executive along with the Director of Finance.   **GW/SG**

45.15 The Committee agreed to note the increases to funding from 1 April 2015, the net recurring shortfall between anticipated income and planned expenditure, the non-recurring under commitment and the efficiency requirement for 2015/16.

46.   Financial Position 30 September 2014

46.1 The Committee noted the previously circulated report providing an overview of the financial position for the period to 30 September 2014.

46.2 The Committee noted the in-month overspend of £436,000 bringing the year to date position of a £3,739,000 overspend including an achieved Local Reinvestment Plan savings.

46.3 It was noted that business units had developed recovery plans in order to help bring the overall position back to financial balance by the year end including focussed efforts to delivery efficiency savings and closer scrutiny of all costs. These plans would be the further scrutiny as part of the Mid Year Review. It was noted that expenditure of £12.6m had been incurred year to date against the capital resource limit.

47. Royal Hospital for Sick Children / Department of Clinical Neurosciences Programme to Financial Close

47.1 Mrs Goldsmith introduced a previously circulated report giving an update on the probable timeline for achieving financial close and therefore start onsite for the new building at Little France.

47.3 Mr Currie explained that in spite of the slippage of the financial close date due to technical and funder issues, progress had been made with Consort at a technical level although their formal approval had still to be obtained. A January date for financial close might be achievable.

47.4 The Committee expressed disappointment and concern at the delays and noted that the requirements for more detailed technical documentation had been set by the Scottish Futures NPD Contract and had been agreed by the contractor as part of the procurement process.

47.5 The Chair commented that the Committee was not reassured by the process and it would be important to demonstrate that risk management was in place before the Committee could be reassured.

47.6 Mr Currie advised that NHS Lothian was managing the project as best as it could but that many of the present issues were outwith NHS Lothian's control. The bidder had signed up to deliver the level of information as agreed at Final Tender Stage and which was considered appropriate to ensure the Board's requirements were delivered. NHS Lothian's legal adviser had stated that NHS Lothian was going above and beyond what they were legally required to do in order to expedite the process.

47.7 Mrs Goldsmith commented that the magnitude of the project was such that due diligence could not be achieved in the time originally allocated.

47.8 The Committee noted that there was a financial risk with the "guesstimate" cost being outwith the control of NHS Lothian. Mr Graham advised the Committee that there was an agreed capital cost of the project.

47.9 The Committee agreed to note the financial close programme and the governance in place to support the Board's requirements.

48. Property and Asset Investment Programme 2014/15

48.1 Mrs Goldsmith introduced a previously circulated report providing an update on the Property and Asset Investment Programme for the current year.

48.2   Mr Graham advised the Committee that the Royal Edinburgh Hospital project was still 2 months ahead of its original date for financial close. Detailed planning permission had been granted for Phase 1 and planning in principle for the masterplan had been granted for a period of 7 years. Scoping works for the Phase 2 project had begun and detailed planning permission for future phases would be sought at an advanced stage in the designs.

48.3   The Committee noted that there were opportunities for accelerating the masterplan which could enable the disposal strategy for the Astley Ainslie Hospital to be revisited. It was anticipated that an accelerated plan could deliver Phases 1-4 by 2019 and provide potential capital cost savings through construction synergies. The project team were in discussions with Hub Co regarding an enhanced Phase 2 which would include integrated Rehabilitation, Facilities Management and the refurbishment of Mackinnon House. The Scottish Government was supportive of the enhanced project and had announced £120m of revenue funded support for future phases of the project. Scoping works had begun for the enhanced Phase 2 with Astley Ainslie services given a priority to assist in a reduction of NHS Lothian's asset costs.

48.4   The Committee noted that an initial agreement had been prepared for new facilities to support the delivery of existing and repatriated services to East Lothian.

48.5   Mrs Goldsmith advised that she would be bringing forward proposed site disposals to the January meeting of the Committee.

48.6   The Committee agreed to note the financial performance to date and the highlighted key risks and issues from the programme of work.

49.   **Full Business Case – Partnership Centre Bundle**

49.1   The Committee noted a previously circulated report with the full Business Case for the proposed partnership bundle including the Blackburn Partnership Centre, Firrhill Partnership Centre and North West Edinburgh Partnership Centre.

49.2   Mrs Goldsmith advised that the capital costs of £32.3m were slightly down from the outline Business Case stage and the gap in revenue funding was £527,000.

49.3   The Committee noted that this expenditure had been anticipated and NHS Lothian would be able to bid against a Scottish Government fund of £40m being targeted at areas of deprivation.

49.4   The Committee agreed to approve the submission of the full Business Case to Lothian NHS Board with a recommendation to proceed to the Scottish Government Health and Social Care Directorates Capital Investment Group. It was also agreed to recommend to the Board that, subject to the approval of the full Business Case by Scottish Government, the approval of the final terms of the project agreement and associated contracts documentation be delegated to the Chief Executive, the Director of Finance for NHS Lothian or another nominated person from the Committee. The Committee agreed to recommend to the Board that, subject to the final approval of the final terms of the project, the signing of the project agreement at financial close be delegated to the Chief Executive or Director of Finance of NHS Lothian. **SG**

50. Primary Care Investments Summary

50.1 Mrs Goldsmith introduced a previously circulated report giving an overview of the Business Cases arising through the Primary Care prioritisation process.

50.2 Mr Small advised the Committee that an updated Primary Care premises prioritisation had been undertaken in support of the strategic plan development under the governance of the Lothian Capital Investment Group. This prioritisation amalgamated the work and engagement undertaken by each Community Health Partnership and the Community Health and Care Partnership with the practices in their respective areas and had generated a pan-Lothian prioritised list of potential Primary Care developments.

50.3 A number of schemes had been identified through this process and were progressing to Business Case. In the case of the General Practice surgery at Ratho, a standard Business Case had been circulated. In the case of Newbyres/Gorebridge, Prestonpans, Loanhead and General Practice capacity in Edinburgh, initial agreements had been circulated. Lastly, an emerging issue at Leith Walk Surgery would have an initial agreement developed.

50.4 Mr White advised the Committee that the six intermediate schemes were a cost effective strategy at £1.1m. He advised that before an e-Health approach could be taken to the delivery of services an appropriate environment would be required. General Practitioners were eager to embrace new technology.

50.5 Mrs Goldsmith advised the Committee that there was, as yet, no well formed idea of what an increased use of the e-Health approach would look like.

50.6 Mr Brettell commented that he was unclear about the potential benefits of the new facilities, particularly at Newbyres and Loanhead.

50.7 Mr Small advised that the contributions to be made by all of the proposed developments would be fully articulated in the final Business Cases.

50.8 Councillor Henderson commented that whilst developers had to make a contribution to Local Authority infrastructure as part of planning gain this did not apply to NHS facilities and he suggested that an approach should be made to Scottish Government to see if this could be considered. **SG**

50.9 The Committee agreed to note the progress of a Primary Care prioritisation work and approve the standard Business Case for the GP surgery at Ratho. The Committee agreed to approve the initial agreements for Newbyres/ Gorebridge, Prestonpans, Loanhead and increasing GP capacity in Edinburgh to include more detail on revenue costs and address the e-Health development issues. It also agreed that information should be included whether the lists at these practices were closed. The Committee also agreed that an initial agreement should be developed for Leith Walk Surgery emerging issue. **DAS**

51. Disposal of Corstorphine Hospital

51.1 Mrs Goldsmith introduced a previously circulated report seeking approval to declare Corstorphine Hospital surplus to Lothian Health Board's requirements.

51.2   The Committee noted that all patients had been moved off the Corstorphine site and the site was now vacant and surplus to NHS Lothian's requirements. Whilst the lodge buildings were currently being used as office accommodation, exit strategies were being explored and it was anticipated that these would be vacant in the near future. It was proposed that the services would relocate to existing NHS Lothian estate and there would be minimum removal costs associated with the relocation. The Learning Disabilities Unit at Murray Park would remain on the site.

51.3   The Committee agreed to grant approval to declare the property surplus to current requirements, allowing the property to be trawled around other Government bodies and if no interest noted, marketed for sale taking cognisance of the current market climate and the Scottish Government's property transaction guidance.

52.   Property Asset Investment Programme 2014/15 – Business Case Monitor

52.1   A previously circulated report providing a detailed overview of the major capital project including progress and performance to date as well as associated key risks and issues was noted.

52.2   The Committee also noted that there were changes anticipated towards the end of the year in the approach to Business Cases by the Scottish Government Health and Social Care Directorate's Capital Investment Group.

53.   Date of Next Meeting

53.1   It was noted that the next meeting of the Finance & Resources Committee would be held on **Wednesday 21 January 2015 at 9.00am in Meeting Room 7, Waverley Gate, Edinburgh.**

The draft minutes of the meeting held on 13 November are attached.

Key issues discussed included:

- Outcome of the Acute Sector Planning session on 6 November and work to develop proposals for improving capacity in primary and community services.
- The need for all aspects for strategic plan to be brought together so that interdependencies were fully understood was confirmed.
- Discussion also took place on the financial position which underpinned strategic delivery
- The emerging plans to establish a clinical change cabinet were noted.
- The Committee considered both the Health Inequality Strategy and Cancer Strategy and agreed that they should be forwarded to the Health Board for approval at the December meeting.
- The formal launch of the Children's Strategy was noted.

Key issues on the horizon are:

- Acute workshop on 16 December and avoiding admissions workshop on 19th December
- Plans for the 14 January Board Development session
- presentation of and update on the Strategic Plan to the February Board Meeting.

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 13 November 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chair); Mrs J Anderson; Mrs K Blair; Mr A Boyter; Mr J Crombie; Mr T Davison; Mrs A Mitchell; Professor A K McCallum; Mrs L Tait; Dr R Williams and Mr R Wilson.

In Attendance: Dr M Douglas (for item 66); Mr P McLoughlin (for item 67) and Mr D Weir.

Apologies for absence were received from Mr J Brettell, Mrs P Eccles, Dr D Farquharson, Mrs S Goldsmith; Professor J Iredale, Ms M Johnson; Mr A Joyce, Professor A McMahon; Mrs A Meiklejohn; Ms D Milne; Mr D Small and Mr G Walker.

62. **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.

63. **Minutes of the Previous Meeting held on 9 October 2014**

63.1 The minutes of the previous meeting held on 9 October 2014 were approved as a correct record.

64. **Matters Arising**

64.1 <u>eHealth Strategic Delivery – e-Communications Project</u> – It was noted the business case had been supported by the Efficiency and Productivity Group. The proposals would be developed further with details coming forward to a future meeting.

65. **Items for Discussion**

65.1 <u>Progress Report: Our Health, Our Care, Our Future 2014 / 2024</u> – It was noted the circulated paper set out the agreements reached at the Private Board meeting on 1 October 2014. The challenge was now to develop a sustainable set of strategic priorities and identify a mechanism for bridging these in the short term.

65.2 The committee noted that a workshop involving staff from all 3 acute sites had been held on 6 November with a further session scheduled for 16 December to agree what currently worked and should be built upon. The discussion would also consider what

needed to change to achieve a successful model of acute care for Lothian. Detailed work would be taken forward following the initial workshop by multidisciplinary groups focussing on the challenges and benefits of alternative models, with the second workshop agreeing specific propositions for consideration with the revised strategic plan.

65.3   It was reported work was being undertaken in benchmarking and the impact on the system if there were no delays greater than 2 weeks. It was noted bed modelling work would be essential and the baseline had now been agreed with consideration being given on how to use this information to develop propositions.

65.4   It was noted in parallel that work was underway involving the Joint Directors and their teams, including GP leads, to identify the priority areas from development across primary and community services. Work was well advanced on developing additional premises and core GP capacity over the next 2 years to improve access. Other work was underway to support planning within the partnership to address deficits and gaps in community services, consolidate existing good practice and to set out proposals for new models and approaches which would improve services for older people, prevent unnecessary admission and improve outcomes in the medium term.

65.5   The committee were advised of a workshop bringing together partnerships with Medicine of the Elderly colleagues to focus on agreeing the principles all partnerships would adopt to 'hospital at home' type services would take place in December 2014. It was noted each partnership was working on social care access plans with a proposal being brought forward soon for care home and supported accommodation to include the Royal Victoria Hospital Integrated Care Facility.

65.6   It was reported that work was underway to review staff skill mix opportunities including a development of a trained band 2-4 care delivery workforce. In addition a number of proposals with challenged current models of service which were not in line with evidenced based health policy direction and these would be explored to identify opportunities and choices which the organisation should consider.

65.7   A proposal was being taken to create a 'Clinical Change Cabinet' consisting of very senior clinical and management staff in order to encourage the development of ideas to address and harness progress towards addressing key issues like achieving earlier discharge of patients and the ring fencing of elective beds. Progress continued around the intensive review process (deep dive) which would focus on regional cancer services and the care of frail elderly people in West Lothian. It was anticipated the recent Clinical Director in cancer appointment would provide clinical leadership in this important area. The committee noted that all ongoing proposals would be brought together in January 2015 and would provide a better idea of models of care, costs and outcomes. This work would link to the local development plan and budget and planning issues around the establishment of the 4 Integrated Joint Boards.

65.8   The committee noted the substantial work being undertaken. A number of Non Executive Board members expressed concern about the apparent lack of a common framework and whether the separate initiatives were working to the same dimensions and strategic direction. It was felt there was a need for more cohesion as the current proposals felt fragmented with no common merge to the strategic objectives. Comments were also raised about the lack of robustness around some of the timescales quoted particularly given the need to meet deadlines around the February

Board meeting given the intervening festive period. Non Executive Board members expressed frustration about the same issue being discussed over and over again whilst they were interested in receiving details of outcomes and how these would effect change to deliver improvements to the service in a quantifiable manner. The specific point was made around the primary care strategy and how services would be reshaped through community partnerships which would not all be about GP premises but should include e-health and tele-health opportunities. In order to make changes there was a need to address the culture within the organisation and to support staff through any change process.

65.9   The point was made that nobody was denying the need for more capacity in primary care given the increase in population and the shift in workload into primary care. In order to address capacity issues there was a need to focus on people in premises. The paper was felt to be uncertain and was sparse around detail of the new Royal Victoria Hospital Integrated Care Facility.

65.10   The Chairman commented the points made were valid and that all aspects of the strategic plan were being looked at. In the short term there was a need to manage the financial gap as well as supporting the key issues contained within the strategy. It was therefore a necessary frustration that the point needed to be reached to identify the short term financial gap and the list of issues needed to address this and to what timescale. He felt there was a need to develop a masterplan to manage the process moving forward and to ensure the Board delivered against that masterplan.

65.11   In response it was noted that progress with different stages of work would report at different points. The Integrated Care Facility at the Royal Victoria Hospital was complex and required multiagency engagement. The Princess Alexandra Eye Pavilion Project Board would include engagement with primary care practitioners and patient groups and would provide an evaluation of different ways of working to include the best use of technology and IT to make a shift in pathways through the developed care model. The different use of technology and facilities would require an investment profile that might prove challenging in the current financial position. Work was underway to understand the options.

65.12   The Chairman commented that, even if the system was some distance away from being able to detail the answers, it would be useful to understand what had already been done, what was in development and the impact this might have on providing costed action plans. He felt it was only once this point had been reached that the Board would be able to determine whether or not it was on track to deliver. The information would then be used as a basis of controlling monitoring. There was therefore a need for a clearly visible plan that quantified specific timescales and costs.

65.13   The point was made that it was difficult to bring all these aspects together from all of the Governance and Executive Committees involved in the process. There was a need therefore for more cohesive centralised control to give ownership on behalf of the Board to a committee to act as mission control with nothing happening or being sanctioned unless it went through that forum.

65.14   The committee noted the update position and remitted it to Ms Tait to discuss the further required developments with Professor McMahon on his return from leave.

66.   NHS Lothian Health Inequality Strategy

66.1   The Chairman welcomed Dr Douglas to the meeting.

66.2   The committee were reminded they had considered the draft strategy in April prior to the consultation process being commenced. The report before the committee took account of the outcomes of the consultation process and would be submitted to the December Board meeting for approval. It was noted that in general most respondents to the consultation had been supportive of the proposals with the main comments being around procurement, employment and people with mental health problems.

66.3   The steering group had looked at the specific issues raised and wherever possible had addressed these through the final strategy. Some aspects like transport were significant and needed to be addressed in partnership with other agencies and through a different forum.

66.4   It was noted that health inequalities could not sit in isolation and needed to be reflected and addressed throughout the organisation through a set of key deliverables that would demonstrate progress. The key issues and overall approach needed to mitigate and tackle health inequalities were detailed.

66.5   The committee noted that the strategy focussed on actions that could be taken forward within NHS Lothian and recognised the organisation could not resolve the problems on its own and needed input from health and community care partnerships and other agencies including the third sector. Detailed actions were provided in both the paper and the accompanying action plan to address milestones, resources, and timescales. It was recognised this would develop over time and that the action plan would be an iterative document.

66.6   The committee welcomed the clarity of the paper. It was noted that housing provision was key to reducing health inequalities and that everyone should have access to a warm secure safe house.   It was noted there were a lot of players in the housing market and this should be developed further within the paper.   Shelter Scotland were in the process of undertaking a health and wellbeing consultation.

66.7   The question was raised about whether inequalities were addressed consistently over the Lothian Health system. It was reported during periods of austerity health inequalities tended to be targeted in places of greater need although the provision of universal services was important.   There was a need therefore to increase the quantity of provision where the need was greatest but this did not mean services would only be provided in these areas. It would be important services were provided in a way that did not stigmatise patients. The committee noted that opportunities around housing would be developed further in the paper as this was a critical area for further development with other agencies.

66.8   The committee agreed that in future, any proposals of a strategic nature would need to demonstrate a correlation with both the strategic plan and the inequalities strategy.

66.9   The committee agreed the NHS Lothian Health Inequalities Strategy should be forwarded to the Board for approval subject to additional inclusion around the importance of housing consequences.

67.   Draft Cancer Strategy

67.1   The Chairman welcomed Mr McLoughlin to the meeting.

67.2   The committee noted that the cancer strategy had been developed alongside the overall strategic plan and had been consulted upon. It was noted the cancer strategy identified resources and timescale and linked to the strategic plan.   There was currently a 2% year on year rise in cancer diagnoses.   The strategy had been finalised following consultation and would be submitted to the December Board meeting for approval.

67.3   It was reported 73% of respondents to the Survey Monkey consultation had been supportive of the strategy. The remainder of respondents had given no indication that their view was either supportive or not and instead provided comments relating to either their personal experience of cancer care in NHS Lothian, or a comment on a specific aspect of the strategy.   Four main themes emerging from the strategy consultation: -

- Early detection of cancer was supported
- A strong focus on prevention of cancer was supported
- There was support for a new regional cancer centre at the Western General Hospital
- The strategy was seen as ambitious and requiring significant investment to deliver

67.4   The committee were advised the strategy would be implemented in 2 phases. The first would be through a deep dive exercise to challenge how things were currently done and to deliver a new service model.   The second phase would be to take the output of the review and develop the outline business case to produce a fully impact assessed strategy.

67.5   The paper and strategy was welcomed and commended by the committee. It was noted Mr McLoughlin had been enthused by feedback around the desire for early detection and prevention of cancer as well as comments about whether what was being proposed was perhaps over ambitious. It was noted Lothian was linking into the national cancer strategy work with it not being possible to deliver on all ambitions. In particular radiotherapy shortfall had been highlighted for some time.

67.6   The point was made that it was difficult to reconcile the proposals for service centralisation through regional cancer centres and the delivery of services to patients close to home. In response it was felt there was a need for a stronger approach on repatriation of chemotherapy services on a local basis. In addition consideration would be given to the diagnostics pathway in respect of community hospitals to provide a locally accessible service.   The provision of open access diagnostic services and links with primary care would be further considered and developed. Evidence supported the view that people would be happy to travel to obtain the best service and treatment available.

67.7   Dr Williams commented that from a primary care perspective he welcomed the proposals and the enhanced primary care perspective. He felt the strategy would provide a Lothian service to patients close to home. In terms of implementation of

the strategy he sought further advice given the current financial position where the £60m of investment for the new facilities at the Western General Hospital would be sourced from.

67.8   The committee were advised that the £60m represented the capital component of the scheme and would be provided either by the Scottish Government or through the non profit distributing route (NPD) the key issue for NHS Lothian however would be the revenue consequences of around £6m. There might therefore be a choice about the phasing and timing of the capital development. It was pointed out as previously advised that radiotherapy was a major issue and that a Monklands satellite unit was being developed. There were possible implications of this development in terms of whether this would attract staff working in existing centres in Edinburgh and Glasgow and this was a current concern. The development of radiotherapy services in Lothian was considered to be a given albeit it might need to be a phased investment at the same time as there being a requirement to invest in issues like primary care premises.

67.9   The committee agreed the cancer strategy should be submitted to the December Board for approval.

68.   Actions from Board Development Day – 5 November 2014

68.1   The committee noted that at the development session on 5 November it had been acknowledged that the strategic aspirations were unaffordable. At the Finance and Resources Committee the in-year financial position had been discussed.   It had been confirmed that financial breakeven would be achieved in-year although there would be a need to pull back expenditure as the system was currently overheating. The financial position would be discussed further at the 3 December Public Board meeting.

68.2   It was reported work was underway to try and articulate the gap through the production of a gap analysis whilst at the same time strenuously continuing to pursue conventional LRP schemes and programmes. A deep dive analysis was being undertaken to look at pathways and how to do things differently. It was reported at a recent visit to Newcastle it had been noted that they treated a bigger cancer population with fewer beds than were available in Lothian. The key issue around the financial position was that marginal efficiencies alone would not resolve the situation. It was noted both the Chair and the Chief Executive of NHS Boards were engaging nationally with the Scottish Government on how to do a raft of things differently. Both the Chair and Chief Executive had attended a guiding coalitions meeting with the Director General and Chief Executive of the NHS in Scotland where a number of positive workstreams had been agreed to set out the areas of required change.

68.3   The committee noted the update report.

69.   Feedback from the Future of Acute Services in the Strategic Plan Workshop – 6 November

69.1   The committee received feedback from the Future of Acute Services Workshop that had been held on 6 November involving participants from all 3 of the acute sites in Lothian. The objective of the event had been to: -

- Encourage staff groups to think outside the box and to consider the impacts of this.
- Understand the challenges that existed across the system in different campuses.
- Facilitate clinical challenge.
- Come back to look at the impacts and the ways in which they change within their own existing methods to make progress.
- It was noted in order to undertake the above that the construct of a flowopoly was adopted the details of which was fully explained to the committee. The focus of the flowopoly had been to look at the busy areas in the Royal Infirmary of Edinburgh, Western General Hospital and St Johns Hospital, issues and blockages in the system. Presentations made by 3 senior clinicians had been brave with it being recognised and accepted that the current way of working was not sustainable.

69.2   The next phase of the work had been for the group to continue to bring challenge to models of care by a degree of cross population of the group. One of the purposes of both the 6 November and 16 December events was to shake up existing groups and silos and encourage lateral thinking through which revised processed would evolve.

69.3   The committee noted that similar exercises where underway in primary care with the previous exercise having looked at whether or not inappropriate missions to the acute sector were being made. The in-depth analysis had suggested this was not the case and where there were instances it tended to be from the care home sector. A system of protected learning was in place in primary care were practices got together to discuss issues. It was stressed that any redesign proposals would have an impact on primary care and appropriate discussions would be needed around potential implications.

69.4   The point was made in terms of some of the successful initiatives in place across the system that there was a need to consider how to upscale these to reduce beds and costs in the acute sector. If this did not happen then additional costs would only be added to the system.

69.5   It was noted in terms of a previous GP lead review of inappropriate admissions to the acute sector that the key issue was about the breakdown in social care requiring a patient to be admitted in the absence of a more appropriate non hospital based solution. It was suggest a benefit of the integration process might be to ensure the availability of immediate social care solutions including out of hours provision.

69.6   Part of the feedback from the session had been the need to enable people to make change and flex resources to address challenges on the ground as there was a real enthusiasm and willingness amongst clinicians and others to do this. It was felt the real success would be if clinicians as a group led the implementation of the strategic plan. There would be different opportunities for different models of care and recruitment would remain a challenge.

69.7   The committee noted the proposed creation of a Clinical Change Cabinet to harness clinical agreements. It was noted although clinical engagement currently occurred this could only scratch the surface given the number of medical and clinical staff employed by NHS Lothian.

69.8 The Clinical Change Cabinet (not a committee) would be about identifying representatives from medicine, nursing, AHPs and other powerful people not in the hierarchy of management to meet and look at specific issues. The desired outcome would be to get change driven by clinicians. This dynamic would be created through a regularly convened forum which would upscale decisions more quickly than was the current position. The idea of creating a clinical senate was also discussed. The point was made there would also be benefit in bringing people together employed within the system who acted as advisors to the Cabinet Secretary or the Scottish Government.

69.9 The point was made in respect of the Clinical Change Cabinet that clear objectives would need to be set along with the expectation of the requirement for genuine and active engagement. It was felt there was sufficient evidence of enough willing clinicians in the system to engage in this type of process. A key issue would be about securing engagement from the ground up and challenging people to think out of the box.

69.10 The committee noted the update report and supported the establishment of the Clinical Change Cabinet.

70. Plan for 14 January 2015 Board Development Session

70.1 The committee agreed that the earlier debate around the creation of an overall masterplan and the need for a more centrally controlled control mechanism would be the focus of debate at the 14 January Board Development Session. This work would need to be supported by costs, timescales and details of desired outcomes. A draft proposal would be issued in advance of the development session for comments. An update would also be provided at the December Board meeting in private session. The committee were reminded from June onwards the 4 Integrated Joint Boards would be enshrined in statute and that significant aspects of primary care and community, social care and acute sectors would be driven by them. They would also be responsible for the strategic planning of accident and emergency services; general medicine; respiratory medicine and rehabilitation. NHS Lothian would therefore have responsibility for the rest of medicine, acute services and regional and national services. It was felt therefore that the Strategic Change Committee should consider Board influence through members of the Board on the Integrated Joint Boards. There was a need to think about how the committee morphed to influence the IJBs to deliver NHS Lothian's strategic direction of travel through the development of their plan.

71. For Information

71.1 Children's Strategy – Launch on 7 November – Noted

72. Any Other Competent Business

72.1 Attendance at Future Meetings – The Chairman commented he had become concerned at the trend over recent months for reduced attendance at meetings of the Strategic Planning Committee. Indeed attendance at the meeting this morning had been particularly poor. He commented that it was essential given the

importance of the strategic and financial issues facing the Board that there was full representation at future committee meetings. He commented that he would be grateful therefore if members of the committee would consider their priorities to enable them to attend future meetings.

73. Date and Time of Next Meeting

73.1 The next meeting of the Strategic Planning Committee would be held at 10am on Thursday 11 December 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

STRATEGIC PLANNING COMMITTEE

The draft minutes of the meeting held on 11 December are attached.

Key issues discussed included:

- Agreement on proposal for the establishment of the Clinical Change Cabinet to meet early in 2015;
- The Financial Sustainability framework was discussed and a number of specific proposals which further the direction of the strategic plan and which contribute to the financial sustainability in the short to medium term were considered.
- An update on the work of the NHS Lothian Innovation Programme was received.
- A presentation on bed modelling was supported.
- The Director of Public Health reported on Policy Choices which could support the delivery of financially sustainable health and care services within the context of improving quality, sustainability and equity of service provision.

Key issues on the horizon are:

- Plans for the Board Development day on 14 January 2015
- Delivery of the updated Strategic Plan actions to the Board in February 2015.
- The Interface between the Strategic Plan and the ongoing work to delivery financial balance in 2015/16 and beyond.

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 11 December 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chair); Mrs J Anderson; Mr A Boyter; Mr J Crombie; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Professor J Iredale; Ms M Johnson; Mr A Joyce; Professor A K McCallum; Professor A McMahon; Mrs A Meiklejohn; Ms D Milne; Mrs A Mitchell and Dr R Williams.

In Attendance: Ms G Campbell; Mr G Cumming (for item 79); Mr A Jackson (for item 80); Mrs L Tait; Mr D Weir and Mr S R Wilson.

Apologies for absence were received from Mrs K Blair, Mr J Brettell, Mrs P Eccles, Mr J Forrest, Mr P Gabbitas, Ms E Mc Hugh, Mr D A Small, Mr G Walker and Mr R Wilson.

74.   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.

75.   Minutes of the Previous Meeting held on 13 November 2014

75.1 The minutes of the previous meeting held on 13 November 2014 were approved as a correct record.

76.   Agenda Reordering

76.1 It was agreed to consider agenda items 3, 6 and 7 consecutively.

77.   Clinical Change Cabinet

77.1 It was noted that the recent Health Improvement Scotland Review of Aberdeen Royal Infirmary and Services for Older People in Acute Hospitals had raised as a key issue the lack of engagement between the Board and clinicians. Within NHS Lothian there had been significant engagement with clinicians over the previous year through acute service recovery initiatives, the Change Fund, Primary Care Development, the Area Clinical Forum, Lothian Medical Committee and the GP Subcommittee who had all been actively engaged with. In addition there had been a number of engagement events arranged as part of the strategic planning process.

77.2 A recent flowopoly event covering all of the acute medical wards and involving a range of senior clinicians both medical and non medical had demonstrated that all of the activity happened at the front door and patients were not flowing through the hospital and being discharged. The exercises had also demonstrated there was little engagement between sites and front and back doors of the hospitals with processes being managed in silos.

77.3 One of the outcomes of the flowopoly event had been a desire to develop processes to engage with clinicians both within management hierarchy posts and others through the creation of a Clinical Change Cabinet with other engagement events continuing as reference points. It would be important clinicians continued to drive the performance agenda and engage with the wider workforce.

77.4 The 3 dimensions of the Clinical Change Cabinet would be to provide a pan Lothian touching stone on quality and overall approach. Traction at acute level meant there was a need to focus on sites and that meant the Clinical Change Cabinet might function across all 3 acute sites with GPs being encouraged to engage with local clinicians. A first specific workstream for the Clinical Change Cabinet would be the closure of Liberton Hospital. The Clinical Change Cabinet would continue the approach of looking at immediate change in clinical practice for example the ring fencing of elective beds and discharging patients rather than boarding them. Job plans would need to be developed to ensure dynamic discharge rounds happened every morning. There was also a need to enhance criteria led discharge via nurses and AHPs.

77.5 A list of names to be included on the Clinical Change Cabinet would be identified following the Acute Services Event to be held on 16 December.

77.6 Professor Iredale commented that the Chief Executive had asked shortly after his appointment what he could do to engage clinicians and had been advised that visibility was a key issue. It was his view that both the Chief Executive and the Chairman were visible within the organisation. He felt in terms of the Clinical Change Cabinet that he was delighted about its creation and that the devil would be in the detail. Professor Iredale was pleased that the proposal was not around the recreation of the Service Change Committee which had never really been successful at spinning out good practice across the system and this should be the default position. The importance of ensuring the correct people were appointed to serve on the Clinical Change Cabinet was stressed as it would be important to develop models to deliver future services and this would involve difficult decisions about staff engagement and discharging patients. There was a need in future to develop processes whereby professionals could feed in to the systems efficiency proposals and for these to be quickly actioned as many key savings could be made from grass roots suggestions.

77.7 The Strategic Planning Committee noted that 6 Lothian consultants had been involved in the Grampian HIS report and had been invited to attend the Patient Safety Experience Action Group chaired by the Chief Executive to provide full and frank consideration on the Aberdeen Royal Infirmary Report in relation to NHS Lothian's own services. The Chief Executive felt whilst there was a lot of visibility with clinicians within Lothian that it was still patchy. The main focus of the Clinical Change Cabinet would be around what NHS Lothian could do for itself moving forward.

77.8 There was agreement that over recent years there had been a significant change in the culture at Board level with better primary care engagement. Managed clinical networks had been established in the past although difficulties had been experienced in getting key people around the table. The point was made in respect of the Clinical Change Cabinet that attendance would be closely linked to personal empowerment of participants to make changes without seeking upward permission. Consideration would have to be given to the mechanism for playing out the deliberations of the Clinical Change Cabinet to a wider audience.

77.9 It was noted that the results of the staff survey would be issued on 17 December 2014 with informal feedback suggesting that NHS Lothian had performed better than in the previous year in 31 of the 33 fields with the number of responses having also increased reflecting the local effort put into encouraging staff to participate through engagement events.

77.10 The committee noted that the Scottish Government Health and Social Care Directorate (SGHSCD) had launched a new initiative called I-matter which was a methodology for taking the temperature of how the organisation engaged with people. It was noted this process overlapped with Investors In People (IIP) with NHS Lothian currently undergoing a revalidation process with the outcome being known in March 2015 and this would determine whether NHS Lothian would be re-accredited for a further 3 years. Going forward there would be a need to consider whether the organisation could continue to utilise both I-matter and IIP given the significant overlap and the need to be reflective of the current financial position.

77.11 The Strategic Planning Committee agreed the proposal to establish a Clinical Change Cabinet and noted the Chief Executive would finalise membership following the acute services event to be held on 16 December 2014.

78. Strategic Framework for Delivery of the Strategic Plan – Strategic Plan Update

78.1 The Chairman reported that the updated report was in part to follow on from issues raised at the previous meeting around the need to develop a confidence framework against which the delivery of the financial plan could be measured and in the shorter term to address the financial imperatives.

78.2 Reference was made to further discussions that had been held at the November Board Development Session and the Private Board meeting in December. It was noted following these events a number of meetings had been held to put momentum around what was needed to develop the framework and clarify the critical paths. An embryonic template was tabled which was intended to focus on the financial sustainability agenda and delivery of the strategic plan proposal. This work would be supported and progressed through the programme office which would continue to develop the framework approach and template. The Chief Executive advised he had written to all members of the Corporate Management Team (CMT) about the need to support financial sustainability.

78.3 The committee noted by January 2015 firmer proposals would be developed to reduce the £70m potential financial shortfall and how much of the strategic plan proposals could be driven forward. Workshop events would continue to develop proposals. This would shape the debate at the January Board Development Session as well as the strategic plan paper to the February Board meeting which

would not represent a revised strategic plan but would include propositions to drive forward within the financial context and to drive the model of change.

78.4   The point was made that moving forward NHS Lothian needed to take control of what it could control. It was pointed out that having presented an unbalanced financial plan to the Board in December that it would be important to bring forward propositions about driving change to get to financial sustainability. It was noted that future work would have huge interdependences and there would be a need for clarity to avoid unintended consequences.

78.5   The Chief Executive advised he had established a small group of Executive Directors to devote significant focus between now and April around the financial position and linkages with the strategic plan and the need to continue to deliver against the 2020 vision. It was noted there was a number of issues within the strategic plan that would need to be delivered because of fundamental patient safety issues and performance considerations ie the redesign of the front door of the Western General Hospital. Other issues that would be taken forward were around the closure of the Astley Ainslie Hospital given that capital coverage was available to move services to the Royal Edinburgh Hospital. The Chief Executive set out his view of what the 2020 vision would look like in Lothian even if it took beyond 2020 for complete delivery of the proposals. All of this work would need to be undertaken over a further 5 year period of austerity and a reduction in public sector spending.

78.6   Lothian had been the first Board to state in a Public Board meeting that it could not balance its books and this had resulted in media coverage about the need to close hospitals. It was noted Corstorphine Hospital had already closed. The media had also reported on maternity services and the possibility of significantly more home births as referred in a recent NICE article although there would be a need to drive strategic change to facilitate such a move in the service delivery model. It was reported in order to sustain the current rota at Simpson Memorial Maternity Pavilion there would require to be an additional 10 consultants recruited at a cost of £1.5m. The Medical Director commented that to undertake 50% of births at home was currently so radical that it was unlikely to be deliverable as people would need to be persuaded of the benefits and this would take time. A more sustainable and deliverable approach would be to provide an obstetrician led service at the Royal Infirmary of Edinburgh, a midwifery unit at St John's whilst continuing to encourage an increase in home birth numbers.

78.7   Dr Williams commented at this stage and without any evidence he could not state that there would be 50% of births in Lothian at home. He did however fully support the work that would explore and evidence whether or not it would be possible, safe and sustainable for that to happen, and whether it would indeed save money. He commented in respect of the issue of midwife led maternity units that he had less concern about this as would the GP population as a whole although he suspected that difficulties would be experienced in recruiting sufficient midwifes.

78.8   The committee were provided with an update of discussions held by Board Chief Executives the previous week which had resulted in a presentation being made to the Chief Executive of the NHS in Scotland and his officials around the coalition workstreams. The general outcome of the debate had been that there would be no downgrading of any HEAT targets and Boards would be expected to manage their own financial positions.

78.9　Professor Iredale commented the proposals moving forward would need to demonstrate sustainability and patient safety. The Board at its meeting had suggested the need for a conversation with the Cabinet Secretary although it was important to recognise that the Board was a sovereign body. Professor Iredale suggested there was a need for the Board to receive radical solutions and proposals. He felt that patient experience and patient safety were at the front and centre of work moving forward and he was confident centralisation of concerned births and the special care baby unit could be evidenced. The point was made that consideration should be given to contraception and preventing unwanted pregnancy and abortions in the first instance. It was felt there were opportunities for the hospital maternity service to provide postnatal contraceptive services.

78.10　The Chief Executive stressed that the Board wanted radical change although sometimes proposals were met with resistance from some quarters. The Board had asked the Chairman to write to the Cabinet Secretary. The Chief Executive updated on parallel steps he had put in place with the Chief Executive of the NHS in Scotland.

78.11　The Chairman commented the update report to the committee had been to respond to the issues previously raised about modelling and the need to evaluate options. The report demonstrated significant work in progress around a series of complex processes and interdependencies that would be key to work through. The purpose of the ongoing work would not be to stifle or stop progress already being made. The point was made that the Board would be working through similar issues for at least 5 years and it was important that the process was adequately resourced.

78.12　The committee noted the update report.

79.　Planning for Board Development Day 14 January 2015 and 4 February Board Meeting

79.1　It was agreed this item had been discussed under the previous debate.

80.　2014/15 NHS Lothian Innovation Programme

80.1　The Chairman welcomed Mr Cumming, Strategic Programme Manager for Health Innovation to the meeting.

80.2　The committee noted that all Health Boards were required to establish an Innovation Programme Board and Innovations Champion. It was noted innovation was not the responsibility of any single person but needed to be embraced by all.

80.3　Mr Cumming updated the committee on the progress being made on the NHS Lothian Innovation Programme plans since it was adopted by the committee in July 2014.

80.4　The committee were advised of the ability to link with other external funding sources eg Social Enterprise Funds for the pump priming of proposals and their subsequent evaluation. The point was made about the need to endorse new ways of working and to ensure previous practices were closed down and disinvested in. The

importance of bottom up feedback from staff and learning lessons from elsewhere was stressed.

80.5   It was reported that 3 corporate objectives had been set for innovation and work had started against all of these. The potential to bring in industry partners to determine whether they could develop the needs identified by staff to produce better shaped technology was discussed and would be subject to focus at a forthcoming event.

80.6   Professor McCallum advised she was the Executive Director Champion for innovation. It was noted work was underway about creating evidence and implementing new models and addressing areas that did not work. Input was also being targeted from colleagues in research and development as there were lots of clinical innovations that could be developed and used across the world. There were issues about possible income generation and joint working with the University around intellectual property rights. The committee noted there were examples of innovation and primary care that could translate into the acute sector if the appropriate process for implementation were put in place.

80.7   The committee noted in respect of ehealth opportunities that links were being made to the information strategy to ensure appropriate linkages to maximise resources. A national review of the ehealth strategy was underway which might change the focus. There was a need to explore all possible areas and bring back propositions to drive progress faster.

80.8   It was reported that there had been significant University of Edinburgh Medical School investment in informatics which would look at e-technology and large data bases to enhance the generation of data to assist in the development of services. The University had recruited a new Chair of Informatics and discussions were under way with NHS Lothian to consider pulling the 2 constituencies together. The University had recently undertaken a 6 yearly peer review exercise and Professor Iredale intended to bring forward a detailed paper to NHS Lothian Board demonstrating since 1993 a range of impacts and changes in primary care. It was anticipated this paper would show how the Board and University had worked together to make progress in developments.

80.9   The committee were advised in terms of engagement with the third sector that work was underway to look at any areas which might assist the more agile delivery of services and to free up NHS staff. The key issue in respect of the third sector was about what services they could legitimately provide on behalf of the NHS. It was noted however that staff side partnership colleagues would have a view on any such proposals particularly in terms of quality and safety issues.

80.10   The committee noted the actions progressed to date and those planned for the remainder of 2014/15.

81.   **Bed Modelling and Benchmarking**

81.1   The Chairman welcomed Mr Jackson, Associate Director to the meeting advising he would provide a presentation on bed modelling and benchmarking. It was noted the context to the exercise had been linkages with the strategic plan and the need to provide a response to unscheduled care. Consideration had also been given to the

repatriation of elective work and sustainable weightings. Capital masterplanning and future proofing aspects had also been considered. All of this work had used 2013 data as the baseline.

81.2 The committee were advised that the waiting list impact on beds was marginal with the main impact being the population shift and activity growth. Potential performance improvements were discussed. The point was made if nothing else changed then by 2030 the Western General Hospital would need 1000 beds and there was therefore a need to undertake work to mitigate this position. It was reported at St John's Hospital because of demographic changes that it would require the creation of a new ward every 5 years and the Site Director was looking at how to mitigate this position. The view was expressed at the Western General Hospital that zones and beds were misaligned based on current performance and there was a need to make shifts between the north and south of the city. The committee were advised that additional analysis had been undertaken around delayed discharges and front door amendments with first steps having been taken around outpatients, theatres and the major trauma centres. This would be discussed further at an acute sector event to be held on 16 December 2014. The next steps in the process would be to expand the benchmarking process and to look at the acute planning process around orthopaedics, surgery, unscheduled care / front door and medicine of the elderly and rehabilitation.

81.3 It was noted that the presentation represented the start of a journey and there would be a need to engage with respective management teams and at ward level. The point was made that bed modelling was central to the planning process and would be instrumental in the development of the 4 Joint Integration Boards.

81.4 The committee supported the ongoing work around bed modelling and benchmarking.

82. Policy Choices

82.1 The committee received a report advising of policy choices consistently identified from a review of evidence and the detail of which had been discussed at a recent Private Board meeting and also individually with a number of Non Executive Board members. General support had been received from those engaged with about this being the start of a series of workstreams and propositions. There was a need to be clear about tangible options and the way services were organised in order to deliver plans in a proper affordable manner that took account of opportunity costs.

82.2 It was reported that the focus of work was in primary care as this area was central to the delivery of different and better services. The committee noted in terms of the performance monitoring template described earlier in the meeting that the policy choices paper was aligned with the key issue being around identifying what areas to progress with.

82.3 The committee supported the proposals to establish a small group to work through the propositions in the paper and identify issues around pace and feasibility as some areas would not be able to be delivered in the shorter term. It was agreed that the scale of the statements in the paper were ambitious and the working group would look at these propositions at a practical level in terms of how to choose what proposals to tackle first. The first part of the process was to obtain the support of

the committee for the direction of travel with a mechanism for delivery and monitoring being determined thereafter. It was noted however that clinical pathways and innovation mechanisms were already in place and could be developed.

82.4 Professor Iredale advised he was supportive of the proposals and stressed the need to progress using technological innovation. He questioned the need to always have a Scottish equivalent to English initiatives such as NICE and commented on the possible economies of scale if a more collaborative approach was adopted. He stressed the need to tread carefully about making judgements around some illness areas and the provision of medication as these would be sensitive. It was noted there was a lot of policy and guidance available through the Area Drug and Therapeutic Committee as well as via NICE and the Scottish Medicines Consortium.

82.5 The committee supported the development of the proposals in the Lothian context to identify ways of improving quality, sustainability and equity of service provision.

83. Date and Time of Next Meeting

83.1 The next meeting of the Strategic Planning Committee would be held at 10am on Thursday 15 January 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 6 November 2014 are attached.

Key issues discussed included:

Scheme of Integration Current Draft Paper– Draft scheme was summarised and discussed.

- **Strategic Plan** – There will be a round of engagement on the plan and then a round of consultation. This will include the third and independent sectors and all the area partnerships. The plan ensures alignment with NHS Lothian strategic plan and the Council plan. Further discussion required regarding the acute sector elements of the plan. The next Shadow Board meeting (22.01.15) will look at the financial implications. Plans have already been agreed in areas such as Mental Health and Learning Disabilities and these will be incorporated into the plan.

- **Joint Financial Planning** – Budget setting for the Council is February 2015 and the NHS is March 2015. Since the IJB will come into being in June 2015 the budgets will be fully known for the first year.

Key issues on the horizon are:

- **Scheme of Integration Draft Paper**

- **Strategic Plan**

- **Joint Financial Planning**

Mike Ash
Chair/Executive Lead

East Lothian H&SCP

MINUTES OF SHADOW BOARD
6TH November 2014
1400 – 1600
Adam Room, John Muir House, Haddington

Present:	Mike Ash, Chairman (MA) Donald Grant, Vice Chairman (DG) Shamin Akhtar SA) Stuart Currie (SC) Jim Goodfellow (JG) David King (DK) Angela Leitch (AL) 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) Jon Turvill (JT)
Apologies:	Maureen Allan Alastair Clubb Sarah Fortune Keith Maloney Graeme Warner
Scribe:	Barbara Gilbert

1. **Welcome and Apologies**
   MA welcomed those present to the meeting.

2. **Minutes of Previous Meeting**
These were agreed as a correct record. A spelling error on page 3 was noted, the text should read "agreement on".
HR/OD plan – MA reported some discussion regarding monies which involved the Change Fund and DK will pick up this item.

3. **Matters Arising**
Nil.

4. **Standing Items**
   4.1 **Chair's Report**
   MA reported that he had undertaken a number of meetings and he felt there was growing awareness of integration. MA conveyed his thanks to all concerned for their help.
   The October visit to Inverclyde had been cancelled due to other pressures on time.
   Dr Alistair Noble from Nairn had met with GP leads on 22nd October 2014.
   The planned visit to Cumbria on 18th November 2014 (agenda was circulated) will provide a good opportunity to learn from other areas.
   MA had attended a meeting at the Queen Margaret University connected with "Wellbeing on Wheels" which, whilst it was focused on children, would be a benefit to East Lothian.
   MA met with GP leads at the EL GP Forum and he had an interesting debate which was positive and expressed his thanks to GPs for making time to see him.
   MA attended a session regarding Quality Improvement in Edinburgh with good attendance from the sector which was extremely interesting with lots of challenges.
   MA had a meeting with Iain Gray at which he reported being interested in the East Lothian Community Hospital and was encouraged to hear about the partnership.
   On 21st October 2014 there had been a visit from the Kings Fund. Thanks was conveyed to CL and Steven Wray.
   MA attended an event with RVS which consisted of small groups in the voluntary sector working with older people. He expressed thanks to Strive for hosting this.
   On 11th December 2014 the next Shadow Board meeting commences at 12 noon and the programme will be issued shortly. Tim Davison and Tim Ellis are attending in addition to the normal membership.

   4.2 **Director's Report**
   DAS reported that work is well underway on the drafting of the Scheme of Integration which is covered in more detail in Item 5.1. The first set of final regulations was laid before Parliament on 6th November and these regulations must sit for 28 days before being issued. This means that the consultation draft to be presented to the Council and NHS Board in December may be

subject to revisions during the consultation period based on the final version of the regulations. The time line presented to the Shadow Board in September has been amended. The final Scheme of Integration will be presented to the Health Board and Council in March 2015 to allow submission to Government by 1st April 2015 at the latest.

It was agreed that the next Shadow Board should receive information on integration of services and early wins.

East Lothian Community Hospital will receive support from the government up to £65m. It is proposed to have a staged programme approach to site development.

MMcK commented that integration of operational services might have an impact on partners and this impact needs to be part of the consultation.

DAS will take this back into discussions and build this in.

5. Items for Discussion

5.1 Scheme of Integration Current Draft Paper

MA welcomed the paper and encouraged members to express their views.

JMcC summarised the draft scheme.

AM enquired how the values element had been developed. CL reported that it was the same as in the draft strategic plan, since these two documents should align.

MA stated that the IJB will be audited separately and there will be an audit committee.

SC pointed out that there are varying approaches in other partnerships in terms of audit and scrutiny. DAS replied there will be external and internal audit. SC stated he was concerned about the scrutiny role. MA commented there is helpful guidance by Audit Scotland; however it is up to the IJB to determine within standing orders. DAS commented there will be powers reserved to the Health Board and Council to intervene in certain circumstances.

AL added that delivery of services will still be the responsibility of the Council and NHS.

AM enquired if we have received guidance from the Government on clinical and care governance. JMcC replied that the guidance will be issued by December 2014.

ML indicated that Social Work Scotland is preparing commentary on Chief Social Work Officer role.

DK commented that management of over spends or under spends will be challenging.

SC enquired about the impact of IJB decisions on the capital planning of Board and Council. DAS agreed that this needed to be part of the development process and consultation on the Strategic Plan to avoid scenarios where the IJB "directed" one of the bodies to carry out an action that was contrary to agreed capital priorities.

MA reminded everyone present that if they would like to have the next version to please advise Barbara.

AL expressed her thanks to JMcC for her hard work.

MA reminded the Shadow Board that they will receive the version that goes out for consultation and the version that is approved for submission to the government.

5.2 Strategic Plan

CL indicated that a copy of this is included in the documents for the meeting.

There will be a round of engagement on the plan and then a round of consultation. This will include the third and independent sectors and all the area partnerships. .

The plan ensures alignment with NHS Lothian strategic plan and the Council plan. The first phase of work involved a strategic assessment which has resulted in very useful data. The draft does not have a financial plan as this is work in progress. Further discussion is needed on the acute sector elements of the plan.

MA welcomed the presentation.

SC enquired how the Musselburgh partnership's wide variations around deprivation would be addressed.

CL stated that one purpose of Strategic Plan is to address this where relevant.

SC enquired how decisions would be made about the change fund and the integrated care fund.

DAS commented that the Change Fund Delivery Group has concluded an analysis of change fund projects and recommended some which could be continued into the new fund. However the new fund has different priorities than the change fund and is only for one year.

MA stated the Change Fund is not a Shadow Board responsibility but that the integrated care fund money will be.

DAS stated there is a timing issue since the initial template has to be with Scottish Government by 12th December 2014. A way will be found to sign this off although initial expression of intention only and not the detail.

MA suggested that the next meeting look at the financial implications. It was agreed that the template should be circulated.

MMcK commented there is limited margin for change in the first year and the new fund was the only unallocated resource that is available.

MA noted this should also go through the Shadow Strategic Planning Group.

AM stated that it would be important to ensure that services are involved in redesign.

AL noted concerns about the vision and the impact on expectations and in terms of priorities for use of resources.

CL added that a key issue would be the release of resources.

MMcK stated she found the material very helpful and that carers would like to see clear recognition that unpaid carers provide more care than NHSL and Council and this needs to underpin decisions and how they are made. There needs to be a stronger message as key objective. MMcK suggested that in values there requires to be recognition of this.

DAS added that there are plans already agreed in areas such as Mental Health and Learning Disabilities and these will be incorporated into the plan.

5.3   Joint Financial Planning
DK circulated a diagram on the financial flows that will feed into the Integrated Budget of the IJB in 15/16 and beyond. The Chief Officer will have an integrated management team (in their capacity as Director of Health and Social Care) which will manage most of the services that IJB will commission.
MA stated that the IJB will only have the money allocated by the Council and NHS.
JG enquired what would happen if a service the IJB commissions was underspent. Could the IJB use the underspend?
DAS explained there are sections of the scheme that deal with under and overspends, these are still drafts.
MA stated that the Council takes a different approach to three year financial planning than the NHS. It will be necessary to align these processes as much as possible.
DK noted that the budget setting for the Council is February 2015 and the NHS is March 2015. Since the IJB will come into being in June 2015 the budgets will be fully known for the first year.

6.   Any Other Business
Three proposed dates for next visits to Health and Social Care Partnerships:-
09.01.15
13.02.15
20.02.15.
Rail travel is being organised for the trip to Cumbria on 18.11.15.

8.   Dates of Future Meeting
11 December 2014 1215 – 1400
Esk Room 1, Brunton Hall, Musselburgh
22nd January 2015   1400 – 1600
Council Chamber, Town House, Haddington

Shadow Health and Social Care Partnership 18 July 2014 – Summary

Future style, format and frequency of meetings

- A number of members have provided positive feedback on the recent Partnership workshop.
- It was agreed that future meetings of the Shadow Partnership adopt a development workshop format, with details of topics, venues, and reporting of routine business, such as performance information, to be confirmed in due course.
- The visits programme will continue.

Integration Programme Status Report and Work Programme

- A programme tracker, incorporating all nine work streams was received.
- The Scottish Government has instructed that all draft Integration Schemes must be submitted before 1 April 2015.
- A review of the options for governance models will be considered by the Council's Corporate Policy and Strategy Committee on 5 August, and the NHS Lothian Board on 6 August.
- The pan Lothian Finance Group has been established and has met twice, and a high level action plan is in development.

Health and Social Care Integration: summary of draft regulations

- Two sets of regulations to underpin the Public Bodies (Joint Working) (Scotland) Act have been issued for consultation.
- Immediate points to note include:

  - Scope of services - Clarity is required about what services are included in the function 'Housing Support Services' delegated by the local authority to the Integration Authority;

  - Scope of Services – delegation of Unscheduled Care Acute Services from the Health Board to the Integration Authority, while recognising that this will pose a challenge for NHS Lothian.

  - The councillor membership of the Integrated Joint Board is currently 7 in the shadow arrangements, however, in the formal arrangements the Councillor membership is likely to be a maximum of 10% of the full Council number so that would be 6 Councillors as a maximum.

Summary of the Edinburgh SHSCP 18 July 2014

Performance Overview

- Details of current performance were provided;
- The main areas where performance is currently on target or where improvement is evident are: continuing to shift the balance of care, criminal justice activities, holding adult protection case conferences within the standard timescale, waiting times for drug and alcohol treatment, child and adolescent mental health services, domiciliary physiotherapy, vasectomy and wheelchair services;
- Key areas where current performance was below target are: delayed discharge, emergency bed days, sickness absence levels, the provision of overnight respite, reviews of people's needs and supports, offenders subject to Multi-Agency Public Protection Arrangements (MAPPA) charged with a sexual or violent offence, community hospital occupancy levels, physiotherapy outpatient waiting times, outpatient DNA levels in REAS, health and safety incident management and eKSF compliance;
- Work is ongoing to develop a performance framework to support the Health and Social Care Partnership.

Financial Update

- Members were given details of the total aligned revenue budget for the Partnership in 2014-15, amounting to £500m, representing a 1.4% increase from the available resources in 2013-14;
- A balanced position for 2014-15 is currently forecast for CEC Health and Social Care at month 2, although this is subject to the successful mitigation of key financial risks;
- The CHP is reporting an overspend of £1.3m, including unmet savings of £0.625m. Tim Montgomery agreed to provide proposals to improve the CHP financial position for the next meeting.

Update report on the development of a Workforce Strategy for Home Care and Care Homes in Edinburgh

- A strategy group has been established to oversee the work required in developing a 5-year workforce strategy for social care staff in care homes, home care and care at home and intermediate care to meet workforce needs for the care sector in Edinburgh. The group includes membership from the Council, NHS Lothian, and the private and voluntary sectors;
- Measures include: more local recruitment; better retention; raising the profile of care as a career; pre-employment academies; and closer working with partners such as Job Centre Plus; and ensuring high quality learning and development is available.

Investment in Prevention of Health Inequality

- The process for setting funding criteria and priorities for community based prevention work was outlined, along with current investment levels and sources was outlined;
- An integrated approach through the Health and Social Care Partnership was agreed, to be reported to the Partnership through the Health Inequality Standing Group;

- Agreed that priority outcomes set out in the report should continue for 2015/16 and that the Health Inequality Standing Group would take responsibility for reviewing funding priorities with stakeholders, assessing applications and recommending awards to the relevant funding partners;
- The Health Inequality Standing Group was asked to ensure it explored all possible funding sources.

NHS Lothian Strategic Plan – draft response to consultation

- The draft Partnership response, highlighting a number of omissions, suggesting additional decision-making criteria and making suggestions a patients" as the focus for service planning was agreed.

Learning Disability Services, Redesign, Modernisation and Integration

- The Partnership noted the extent of the strategic intend of the redesign, modernisation and integration of specialise learning disability services, and supported the overall vision;
- The approach taken to service redesign in this programme was welcomed, and it was agreed it should be applied to other regional services, such as addictions/substance misuse services.

Minute of Meeting

Shadow Edinburgh Health and Social Care Partnership

City Chambers, Edinburgh 18 July 2014

Present:-
Councillor Ricky Henderson (Chair), Councillor Elaine Aitken, Carl Bickler, Dr Gordon Scott, Richard Williams.

Also Present – Non Voting Members:- Kirsten Hey, Christine Farquhar, Angus McCann, and Ella Simpson.

In Attendance – Monica Boyle, Linda Cowie, Peter Gabbitas, Tim Montgomery, Susanne Harrison, Ian McKay, Michelle Miller, Angus McCann and Christine Farquhar.

Apologies:- Councillors Day, Howat and Work, Shulah Allan, Kay Blair, Wanda Fairgrieve and Robert Wilson.

1   Welcome and Introduction

The Chair welcomed everyone to the meeting.

2   Minute

Decision

To approve the minute of the Shadow Health and Social Care Partnership of 16 May 2014 as a correct record.

3   Future Style, Format and Frequency of Meetings

The Convener noted the success of the recent Partnership workshop. He had received positive feedback from a number of members, who had suggested that the more informal format was a better vehicle for encouraging dialogue and a mutual understanding of the issues around integration.

In the light of this, and the ongoing national and local debate about integration models, he suggested that development workshops replace the formal, round-table, meetings for the time being.

Decision

1) To agree that future meetings of the Shadow Partnership adopt a development workshop format, subject to further information on topics, venues, reporting of routine business (eg performance information) etc.

2) To agree that the focus of an early development meetings would be achieving a shared understanding of the key outcomes of integration.

3) To agree to secure facilitation support, at the discretion of the Chair, to future development sessions.

4   Integration Programme Status Report and Work Programme

Progress with the integration workstreams, key deliverables and milestones was reported. Key developments included Edinburgh's allocation of £615k transition funding for 2014/15; consultation on Sets 1 and 2 of the Public Bodies (Joint Working) Regulations, and a requirement for all draft Integration Schemes to be submitted before 1 April 2015.

Decision

To note the report.

(Reference – report by the Joint Director of Health and Social Care, submitted)

5   Summary of Regulations

Set 1 of the regulations underpinning the Public Bodies (Joint Working) (Scotland) Act 2014 had been circulated for comment until 1 August 2014. Set 2 had also been issued, and its consultation ran until 18 August 2014. The key elements of both were summarised. Attention was drawn to the Scope of Services, and the need for clarity around "Housing Support services". The inclusion of Acute Health Services was welcomed, while recognizing this would pose a challenge for NHS Lothian. Also, it was highlighted that Set 2 envisaged a maximum of six Councillors on the Integration Joint Board, compared with seven at present.

Decision

1) To note the summary of the Regulations, and the consultation deadlines.

2) To request that a copy of a recent Cabinet Secretary letter on acute services be circulated to all members.

3) To note the requirement to review the voting membership of the Partnership to match the requirements of the Regulations.

(Reference - report by Joint Director of Health and Social Care, submitted)

6 Performance Overview

A summary of activity and performance across the Health and Social Care Partnership was reported. A brief update was also provided on progress towards the development of an integrated performance framework.

83 measures had been identified, reflecting activity and performance across Health and Social Care, Edinburgh CHP and REAS. Of these, 51 had agreed targets. 24 areas were currently meeting these targets, with the same number falling short, and three within an acceptable range. Details were provided of each, including actions being taken to address under-performance.

Decision

1) To note the ongoing work to develop a performance framework to support the Health and Social Care Partnership.

2) To note the performance report for July 2014, the good progress that had been made in a number of areas, and that work was ongoing to address areas falling short of target.

(Reference – report by the Chief Social Worker, CEC, submitted)

7 Financial Update

Information was provided on the aligned revenue budget for 2014/15; the current position at month 2, and the future of the Change Fund.

Decision

1) To note the aligned revenue budget 2014/15 for services in scope of integration and related investment in services and savings targets.

2) To note the revenue position as at Month 2 and the actions necessary within the NHS to move towards a balanced position against available budgets.

3) To note the update on the Change Fund, and the future Integrated Care Fund, and the work required to determine which Change Fund projects would transfer to the Integrated Care Fund.

(Reference – report by the Joint Director of Health and Social Care, submitted)

8 Workforce Strategy for Home care and Care Homes in Edinburgh

A summary was given on work underway to develop a workforce strategy for Home Care and Care Homes in Edinburgh, including the essential training and development required to have a confident and competent workforce. Measures included more local recruitment; better retention; pre-employment academies; closer working with partners (eg Job Centre Plus).

Longer term it was hoped to promote career progression; workplace experience and an academy for school pupils; modern apprenticeships etc. Better marketing and improved training opportunities were also planned.

Decision

To note and support the work of the project team in developing and implementing the workforce strategy for older people, the integrated workforce plan and learning and development strategy.

(Reference – report by the Joint Director of Health and Social Care, submitted)

9 Investment in Prevention of Health Inequality

The process to set funding criteria and priorities for community based prevention work was outlined, together with current investment levels and sources. An integrated approach through the Health and Social Care Partnership was proposed.

Decision

1) To agree that the Health Inequality Standing Group should be retained and should report to the Board on this issue, in view of the partnership responsibility for tackling health inequality.

2) To agree that the priority outcomes noted in the report should continue for 2015/16, and to delegate responsibility to the Health Inequalities Standing Group to review funding priorities with stakeholders; assess applications and recommend awards to the relevant funding partners, as required.

3) To agree to recommend to the Council and NHS Lothian that the separate resources used to fund preventive action on health inequality be brought together as a single budget in the Integrated Authority for 2016/17.

4) To agree to consider in due course progress reports on the prevention programme, as part of the Health Inequality Action Plan.

5) To invite the Group to explore all possible funding sources.

(Reference – report by the Chief Social Worker, CEC, submitted)

10   NHS Strategic Plan – Draft Response to Consultation

NHS Lothian had launched its draft strategic plan for 2014 – 24, "Our Health, Our Care, Our Future" for consultation. Comments had been invited by 8 August 2014. Key challenges identified included:-

- Demography, inequalities and ill health
- Multimorbidity
- Increase in demand for health services
- Tighter finances

A draft Partnership response was proposed. This highlighted a number of omissions; suggested additional decision-making criteria, and made suggestions about service user engagement and the use of "representative patients" as the focus for service planning.

Decision

To approve the submission of the draft response to the consultation on the NHS Lothian Strategic Plan.

(Reference – report by the Interim General Manager, REAS, submitted)

11   Learning Disability Services – Redesign, Modernisation and Integration

The Partnership was invited to note an overview of a planned redesign and modernisation of NHS and the four Shadow Lothian Health and Social Care Partnership services for people with learning disability. Information was provided on the context for change, the relationship with the Royal Edinburgh Campus reprovision; the emergence of new integrated models of service delivery and early financial headlines of the planned whole systems change.

Decision

1) To note the extent of the strategic intent of the redesign, modernisation and integration of specialist learning disability services and supports the overall vision.

2) To support the proposed phases and key service developments required to deliver the overall vision, including endorsement of :
   - the model for focussed efficient and effective in patient assessment and treatment services;
   - development of integrated community teams with capacity appropriate to deliver national targets;
   - development of the key milestone service developments such as the Learning Disability/ASD joint community service;
   - the development of further joint models of care such as those required to deliver local services for people with profound and multiple disabilities.

3) To acknowledge the indicated increase in total revenue required to deliver national policy and the modernisation of the whole system of services for people with learning disability.

4) To welcome the approach taken to service redesign in this programme, and agree the application of the approach for other regional services, such as addictions/substance misuse services.

(Reference – report by the Interim General Manager, REAS, submitted)

1.13

MINUTES of **MEETING** of the **MIDLOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP SHADOW BOARD** held in the Committee Room, Midlothian House, Buccleuch Street, Dalkeith on Thursday 23 October 2014 at 2.00pm.

Present:-

NHS Lothian:– P Johnston (Chair); C Levstein and J McDowell

Midlothian Council:– Councillors B Constable, C Johnstone (Vice-Chair) and D Milligan

In Attendance:-

User/Carer Representatives:– J Cuthbert and J Foster.

Third Sector Representative:– G Wilson (MVA).

Midlothian Health and Social Care Partnership:- J Megaw.

NHS Lothian:– H Reid (Clinical Director) and D King (Head of Finance).

Midlothian Council:– E McHugh (Joint Director of Health and Social Care), G Fairley (Head of Finance and HR), A Short (Head of Health), A White (Head of Adult and Social Care), T Welsh (Integration Manager) and M Broadway (Clerk).

Apologies:– Councillor B Pottinger (Midlothian Council); P Eccles (NHS Lothian); M Gill (User/Carer Representative); K Lawrie (Chief Executive, Midlothian Council); and A MacDonald (Chief Nurse, NHS Lothian).

1. **Order of business**

   At the suggestion of the Chair, it was agreed to make a minor change to the order of business and take Agenda Items No 8 (Partnership Joint Finance Lead) and No 9 (Report on Financial Planning for 2015/16 and Beyond) immediately after the Minutes (Agenda Item No 4).

2. **Declaration of Interest**

   No declarations of interest were intimated.

3. **Minutes of Meeting**

   The Minutes of Meeting of 26 June 2014 were submitted and approved as a correct record.

4. **Matters Arising – (a) Voluntary Sector Representation**

George Wilson, MVA, advised that Ruth McCabe, Alzheimer Scotland, Deputy Regional Manager, Lothian and Borders had agreed to take on the role of representing the Voluntary Sector on the Shadow Board, and that with the Shadow Board's agreement, they would both attend the next round of meetings in order to familiarise Ruth with the proceedings.

Decision

(i)   To approve the appointment of Ruth McCabe as the Voluntary Sector representative on the Shadow Board;

(ii)   To support plans to assist Ruth in becoming familiar with her role and agree to allow George to assist her at forthcoming Shadow Board meetings; and

(iii)   To otherwise welcome Ruth's appointment.

(b) Service Visits (paragraph 11)

With regards the programme of visits to local services covering the period through to May 2015, the Shadow Board discussed the very successful visit to RIE Accident and Emergency which had taken place on Wednesday 20 August.

Decision

To note the next visit in the programme was on Wednesday 3 December 2014 at 2.00pm to Newbyres and Thornlee Care Homes - Older Peoples Services.

(c) Delayed Discharge Statistics

Arising for the above, the Joint Director, Health and Social Care, gave an update on the delayed discharge statistics which had just been received.

The Shadow Board, in considering the current position, which in terms of Midlothian was very encouraging, discussed the broader issues raised by delayed discharges, unnecessary admissions, etc. Whilst the long term challenges that these issues posed were acknowledged, the importance of making staff aware of the fact that their efforts in trying to minimising the impact did not go unnoticed and where very much welcomed was also emphasised.

Decision

(i)   To note the delayed discharge statistics; and

(ii)   To support staff being made aware, in appropriate manner, of the fact that their efforts in trying to minimising the impact did not go unnoticed and where very much welcomed by the Shadow Board.

5.   **Partnership Joint Finance Lead**

There was submitted report, by the Joint Director, Health and Social Care, setting out proposal for a Joint Interim Finance Lead for the Shadow

Partnership to be appointed until March 2015 or until the Partnerships was duly constituted.

The report explained that the decision to establish an Integrated Joint Board (IJB) meant that once formally constituted, the IJB would be required to appoint a Chief Financial Officer in terms of Part 7 of the Local Government (Scotland) Act 1973. Currently, the Joint Director was supported by two finance teams led by the Council's Chief Financial (S95) Officer and NHS Lothian's Director of Finance. Although both teams worked closely together there was currently not a single finance lead who could support the Joint Director and the Shadow Board on Partnership wide issues, and for this reason it was proposed that a Joint Interim Finance Lead be appointed. This would be done in conjunction and with the support of both current finance teams. Operational financial management support to the services the Joint Director manages within the CHP and the Adult Social Care department would continue to be provided by the current arrangements. Financial Governance would remain the responsibility of NHS Lothian's Director of Finance and Midlothian's S95 Officer as appropriate.

Decision

Having heard from the Joint Director of Health and Social Care, Eibhlin McHugh, and the Head of Finance, NHS Lothian, David King, the Shadow Board agreed to support the appointment of an Interim Finance Lead for the Shadow Partnership; which would be undertaken by David King, Head of Finance, NHS Lothian.

6.   **Financial Planning for 2015/16 and beyond**

There was submitted report, by the Joint Director, Health and Social Care, examining the financial planning issues and process which were likely to impact on the Integrated Joint Board's (IJB) financial plan for 2015/16 and beyond, and considering the outline financial plan for the Joint Management Team for 2015/16.

The report highlighted that the four key elements of the IJB's Integrated budget were:-

- The budgets for Adult Social Care
- The Core budgets for the CHP – these being the core HCH budgets, GMS budgets, Prescribing budgets and Resource Transfer budgets
- A share of the NHS Lothian 'hosted services'. These were services managed on behalf of NHS Lothian by each of the CHPs. Most of these hosted services were to be delegated to the IJBs and an appropriate share of each hosted service would be included in the IJB's Integrated budget. In the case of Midlothian, the CHP hosted the Dietetics, Art Therapy and Music Therapy services.

- A share of the Acute services that were delegated to the IJBs. Discussions were still ongoing as to a final list of 'acute' functions that would be delegated to the IJB.

The Shadow Board, having heard from David King, Head of Finance, NHS Lothian, discussed the emerging financially challenges and pressures and

acknowledged that the maximisation of resources would be critical to the future success of the Partnership.

Decision

To note the report.

7   **Integration Scheme Presentation**

The Shadow Board received a presentation from Jamie Megaw, who provided an update on progress in the preparation of the Midlothian Integration Scheme, in which he outlined:-

- The Key Stages in the preparation of the Integration Scheme
- The timeline for the Integration Scheme process prior to the planned establishment of the IJB in May/June 2015.
- Details of what must be covered in the Integration Scheme – This had become clearer following publication by Scottish Government of two sets of draft regulations; consultation on which had now concluded. These regulations were currently due to be laid before Parliament in final form in October/November and to come into force in December 2014, when the Parliamentary process was due to end.
- Details of the Social Care Functions and the NHS Functions to be included in the Integration Scheme.
- The key sections to be included in the Midlothian Integration Scheme.

Lead officers from the Council and NHS were currently working to develop the various sections that would go to make up the Scheme; a key meeting of the senior Health and Social Care team was planned for Friday 24 October. NHS Lothian where seeking where possible for consistency across the four local Integration Schemes, so dialogue was also ongoing with the other three Local Authorities in the Lothian area.

The Shadow Board thanked Jamie for his presentation and discussed the progress being made in the preparation of the Midlothian Integration Scheme.

Decision

(a)   To note the presentation; and

(b)   To note that further updates would be provided, in due course.

8   **Values and Vision**

There was tabled report, by the Joint Director of Health and Social Care, summarising the responses received to the questionnaire on a vision for the Partnership.

The Shadow Board, having heard from the Joint Director of Health and Social Care, Eibhlin McHugh, broke into small groups to discuss the responses in more detail and to consider a possible vision for the Partnership.

Decision

(a)   To note the responses received to the questionnaire; and

(b)   To agree that the vision for the Partnership should encapsulate that by working together the IJB would aim to 'enable people to live longer, healthier and better quality lives'.

9.   Strengthening User and Carer Engagement

There was submitted report, dated 13 October 2014, by the Integration Manager, seeking the approval of the Board for a number of actions intended to strengthen the involvement of users and carers in planning and decision-making regarding local health and social care services.

The report highlighted the work already undertaken locally to ensure effective arrangements were in place for user and carer engagement in health and social care. It also detailed the further work that was planned to strengthen the Public Partnership Forum based on the experience of the past 8 years and taking account of the review of Neighbourhood Planning. These arrangements were set out in detail in the Local Action Plan appended to the report.

The Integration Manager, Tom Welsh, in speaking to the report, highlighted the importance of sustaining the work already undertaken and to continuing to develop and improve user and carer engagement in the future.

Decision

(a)   To note and endorse the development of the Local Action Plan designed to strengthen user/carer engagement;

(b)   To approve the actions relating directly to improving engagement at Board and Locality level being taken forward;

(c)   To agree to receive a further report in January/February 2015 regarding proposals for mechanisms to replace, adapt or continue the CHP Public Partnership Forum; and

(d)   To agree to review the arrangements for the involvement of user and carer members on the Shadow Board with a view to determining a longer term solution.

10   Strategic Commissioning

With reference to paragraph 10 of the Minutes of 26 June 2014, there was submitted report, dated 14 October 2014, by the Integration Manager, informing the Shadow Board of the progress being made in the development of the strategic commissioning plan and other related issues.

This report summarised progress and outlined future plans relating to the creation of a Midlothian Strategic Commissioning Plan. It also highlighted the need to produce a plan for the utilisation of the Integrated Care Fund by December 2014 in advance of the completion of the Strategic Commissioning Plan; a timetable for completion of the Strategic Commissioning Plan was appended to the report.

Decision

The Shadow Board, having heard from the Integration Manager, Tom Welsh, agreed:-

(a)   To note the progress with the development of the Strategic Commissioning Plan and agree that the final draft of the plan should be completed by March 2015 allowing a further period of consultation prior to the Board's formal approval in June 2015;

(b)   To note the link to the Adult Health and Care Section of the Midlothian Single Plan and agree to receive a further report in February 2015;

(c)   To receive a further report on the establishment of a formal Strategic Commissioning Group following receipt of the final regulations; and

(d)   To receive a further report at the December meeting detailing the proposals for the utilisation of the Integrated Care Fund.

11   Review of Midlothian Community Hospital

There was submitted report, by the Joint Director of Health and Social Care, invite the Shadow Board to note and support the redesign of services within Midlothian Community Hospital (MCH).

The report advised that the vision for the Midlothian Community Hospital (MCH) was to have a fit for purpose facility that met the heath and care needs of the Midlothian population, through the delivery of person-centred integrated care, supported by community based services. A key outcome would be to focus on how the hospital could support wider work in Midlothian to enable people to live as independently as possible within their own home or a homely setting in their community. An outline of the current and proposed usage of MCH was contained in and appendix to the report

Having heard from the Head of Health, Allister Short, the Shadow Board discussed the vision for the Midlothian Community Hospital.

Decision

(a)   To support the development of proposed changes to current service pathways that increases the utilisation of Midlothian Community Hospital;

(b)   To support the strategic principle of achieving a higher proportion of repatriation of services and patients to Midlothian from acute and post-acute care services currently provided from within facilities in Edinburgh; and

(c)   To recognise and support the need for reallocation of resources across redesigned pathways to reflect.

12.   MELDAP - The Transformation of Substance Misuse Services in Midlothian

There was submitted report, dated 13 October 2014, by the MELDAP Team Manager, informing the Shadow Board of the outcome of the "Over the Horizon" redesign and reorganisation process and the strategic direction of future delivery of substance misuse related services in Midlothian.

The report highlighted the national policy drivers that had influenced the development of services locally and detailed the very significant work that had been undertaken to better understand need locally and more importantly to ascertain the views of local service users and their families. The report outlined the proposed transformation of services to ensure that recovery was embedded throughout all services and highlighted some significant service developments that had already taken place.

Decision

To note and endorse the redesign of substance misuse services as outlined in the report.

13.   **Date of Next Meeting**

The Shadow Board noted that the next meeting was due to take place on **Thursday 11 December 2014** at **10.00am** in **VOCAL Midlothian Carer Centre, 30/1 Hardengreen Estate, Dalhousie Road, Dalkeith**.

The Meeting terminated at 5.05 pm.

MEETING	KEY ISSUES	ACTION
West Lothian CHCP Sub-Committee - 18th December 2014	Themed Agenda Safer Communities – We Live in Resilient Cohesive and Safe Communities/People at Risk are protected and supported to achieve improved life chances	A presentation providing an update on various suites of indicators covered under Community Safety
	Reducing Re-Offending Annual Report	A report was provided highlighting the main activities and initiatives which have been taken forward in the previous 18 months
	Almond Project Update	A report was provided giving an update on the success of the project and proposal to extend the provision.
	Early Effective Intervention/Whole Systems Approach	A report was provided describing the Whole System Approach that has consolidated a range of already existing good practice in West Lothian
	MAPPA Annual Report	The MAPPA annual report was shared with the committee.
	Public Protection Update	A report was provided giving an update on how West Lothian CHCP are working with partners to deliver outcomes related to public protection
	LUCS Review Paper	The LUCS review paper was brought to the Sub Committee for consultation

DRAFT

Minutes of the West Lothian Sub Committee held on 18th December 2014, 1400 – 1600, Strathbrock Partnership Centre.

Present	Frank Toner (FT)	Chair, West Lothian CHCP
	Jim Forrest (JF)	Director, West Lothian CHCP
	Marion Christie (MC)	Head of Health / General Manager, WLCHCP
	Jennifer Scott (JS)	Head of Social Policy, WLC
	Alan Bell (AB)	Senior Manager, Community Care Support & Services
	Lindsay Seywright (LS)	West Lothian College
	Gill Cottrell (GC)	Chief Nurse
	Chris Stirling (CS)	SJH Site Director
	Jane Kellock (JK)	Senior Manager, Children & Early Intervention
	Ian Buchanan (IB)	Public Partnership Forum Rep
	Lorraine Gillies (LG)	Community Planning Development Manager
	Tim Ward (TW)	Senior Manager
	Elaine Duncan (ED)	Clinical Director CHCP
	Sian Tucker (ST)	Clinical Director LUCS
Apologies	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
	Andreas Kelch (AK)	GP PCCF Rep
	Moira Niven (MN)	Deputy Chief Executive
	Julie Cassidy (JC)	Public Involvement Co-ordinator
In Attendance	Marjory Brisbane	Admin Manager (Minutes)
	Norma Paterson	Service Development Officer

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 9th October 2014 were approved as being an accurate record.

6. **CONFIRMATION OF ACTION POINTS**
   Action points confirmed

7.   **MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR
      HEALTH CARE (WLPPFHC) MEETING**
      Noted minutes of 25/09/14

8.   **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**
      Noted minutes of 09/10/14

9.   **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP
      AND SUB GROUPS REPORT**
      Noted minutes of 12/11/14

10.   **MINUTES OF COMMUNITY PLANNING STEERING GROUP**
      Noted minutes of 03/11/14

11.   **COVALENT REPORT SAFER COMMUNITIES**
      TW talked to a presentation providing an update on various suites of indicators covered
      under Community Safety.

      Areas which were highlighted included the high success rate of woman engaging with
      the Almond Project and has been recognised that a more challenging target requires to
      be set. High success rate of MAPPA was acknowledged with a report being provided
      later on the agenda.

12   **REDUCING RE-OFFENDING ANNUAL REPORT**
      TW talked to the report highlighting the main activities and initiatives which have been
      taken forward in the previous 18 months. The main activities include the
      - Almond Project launched in August 2012,
      - Pilot of the Persistent Offender Partnership in November 2012,
      - Recognition that substance misuse is a significant factor of persistent offending
        and the subsequent commissioning of West Lothian Drug and Alcohol Service
        (WLDAS) and Circle to provide relevant services,
      - One to one programmes for perpetrators of domestic abuse
      - Ongoing development of the Whole Systems Approach and Early Effective
        Interventions,
      - Through-care needs of short term prisoners in Addiewell Prison being met by a
        WLDAS worker
      - Offender profile was undertaken to help inform the Reducing Re-Offending
        Strategic Plan 2013 – 2018.

       Reports under some of these areas will follow later on agenda.

      The Sub Committee noted the report.

13.   **ALMOND PROJECT UPDATE**
      TW talked to the paper providing an update on the success of the project. 70 referrals
      have been made so far with a proposal to extend the provision. The specific areas of
      support are based on woman's needs and include helping woman comply with statutory
      orders, support with housing and accommodation issues, support at children's' hearings,
      court and lawyers, and help to access alcohol, drug and mental health services.

      ED asked for clarity around the referral criteria. TW confirmed any woman known to the
      criminal justice service can be referred. The service currently feels they are meeting the
      demands and there are no known gaps in the service.

      The Sub Committee noted the report..

14. **EARLY EFFECTIVE INTERVENTION/WHOLE SYSTEMS APPROACH**

TW talked to the report describing the Whole System Approach that has consolidated a range of already existing good practice in West Lothian. This is being developed and implemented through a partnership approach to meet the needs of young people who offend to reduce the necessity for statutory measures, secure care and custody.

The Early Effective Interventions which has proven to be successful for 8 – 15 year olds now includes 16 and 17 year olds. A multi-agency screening group provides a menu of services and packages to work with children and young people who offend. The success of the project has been measured by the reduction of referral to the Children's Reporter from 658 in 2009 to 213 in 2014.

The Sub Committee noted the report.

15. **MAPPA ANNUAL REPORT**

TW talked to the reporting highlighting there is nothing specific for West Lothian in the Annual report but provides generic update across Lothian. Numbers are too small to pull out for West Lothian and would highlight a data protection issue. The report is a requirement for the Scottish Government. TW confirmed MAPPA is well managed across West Lothian.

The Sub Committee noted the report.

16. **PUPLIC PROTECTION UPDATE**

TW talked to the report providing an update on how West Lothian CHCP are working with partners to deliver outcomes related to public protection. There are three main areas, Child protection, Adult protection and Multi –agency public Protection Arrangements (MAPPA). TW highlighted there are currently two main areas under MAPPA with a proposal to move to a third area to include violent offenders being managed under local arrangements. A review is currently being undertaken in line with the Government strategic plan of which JS is sitting on the oversight group.

The Sub Committee noted the report..

17. **LUCS REVIEW PAPER**

ST talked to the report recommending the Sub Committee consider the review report as part of the engagement process. The review was carried out by Pat Dawson to ensure the sustainability of the service. 48 recommendations have been identified and a service improvement plan has been developed. Extensive engagement has taken place with staff and internal stakeholders, findings of the review have been fed back through three general staff meetings. The review report is now being shared with corporate management team, Sub Committee and public engagement processes. There are no significant changes identified for West Lothian.

MC highlighted the capacity issues raising problems with low staff morale. Currently nursing shifts are being covered by GP which is causing a financial issue, 4 nurses have been trained in the last year to try and alleviate this problem.

ST informed the Sub Committee Lanarkshire GP's are opening on a Saturday from January 2015. This proposal was put to West Lothian GP last year but they declined to provide this service due to shortage of GP's.

JF asked when the final sign off would be carried out. This would be carried out following further public consultation and then taken back to East Lothian CHCP who host the service for approval. Clarity around dates for final sign off will be provided around March/April 2015.

FT requested the paper to be brought to West Lothian CHCP Board. MC to consult with ST re appropriate timescales.

18. **ANY OTHER COMPETENT BUSINESS**
The meeting closed at 4.00pm

DATE, TIME OF NEXT MEETINGS
CHCP Sub Committee meetings at 2pm – 4pm in Strathbrock Partnership Centre.

12th February 2015
16th April 2015
11th June 2015

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West Lothian

Community **H**ealth and **C**are **P**artnership

MEETING	KEY ISSUES	ACTION
West Lothian CHCP Board 9 December 2014	Risk Management	Updated CHCP Risk Register agreed.
	Resilience / Emergency Planning	Progress noted and supported plan to conduct any future exercises as determined by the analysis of the exercise.
	CHCP Winter Plan 2014/15	Plan was endorsed.
	Crisis Care Service	Noted positive impact of the implementation of the Crisis Care service which focussed on early interventions to prevent negative outcomes.
	Integrated Care Fund	Approved contents of the report.
	Clinical Governance (Linlithgow Family Practice)	Noted that plans were progressing for a smooth transition.
	Care Governance (CSWO Annual Report 2013-14)	Noted report and strong performance by teams across Social Policy.
	Financial Governance	Noted.
	Resource Transfer Monitoring Report	Noted contents and that CHCP had maintained zero delayed discharge in the second quarter of the financial year.
	Staff Governance	Noted - PVG Retrospective Checking within NHS Lothian; Study Leave Policy and Procedure; West Lothian Council 2014 Employee Survey.
	Director's Report	Noted - The recent positive report West Lothian Community Planning Partnership had received from the Accounts Commission. The improvement in performance within the Community Payback Service. Website usage. Publication of Issue 28 of West Life. Integration update.

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 9 DECEMBER 2014

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), Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), (Gill Cottrell (Chief Nurse, NHS Lothian), Carol Mitchell (Assistant Director of Finance, NHS Lothian), Dr Elaine Duncan (Clinical Director), Pamela Main (Senior Manager, CHCP), Carol Bebbington (Primary Care Manager, NHS Lothian); Ian Buchanan (PPF)

1.   OPENING REMARKS

        The Chair welcomed Ian Buchanan to his first meeting as representative of the West Lothian Public Partnership Forum. He thanked John Richardson for his contribution as the previous representative.

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 7th October 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 14th August 2014.

6.   MINUTES OF MEETINGS OF THE PRIMARY CARE JOINT
        MANAGEMENT GROUP

        The Board noted the undernoted minutes of the Primary Care Joint
        Management Group:-

        • 8th May 2014

        • 12th June 2014

        • 14th August 2014

        • 11th September 2014

7.   RISK MANAGEMENT

        The Board considered a report (copies of which had been circulated) by
        the Community Health and Care Partnership Director providing an update
        on the review of the CHCP risk register.

        The report recalled that the CHCP risk register was reviewed and updated
        in June 2013 and the risk were recorded in West Lothian Council's
        Covalent system and on NHS Lothian's Datix system.

        The purpose of the register was to provide a record of the high level risks
        which could threaten the ability of the CHCP to achieve its objectives.
        The recording of risks in the register ensured that management had
        identified and considered risks and were satisfied that they were either
        appropriately controlled or had planned actions in place to mitigate the
        risks.

        The CHCP risk register had last been presented to the Board in May 2014
        and more recently reviewed by the CHCP's Senior Management Team in
        November 2014. This had involved a review of risks, their scores and
        associated risk actions. The report provided an overview of the outcomes
        resulting from the review.

        The updated CHCP risk register, including a progress bar for each action,
        was shown in the updated register that had been provided as an appendix
        to the report. This was supplemented by more detailed risk information
        and a copy of the matrix used to score the results, which had also been
        provided as appendices to the report. Of the 10 risks included in the
        register, nine were assessed as medium risks and one as low risk.

        The report concluded that the CHCP risks had been reviewed and
        updated to more accurately reflect the currents risks to the CHCP and the
        actions required to further mitigate those risks. Progress in implementing
        risk actions would continue to be monitored using Covalent.

        Decision

To agree the updated CHCP risk register.

8.   RESILIENCE/EMERGENCY PLANNING

The Board considered a report (copies of which had been circulated) by the Head of Health Services and the Head of Council Services providing a summary of the resilience/emergency planning desktop exercise which had been held on 20 November 2014.

The report stressed that continuity of health and care services was a major priority in relation to the CHCP's response to emergencies, as was the safety and wellbeing of children, adults and older people in the community and CHCP staff. As it had been some time since there had been a desktop or live exercise to test the CHCP's resilience/emergency planning, a desktop exercise involving relevant staff from acute services, community-based services and social policy had taken place in the Civic Centre on 20 November 2014.

The report provided an overview of the desktop exercise, entitled "Die-Hard-ish". The scenario had been split across three timelines, the first of which begun with a number of challenging situations. Over the next two timelines, updates were given as the situations developed. Working in their service groups, staff were asked to consider their response strategy, whether it was evidenced in any plans, what significant gaps there were and if any further action was required and by whom.

Feedback on the event had been sought from participants which would be analysed to establish whether there was a requirement to undertake further exercises. It was possible that social policy would wish to undertake an exercise related to the setting up of a rest centre as that was a them in the "Die Hard-ish" exercise.

Decision

1. To note the progress made in undertaking the emergency planning resilience exercise, which would ensure key services were maintained for critical patients and customers, and the organisation's reputation was protected.

2. To support the plan to conduct any future exercises as determined by the analysis of the exercise.

9.   CHCP WINTER PLAN 2014/15

The Board considered a report (copies of which had been circulated) by the Head of Health Services advising that the National Health Service and Social Care departments were required to plan for the winter period when it was recognised that demand for services was likely to be at its highest level. The expectation was that plans for 2014/15 would build on previous winter plans and take into account the lessons learned.

The report explained that the CHCP was required to ensure the following outcomes:-

- Clear identification of the senior managers who were the accountable persons for ensuring that effective winter plans existed within the CHCP/local health and social care communities.

- That comprehensive plans were in place in the CHCP/social care communities covering the headings in the Scottish Government Winter Planning communications.

- The provision of high quality services were maintained through periods of pressure.

- The impact of pressures on the levels of service, national targets and finance were effectively managed.

- That a process was in place to meet the reporting requirements of the Scottish Government.

Decision

To endorse the CHCP Winter Plan for 2014/15.

10.   CRISIS CARE SERVICE

The Board considered a report (copies of which had been circulated) by the Head of Social Policy outlining the purpose, performance and impact of the Crisis Care Service.

The report recalled that Crisis Care had been implemented in 2012 and worked in partnership with the community nursing service and the Rapid Elderly Assessment Care Team (REACT) to provide a 24/7 response for people who were or had recently experienced a health or social care crisis and required support to be able to deal with the immediate crisis in their own home. Responses were streamlined, moving from a complex multi-agency response to a single point of contact, freeing valuable time for other professionals to target resources more appropriately. Unlike other similar models, the service was universal and was not limited to people who already had Home Safety service in their homes.

Early intervention allowed the opportunity for a responsive assessment in the context of an approach which was designed to maximise independence. A key objective of the service was to ensure that unnecessary admission to care homes was avoided. Feedback from key stakeholders was very positive with General Practitioners in particular valuing the single point of contact. A referral pathway with the Scottish Ambulance Service had also been implemented which was consistent with national recommendations. A list of the key features of the Crisis Care Service was given in the report.

The report provided the Board with an overview of the service levels and performance including information on the average number of monthly calls to the service, approximate number of calls related to falls which were screened to consider the future risks. Average response times were consistently low and currently under 30 minutes. It was recognised that the speed of response, particularly in relation to falls, had a significant impact on recovery.

The report concluded by highlighting that during the reporting period, a total of 83 users had been supported with short term intensive interventions, the average length of intervention at 7 days. This was deemed to equate to a total of 71 admissions being avoided. Reasons for crisis care input on a short term basis were defined in the report. The service was now well established in West Lothian and delivered a crucial element of the integrated pattern of services which seek to shift the balance of care in favour of community based services.

Decision

To note the positive impact of the implementation of the Crisis Care service which focussed on early interventions to prevent negative outcomes.

11.   INTEGRATED CARE FUND

The Board considered a report (copies of which had been circulated) by the CHCP Director advising of the Scottish Government's Integrated Care Fund.

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 the 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 £100m resource would build upon the Reshaping Care of Older People (RCOP) Change Fund, which would continue until April 2015. The new integrated care fund would be accessible to local partnerships to support investment in integrated services for all adults. Funding would support partnerships to focus on prevention, early intervention and care and support for older people with complex and multiple conditions, particularly where multi-morbidity was common in adults under 65, as well as in older people.

The report explained that the Scottish Government recognised that the full ambitions of the RCOP ten year programme of reforms had still to be fulfilled; in particular where there had only been limited progress in achieving the required shift in resources away from institutionalised care. The government therefore expected partnerships to continue to make progress with Reshaping Care for Older People. Strategic Commissioning would be critical to achieve this.

The report then provided an overview of the six principles which must

underpin the use of the fund. Integrated care plans should focus on tackling the challenges associated with multiple and chronic illnesses for adults and older people. The Integration Joint Board, through the Interim Chief Officer, or Chief Executive in a lead agency, would take responsibility to work with all partners to develop the plan. The plan would be required to clearly outline the role of the non-statutory partners and should describe the level of support to carers. Plans would be agreed and signed off by representatives from the NHS, local authority, the third sector and independent sectors.

West Lothian's allocation from the fund was £2.85m which represented an increase of over £1m in the Older People Challenge Fund. The report stressed that the scope of the fund was significantly greater. It was proposed to use the Reshaping Care for Older People partnership on the basis of the local partnership to oversee the development and implementation of the Integrated Care Fund Plan. It was anticipated that many of the important initiatives from the RCOP programme would continue within the Integrated Care Fund plan which was required to be submitted to the Scottish Government by 12 December 2014.

Decision

To approve the contents of the report.

12.   CLINICAL GOVERNANCE

The Board considered a report (copies of which had been circulated) by the Clinical Director detailing the arrangements in place for the transition of the Linlithgow Family Practice following the retiral in June 2014 of the single handed practitioner.

The report recalled that following the retiral of the single handed practitioner in June, the practice had been advertised in whole or in part to seek a suitable replacement. In the interim, West Lothian CHCP had taken on the running of the practice with staff TUPE transferred to NHS Lothian and the retiring practitioner employed on a locum basis to provide interim cover.

The Board recalled that initially, a sole application had been received from the Richmond Practice in Bo'ness. Following an unsuccessful attempt to recruit additional GPs, the practice had advised that they were not in a position to proceed within the agreed timescales.

The report explained that it had been considered a high risk to embark on a further round of advertising given the current GP workforce crisis and, as the current incumbent could not stay of indefinitely to provide cover, the decision had been taken to dissolve the practice and disperse the patients to other practices in the local area. Patients living outwith the practice area had been advised to reregister with a GP practice local to them, whilst those living within the practice area would automatically be reregistered with an alternative practice according to geographical location. The change would become effective on 1st April 2015.

Linlithgow Group Practice, who would take on the largest share of patients, had advertised for additional doctors and as the practice was attractive to new GPs, they had received several applications.

<u>Decision</u>

1. To note the contents of the report.

2. To note that plans were progressing towards a smooth transition and that appropriate clinical governance arrangements were in place.

13.   <u>CARE GOVERNANCE</u>

The Board considered a report (copies of which had been circulated) by the Head of Social Policy providing an overview of the statutory work undertaken during 2013-14 and providing the Board the opportunity to comment on the annual report of the Chief Social Work Officer.

The report advised that for the first time, a template and related guidance had been produced to assist Chief Social Work Officers (CSWOs) in the development of their Annual Report to ensure that reports covered the key issues of interest to a range of relevant audiences, in addition to local council committees and elected members and, in the future, to Health and Social Care Partnerships. Use of the template would help in sharing of information across services about social work good practice and improvement activities.

The annual report produced by the council's Chief Social Work Officer, covering the period 31.03.2014 – 31.03.2014, was appended to the report and covered the following sections:-

- Partnership Structures/Governance Arrangements
- Social Services Delivery Landscape/Market
- Finance
- Performance
- Statutory Functions
- Continuous Improvement
- Planning for Change
- User and Carer Empowerment
- Workforce Planning/Development
- Key challenges for the Year Ahead

<u>Decision</u>

To note the contents of the annual report and the strong performance demonstrated by teams across Social Policy.

14.   <u>FINANCIAL GOVERNANCE</u>

a)   <u>2014/15 Revenue Budget - Monitoring Report as at 30 September 2014</u>

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 30 September 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 underspend of £70,000.

<u>Decisions</u>

1.   To note the information in the report regarding financial performance in the CHCP to 30 September 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 underspend of £70,000.

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.

b)   <u>Resource Transfer Monitoring Report to 30th September 2014</u>

The Board considered a report (copies of which had been circulated) by the Head of Social Policy providing details of phased expenditure incurred in the period to 30 September 2014.

The Board was advised that the council had invested £3.32 million of the total £6.72 million resource transfer monies to the end of September 2014. The CHCP had maintained a zero delayed discharge position in the second quarter of the financial year.

<u>Decision</u>

1. To note that the CHCP had invested £3.32 million of the total £6.72 million resource transfer monies to the end of September 2014.

2. To note that the CHCP had maintained a zero delayed discharge position in the second quarter of the financial year.

15.   <u>STAFF GOVERNANCE</u>

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 recalled that the Protection of Vulnerable Groups (PVG) legislation had replaced the disclosure arrangements for people working with vulnerable groups to help ensure that people who had a known history of harmful or abusive behaviour were unable to work with children and protected adults. To qualify for a PVG check, employees had to be in a regulated role involved with direct patient care. After October 2015, it would be illegal for anyone involved in regulated work not to be on the PVG Scheme. NHS Lothian required to have everyone in regulated work on the Scheme by July 2015.

The report explained that each member of staff was responsible for completing their own PVG forms correctly and returning them to their line manager with the relevant identification. Incomplete forms could potentially lead to Disclosure Scotland terminating applications so it was essential that all information requested was supplied and contact details entered on the form. CHCP staff were currently completing the process with approximately 90% having completed an up to date disclosure.

The report then went on to highlight NHS Lothian's commitment to supporting staff education, training and development, recognising the benefit to both the employee and the services provided. The Study Leave Policy and Procedure set out the process through which staff could apply for support to undertake education, training or development and supported NHS Lothian policies on Personal Development Planning and Review and the Equal Opportunities policy. The report provided the Board with an overview of the key benefits of the Study Leave policy.

The report concluded with information on the focus groups which had been held throughout Social Policy to review the results of the council's 2014 Employee Survey. The outputs from those focus groups were being reviewed to prepare a service specific plan. The improvement plan, which required to be submitted to HR Services by 30 November 2014, would set out improvement activities to be progressed over the next 12 months, which would be reported to the HR Programme Board on a quarterly basis.

Decision

To note the information provided in relation to:-

1. PVG Retrospective Checking within NHS Lothian;

2. Study Leave Policy and Procedure; and

3. West Lothian Council 2014 Employee Survey.

16.   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 recent positive report West Lothian Community Planning
     Partnership had received from the Accounts Commission.

b)   The improvement in performance within the Community Payback
     Service.

c)   Website usage.

d)   Publication of Issue 28 of West Life.

e)   Integration update.

NHS LOTHIAN

Board Meeting
4 February 2015

Executive Nurse Director

SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION

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 0.33 (198 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 0.50 (311 incidences) this breaches NHS Lothian Target. New antimicrobial guidance to be issued on 2 February 2015.	3.3
• Norovirus outbreaks: since August 2014 there have been 36 incidents of gastro-enteritis investigated in NHS Lothian, with 180 patients and 35 staff affected.	3.4
• Ebola Preparedness: NHS Lothian as the Scottish National Viral Haemorrhagic Fever Testing Service has tested 8 samples, 7 negative 1 positive since December 2014.	3.5
• Antimicrobial Management Team: since November 2014 compliance with documentation of indication for an oral antibiotic has averaged 95% compliance but compliance with the UHS Antibiotic Prescribing Guidelines has varied from 70 to 100% for all three acute sites.	3.6
• Healthcare Environmental Inspectorate: Carried out an unannounced inspection at Western General Hospital in November 2014, report published 26 January 2015 with 8 requirements and 1 recommendation.	3.7
• Vale of Leven: The Inquiry Report published 24 November 2014 has 75 recommendations of the 65 for NHS Scotland Health Boards NHS Lothian has assessed 14 are fully implemented, 33 as Mostly implemented, 17 partially implemented and 1 not applicable.	3.8

Fiona Cameron
Head of Infection Prevention and Control Services
26 January 2015
fiona.cameron@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 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(HAI) across NHS Lothian. Any member wishing additional information should contact the Executive Nurse Director in advance of the meeting.

2   Recommendations

2.1   The Board is recommended to:
- acknowledge receipt of the Healthcare Associated Infection Reporting Template for December 2014. (Appendix 1)
- 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 0.33 (198 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 0.50 (311 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*.
- note NHS Lothian completion and submission to Scottish Government on the Vale of Leven Inquiry Reports 65 Health Board Level Recommendations
- acknowledge and support ongoing actions to address gaps identified within the response to Vale of Leven Inquiry recommendations
- note the publication on the 26th January of the Healthcare Environment Inspectorate report for the Western General Hospital 8 requirements and 1 recommendation

3   Discussion of Key Issues

3.1   Progress against Health Efficiency Access Treatment (HEAT) Targets March 2015
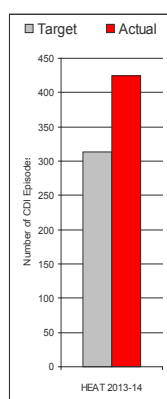
Figure 1:   No. of CDI Episodes 2014-15
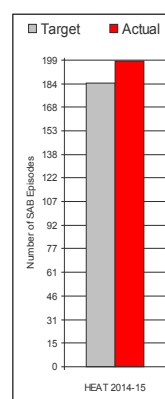
Figure 2:   No. of SAB Episodes 2014-15

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 0.33. There were 19 episodes of *Staphylococcus aureus* Bacteraemia in December 2014 (1 Meticillin Resistant *Staphylococcus aureus*, 18 Meticillin Sensitive *Staphylococcus aureus*), compared to 27 in November 2014 (4 Meticillin Resistant *Staphylococcus aureus*, 23 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	198

* Cumulative to date

3.2.1   Actions planned:
- Skin and Soft tissue Infection
  - NHS Education for Scotland Aseptic Technique and Wound Care sessions in the community and education for district nurses on wound management/ pressure ulcers by the Tissue Viability Nurses
- Vascular Access Device Infection
  - Awareness campaigns to support policy and safe practice (e.g. *Keep it on the RADAR Poster and Intranet messages)*
  - Patient Safety Care Bundles
  - HAI e-learning modules as part of Corporate Induction for Nursing Staff. For Medical Staff HAI Module will form part of FY1 cross border passport programme.
  - Clinical team monitor care bundles through Quality Improvement Data Systems
  - Pilot Aseptic Technique training within haematology services (Ward 8 WGH)
- Related to IV Drug Abuse
  - Multi-disciplinary team investigation into IVDU related infections associated with "legal highs"

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 0.50. There were 33 episodes of *Clostridium difficile* Infection in patients aged 15 or over in December 2014, compared to 33 in November 2014.

NHS Lothian is investigating an increased incidence of *Clostridium difficile* Infection in five wards at the Royal Infirmary of Edinburgh since 18 December 2014.

Target Date	Target	Actual
Year Ending 31/3/2013	418	364
Year Ending 31/3/2014	313	425
Year Ending 31/3/2015	262	311

* Cumulative to date

. 3.3.1 Actions Planned
- SLWG reviewing Infection control *Clostridium difficile* Infection control policy and associated documentation.
- There is a Short Life Working Group reviewing antimicrobial guidance with a focus on antimicrobials associated with increased risk of Clostridium *difficile* infection. The new guidance is scheduled for release in February 2015.

3.4   Norovirus: since August 2014 there have been 36 incidents of gastro-enteritis investigated in NHS Lothian, with 180 patients and 35 staff affected. In comparison for the same period for season 2013/14 there have been 49 incidents of gastro-enteritis investigated in NHS Lothian, with 342 patients and 96 staff affected. There have been 183 bed days lost so far for season 2014/15, in comparison for the same period for season 2013/14 there have been 421 NHS Lothian bed days lost.

3.5   Ebola Preparedness: in response to the on-going outbreak of Ebola Virus Disease in Sierra Leone, Guinea and Liberia, NHS Lothian has planning meeting organised for table top exercise at the Western General Hospital on the 13 January 2015 and at the Royal Infirmary of Edinburgh on the 15 January 2015.

3.5.1   NHS Lothian is the host of the Scottish National Viral Haemorrhagic Fever Testing Service, which is based at Royal Infirmary of Edinburgh and commenced operations on 1 December 2014 replacing the requirement to transport Scottish specimens to the Rare & Imported Pathogens Laboratory at Porton Down, Wiltshire. To date, there have been 8 samples (from 8 patients) processed for the Scottish health boards (7 Ebola-negative and 1 Ebola-positive); the turn-around time for 'high possibility' samples is 6 hours from time of receipt at the Royal Infirmary of Edinburgh.

3.5.2   NHS Lothian have had 3 possible Ebola cases (2 'high possibility'; 1 'low possibility') and although tested negative at Scottish National Viral Haemorrhagic Fever Testing Service, the incidents entailed activation of local and national action plans, which worked well through a structured national public health approach that involved key local and national agencies.

3.6   Antibiotic Prescribing indicators: in clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines was below the target level for all three acute sites. Documentation of indication for antibiotic treatment was at or just below the target level for all sites and ranged from 82-100%. For surgical prophylaxis, the data collection has focused on colorectal surgery but as compliance with the Colorectal Surgical Prophylaxis Policy has been sustained at 100% compliance for over 12 months data collection is now focussing on caesarean sections from January 2015.

Since November 2014 compliance with documentation of indication for an oral antibiotic has averaged 95% compliance but compliance with the UHS Antibiotic Prescribing Guidelines has varied from 70 to 100% for all three acute sites. Documentation of intended duration of an oral antibiotic has averaged 73% compliance for all sites.

3.7   Healthcare Environmental Inspectorate: the Healthcare Environment Inspectorate requested a 16 week update on the action plan developed following the Unannounced Inspection at St John's Hospital on 20-21 August 2014 and a return visit on 27 August 2014. The update was returned to the Inspectorate on 6 January 2015.

3.7.1   The factual accuracy and action plan for the Unannounced Inspection at Western General Hospital on 18-19 & 27 November 2014 was returned to the Inspectorate on 8 January 2015 with final report publication date of 26 January 2015. There were 8 requirements and 1 recommendation. The main themes off concern for the inspectors were related to environmental cleaning standards and apparent lack of cleanliness of near patient equipment including beds.

Remedial action was instigated immediately from the initial inspection this included additional cleaning to address the environmental issues and a focus on near patient equipment cleaning. The inspectorate noted significant improvement on the return visit on 27 November 2014. There is an on-going detailed action plan lead by the Site Chief Nurse which includes increased scrutiny and review of standards for bed cleaning, near patient equipment and environmental cleaning in conjunction with education for staff.

NHS Lothian has requested specific support from Health Protection Scotland and NHS Education Scotland to review Healthcare Environment Inspectorate issues at the Western General Hospital.

3.7.2 The Healthcare Environment Inspectorate will be introducing inspections of antimicrobial stewardship to all community hospital inspections from January 2015. The inspectors will be looking for clear evidence of antimicrobial management team's stewardship and availability and implementation of antimicrobial policies.

3.8 <u>Vale of Leven Enquiry</u>: The Inquiry Report has 75 recommendations. Nine recommendations are for Scottish Government Health Department, one for Crown Office and 65 are for NHS Scotland Health Boards. The Cabinet Secretary for Health, Wellbeing and Sport has accepted all 75 recommendations. The key themes of the recommendations to Health Boards are:

Scottish Government Health Department provided a template to boards to undertake a review against the recommendations and will be publishing their response to the recommendations in Spring 2015. The template notes current position, what more requires to be done, timescale for completion and recommendation delivery status of Fully Implemented, Mostly Implemented, Partially Implemented or Not Started. NHS Lothian submitted the response to Scottish Government on 19 January 2015. 18 recommendations have been fully implemented. NHS Lothian will be progress actions to address the gaps in the remaining recommendations.

3.8.1 Summary NHS Lothian position on the Vale of Leven Enquiry Recommendations

Theme	No. of Recommendations for NHS Scotland Boards	Fully Implemented within NHS Lothian	Mostly Implemented within NHS Lothian	Partially Implemented within NHS Lothian	Not Started within NHS Lothian
National Policies and Guidance	1	0	1	0	0
Creation, Leadership and Management of Clyde Directorate	2	1	1	0	0
Clinical Governance	1	0	1	0	0
The Experience of Patients and Relatives	3	0	3	0	0
Nursing Care	21	3	15	3	0
Antibiotic Prescribing	1	0	0	1	0
Medical Care	6	0	3	3	0
Infection Prevention and Control	25	10	6	8	(1 n/a)
Death Certification	2	0	2	0	0
Investigations from May 2008	2		1	1	0
Experiences of CDI within and beyond Scotland	1	0	0	1	0
Total	65	14	33	17	1

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.

Fiona Cameron
Head of Infection Prevention and Control Services
26 January 2015
fiona.cameron@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian

NHS LOTHIAN

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
MRSA	0	1	1	2	2	0	1	1	4	3	4	1
MSSA	16	20	22	15	8	24	21	25	20	26	23	18
Total	16	21	23	17	10	24	22	26	24	29	27	19

Clostridium difficile Infection Monthly Case Numbers

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Age 15-64	10	9	9	10	8	10	15	18	9	14	10	11
Age 65 plus	27	24	13	24	31	24	24	20	20	18	23	22
Total	37	33	22	34	39	34	39	38	29	32	33	33

Hand Hygiene Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
AHP	94.97	97.22	96.27	95.27	96.48	96.94	95.51	96.88	96.63	93.89	94.83	n/a
Ancillary	93.11	91.44	88.41	93.02	94.07	91.45	91.55	90.08	90.71	94.60	91.61	n/a
Medical	94.78	94.03	92.77	93.34	92.91	92.86	94.96	93.27	93.44	94.06	93.30	n/a
Nurse	98.59	98.37	98.32	98.49	98.38	98.64	98.17	98.49	98.05	98.24	98.18	n/a
Board Total	97.00	96.91	96.35	96.74	96.79	96.80	96.79	96.74	96.53	96.62	96.41	n/a

Cleaning Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	96.46	96.23	95.95	96.65	95.96	96.14	96.44	96.25	95.60	96.10	95.70	95.10

Estates Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	96.52	96.19	97.06	96.49	96.47	97.05	96.93	96.46	96.80	96.40	97.20	97.10

Healthcare Associated Infection Reporting Template (HAIRT)

ROYAL INFIRMARY OF EDINBURGH

Staphylococcus aureus Bacteraemia Monthly Case Numbers

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

Clostridium difficile Infection Monthly Case Numbers

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Age 15-64	3	0	2	5	1	1	2	6	2	2	2	2
Age 65 plus	9	7	4	10	12	6	9	6	6	2	8	5
Total	12	7	6	15	13	7	11	12	8	4	10	7

Cleaning Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	96.87	96.79	96.92	96.99	96.51	96.83	97.09	97.07	96.60	97.01	96.63	96.72

Estates Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	95.73	95.72	95.69	96.29	95.74	96.08	96.92	96.63	95.82	96.33	97.98	96.10

Healthcare Associated Infection Reporting Template (HAIRT)

WESTERN GENERAL HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

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

Clostridium difficile Infection Monthly Case Numbers

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

Cleaning Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	97.81	97.59	97.19	97.69	97.32	97.16	97.52	96.87	95.01	96.33	94.02	93.55

Estates Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	99.24	98.80	99.01	99.07	98.77	99.35	99.04	98.31	97.86	98.24	97.75	97.73

Healthcare Associated Infection Reporting Template (HAIRT)

ST JOHNS HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

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

Clostridium difficile Infection **Monthly Case Numbers**

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

Cleaning Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	95.39	94.95	94.79	96.26	95.02	95.83	95.13	95.05	93.83	95.43	95.38	95.02

Estates Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	93.78	94.90	93.87	95.00	95.66	95.82	94.42	93.51	94.75	95.29	95.63	95.43

Healthcare Associated Infection Reporting Template (HAIRT)

LIBERTON HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

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

Clostridium difficile Infection **Monthly Case Numbers**

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

Cleaning Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	96.79	95.19	94.27	95.69	96.19	95.65	97.67	97.61	96.83	97.70	97.02	96.71

Estates Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	93.43	89.52	92.23	95.86	95.50	93.47	96.93	95.94	93.66	95.12	97.43	98.11

ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus Bacteraemia Monthly Case Numbers

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

Clostridium difficile Infection Monthly Case Numbers

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
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 (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	94.84	99.22	94.94	94.42	95.03	94.50	95.18	95.20	93.67	94.21	95.13	95.83

Estates Monitoring Compliance (%)

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
Board Total	99.26	98.73	99.77	99.20	98.56	99.28	99.19	99.87	97.59	97.21	98.29	99.00

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

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

Clostridium difficile Infection Monthly Case Numbers

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

OUT OF HOSPITAL INFECTIONS

Staphylococcus aureus Bacteraemia Monthly Case Numbers

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

Clostridium difficile Infection Monthly Case Numbers

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

NHS LOTHIAN

Board Meeting
4 February 2015

Executive Director: Nursing, AHPs and Unscheduled Care

SUMMARY PAPER - UNSCHEDULED CARE & WINTER PLANNING

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 December 2014 was **92.34%**	3.1.1
• Overall NHS Lothian's performance against the 4 hour standard <u>during 2014</u> was **93.13%** with the individual monthly performances outlined below.	3.1.5
• The overall number of Delayed Discharges across NHS Lothian has increased from 136 during April 2014 to 196 during December 2014	3.4.1
• The new Day Medicine and Medical Admissions Units have now opened.	4.1
• Work to create a new Surgical Assessment Unit, expand ARAU Beds and convert Trolleys to Day Medicine has now finished.	4.2
• The new Day Medicine 'Hotline' pilot began on 14 January. This hotline has been developed in partnership with local GP representatives and should enable front-door service to better plan daily medical workload.	4.4
• An update on NHS Lothian's LUCAP was submitted to the Scottish Government in September and <u>again on 23 January 2015</u> as part of the quarterly reporting process.	5.1
• A total of £3.6 million has been allocated this year to support winter planning although we continue to use a number of unfunded beds across the acute hospitals to support patient flow on a daily basis.	6.1.2
• A maximum of 114 winter beds are potentially available including up to 60 beds at Gylemuir House	6.2.1
• Overall there are 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.	6.2.3
• As winter ends in March 2015 all additional beds funded by *Winter* or other temporary funding will need to close.	6.2.4

Neil Wilson
Unscheduld Care Manager
26 January 2015
Neil.wilson@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 2015

Executive Director: Nursing, AHPs and Unscheduled Care

UNSCHEDULED CARE & WINTER PLANNING

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

- £3.6 Million to support winter planning

- Additional bed capacity has been identified

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 December 2014 was **92.34%** (94.08% during November)**.**

3.1.2   The performance across individual sites for December 2014 was as follows (November figures are shown in brackets)*:*
- RIE – **92.27%** (94.51%)
- WGH – **85.80%** (88.90%)
- StJ – **92.63%** (94.34%)
- RHSC – **97.64%** (97.40%)

3.1.3   The latest compliance data for NHS Lothian shows that our overall performance at the end of October falls short of the revised agreed LUCAP December 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.]

NHS Lothian: 4 Hour Performance
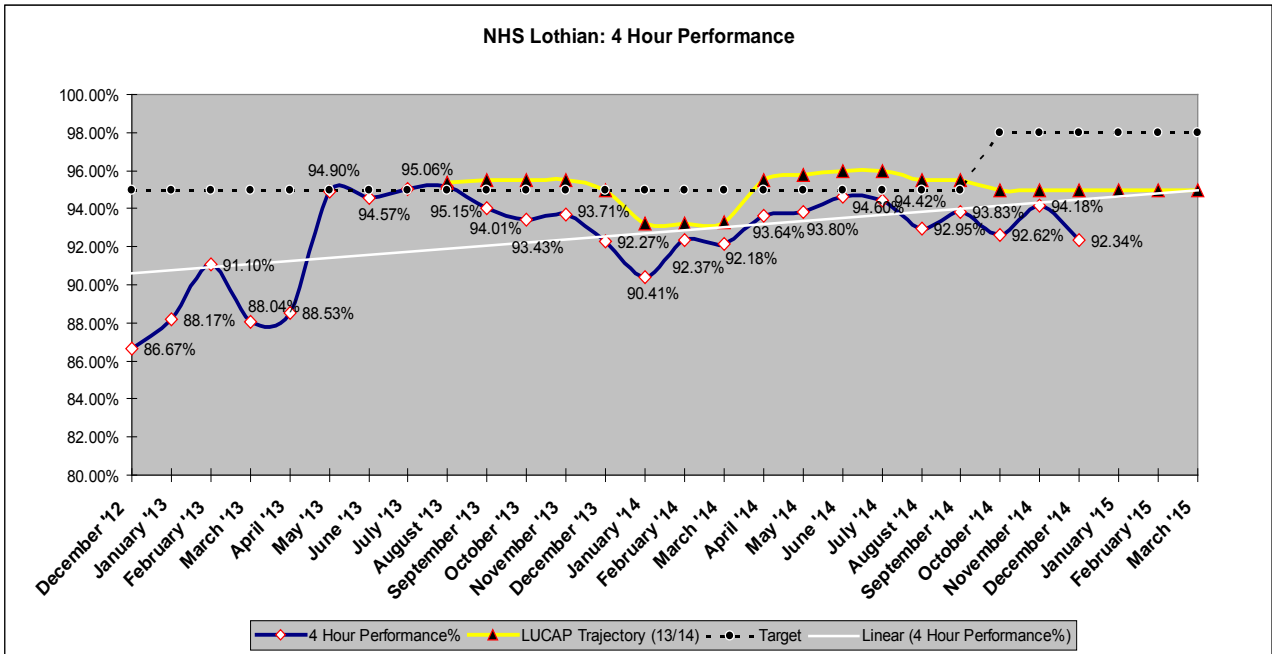
3.1.4 The number of admissions mapped against the total number of attendances per month during 2014, is shown in the following line graph. It shows that admissions have remained relatively constant throughout 2014.
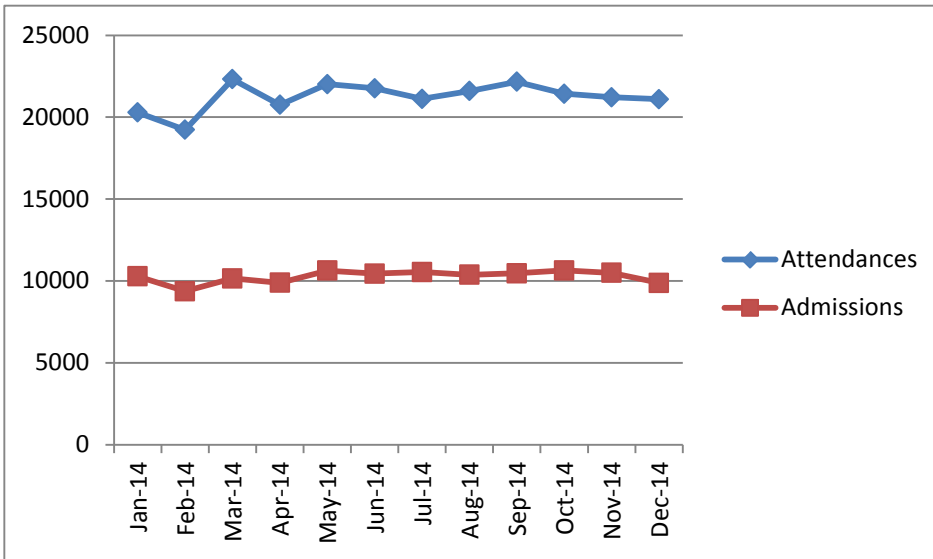
3.1.5 Overall NHS Lothian's performance against the 4 hour standard <u>during 2014</u> was **93.13%** with the individual monthly performances outlined below.

Month	Monthly %
January 2014	90.41%
February 2014	92.37%
March 2014	92.19%
April 2014	93.67%
May 2014	93.81%
June 2014	94.57%
July 2014	94.42%
August 2014	92.95%
September 2014	93.83%
October 2014	92.62%
November 2014	94.18%
December 2014	92.34%

2

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.

The graph below plots NHS Lothian's performance against both (Dec 12 – Dec 14).

NHS Lothian: 8 and 12 Hour Breaches
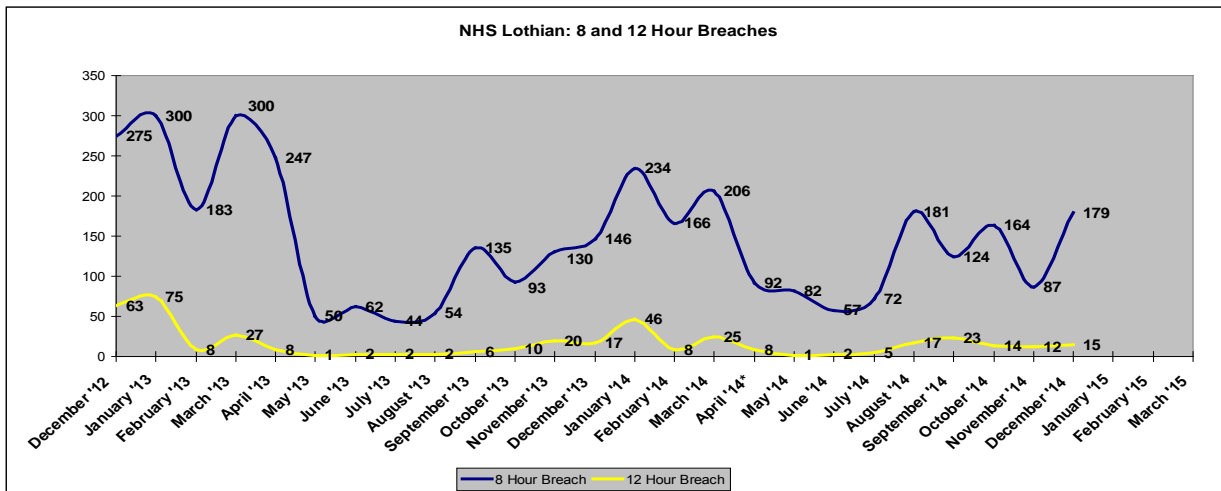
3.3   Boarding of Patients

3.3.1 The following graph shows the number of patients 'boarded out' across the system for the period since October 2013. The trend indicates a steady increase over this period, largely due to the most recent spike in numbers. Note also the spike during the same period last year.

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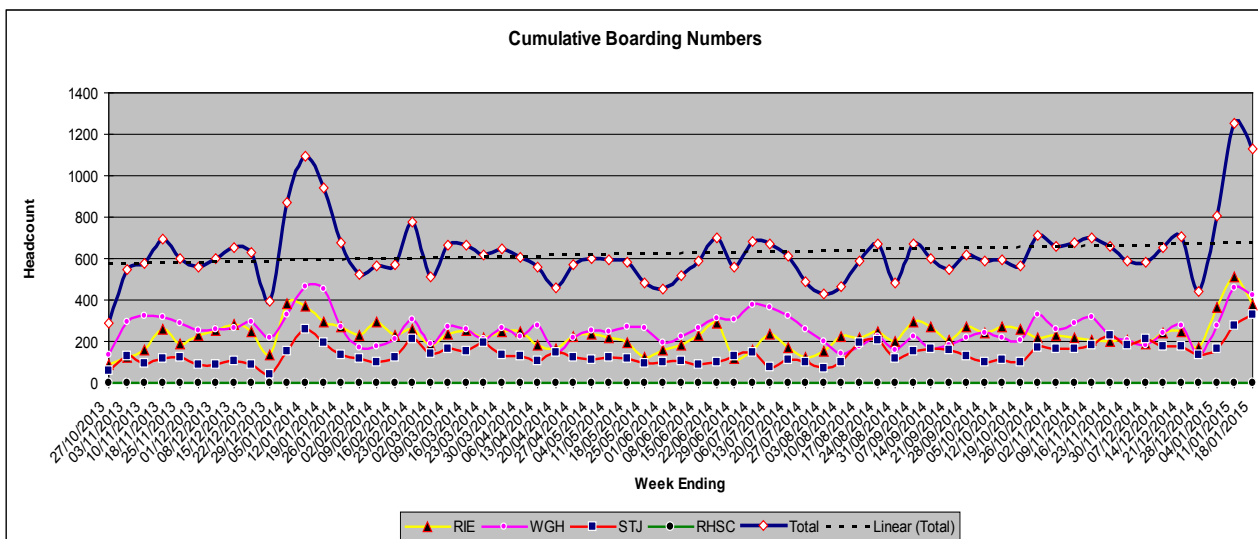
3.3.2 Information on boarding is currently undertaken on a 'snapshot' daily basis by the Site and Capacity Team. The primary function of this data is for daily operational use to support the safe management of flow and ensuring patients are safely under a consultant at all times.

3.4 Delayed Discharge Performance

3.4.1 The overall number of Delayed Discharges across NHS Lothian has increased from 136 during April 2014 to 196 during December 2014 – and is well above the figure recorded at the same time last year. Using the latest Monthly Census data, the following tables outline the delayed discharge numbers in more detail.

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			
Edinburgh	97	133	139	133	147	114	151	108	141			
East Lothian	25	19	30	25	30	43	30	37	31			
Midlothian	7	13	11	13	18	10	3	8	8			
West Lothian	5	4	4	5	9	8	9	9	12			
Non-Lothian	2	4	1	1	6	3	2	2	4			

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

3.4.2 Using the latest Monthly Census data (as at December 2014) 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	4
	11B - Awaiting completion of post hospital social care assessment	10
	24A - Awaiting place in Local Authority Residential Home	16
	24C - Awaiting place in Nursing Home (not NHS funded)	35
	24D - Awaiting place in Specialist Residential Facility for under 65 age groups	2
	24F - Awaiting place availability in care home (EMI/Dementia bed required)	18
	25D - Awaiting completion of social care arrangements -in order to live in own home	22
	25DOT - Health OT assessed POC under 14hours	19
	25E - Living in own home - awaiting procurement/delivery of equipment	1
	25F - Specialist Housing Provision (including homeless patients)	11
	67 - Disagreement between patient/carer/family and health/social work	3
City of Edinburgh Total		141
East Lothian	-	1
	11A - Awaiting commencement of post-hospital social care assessment	8
	11B - Awaiting completion of post hospital social care assessment	3
	24A - Awaiting place in Local Authority Residential Home	2
	24C - Awaiting place in Nursing Home (not NHS funded)	11
	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	1
	25F - Specialist Housing Provision (including homeless patients)	1
	67 - Disagreement between patient/carer/family and health/social work	1
East Lothian Total		31
Midlothian	11B - Awaiting completion of post hospital social care assessment	3
	24C - Awaiting place in Nursing Home (not NHS funded)	4
	25F - Specialist Housing Provision (including homeless patients)	1
Midlothian Total		8
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
	25D - Awaiting completion of social care arrangements -in order to live in own home	1
	25F - Specialist Housing Provision (including homeless patients)	1
Non-Lothian Total		4
West Lothian	24C - Awaiting place in Nursing Home (not NHS funded)	1
	25D - Awaiting completion of social care arrangements -in order to live in own home	11
West Lothian Total		12
Grand Total		196

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

Average Length of Delay Excluding all X-codes

	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			
Average LOS/days	27	33	36	38	33	38	31	31	32			

	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
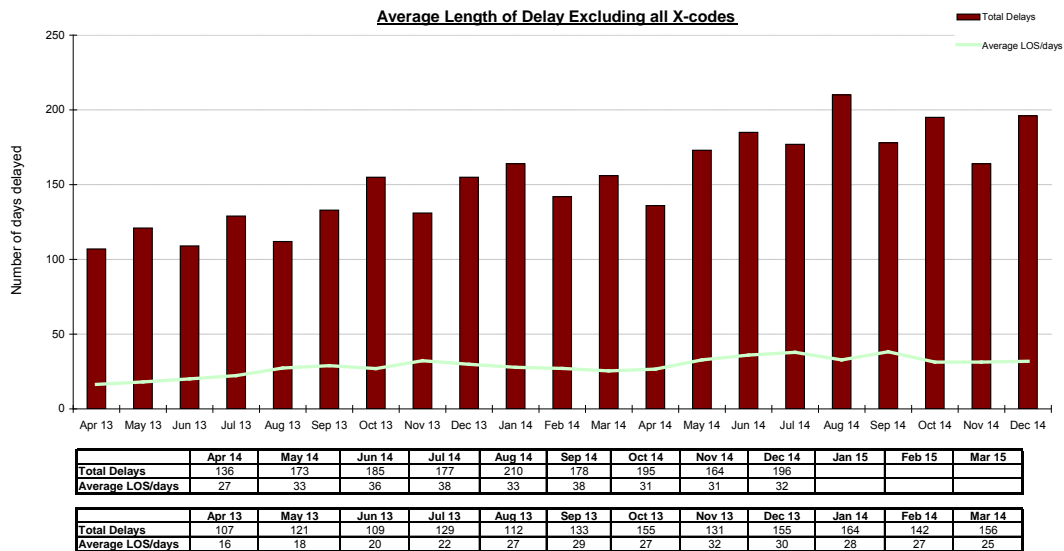
[1]Total includes Non-Lothian
[2]Total excludes x-codes

4   New Medical and Surgical Models (WGH)

4.1   The new Day Medicine and Medical Admissions Units have now opened. This has allowed patients to be offered scheduled appointments earlier in the day with some booked to attend the day following initial referral. The new Day Medicine Hotline diverts patients directly to specialty services avoiding unnecessary stays in acute receiving. Work continues to develop this model

4.2   Work to create a new Surgical Assessment Unit, expand ARAU Beds and convert Trolleys to Day Medicine has now finished. The new ARAU Beds extension opened on 14 January adding an additional 10 beds to the Medical Admissions Unit.

4.3   The extension to beds enables the front-door to directly admit patients who will require an overnight stay in the assessment unit. This began initially for a handful of patients as tests of change were conducted to refine the process model. This has since been expanded as the front-door moves towards adopting this as a consistent pathway for every patient arriving into Medical Admissions.

4.4   The new Day Medicine 'Hotline' pilot began on 14 January. This hotline has been developed in partnership with local GP representatives and should enable front-door service to better plan daily medical workload.

4.5   The hotline schedules patients that would have otherwise arrived in an unscheduled fashion. 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. The hotline also diverts a number of patients direct to specialities thus avoiding unnecessary stays in Day Medicine or Medical Admissions.

4.6   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.

5   LUCAP

5.1   An update on NHS Lothian's LUCAP was submitted to the Scottish Government in September and <u>again on 23 January 2015</u> as part of the quarterly reporting process. The final quarterly update is required in March 2015.

5.2   Following NHS Lothian's Local Unscheduled Care Action Plan (LUCAP), submission to the Scottish Government, a total of £1,120k has been provided to NHS Lothian in support of unscheduled care.

5.3   A further sum of £1050k (non-recurring) has also been received from the Scottish Government to specifically support initiatives in partnership with local councils to tackle our discharge from hospital performance.

6   Winter

6.1   <u>Winter funding/ allocation of resource</u>

6.1.1   For the purposes of Planning in NHS Lothian, 'winter' is defined as January, February and March 2015.

6.1.2   A total of £3.6 million has been allocated this year to support winter planning although we continue to use a number of unfunded beds across the acute hospitals to support patient flow on a daily basis. These cost pressures are reflected in the acute unscheduled care budget overspends.

6.1.3   Considerable reviews of current models for unscheduled care across NHS Lothian have been undertaken in the past year. 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.

6.1.4   An evaluation of our current capacity against increasing patient demand and to plan our approach, with our healthcare partners has enabled NHS Lothian to build on its current capacity and capability in supporting safe, effective and person centred care.

6.1.5   However key challenges remain, in particular our performance against the 4 hour Emergency Access standard, boarding of patients and Delayed Discharge. As winter progresses, these issues are likely to be heightened.

6.2   <u>Winter Capacity</u>

6.2.1   The following outlines the additional winter beds that are available to NHS Lothian this year. This includes the additional capacity at Gylemuir House that opened on 5 January 2015.

Site	Bed Numbers
St Johns (Ward 15)	12 (18 if required)
Western General (Ward 15)	26
RHSC.	10
Available Nursing Home Capacity	60
TOTAL (Winter 2014-15)	**108 (114)**

6.2.2 The above is on top of the additional bed capacity that has been created and come on stream in the last year. This is outlined in the table below.

Site	Bed Numbers
Royal Infirmary, Edinburgh	31
Step Down (City of Edinburgh Council)	52
Step Down (East Lothian Council)	20
Milestone House	12
Total additional capacity	**115**

6.2.3 Overall there are 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. Should further bed capacity be required then substandard facilities may require to be used. There is no further funding available to open these beds so this will increase the over-spend in Unscheduled Care. The need to open this bed capacity would be escalated by the Director of Unscheduled Care and the decision taken by the Acute Recovery Group.

6.2.4 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. To achieve this, significant improvement in patient flow processes is required and we may have to tolerate some deterioration in the 4 hours emergency access target.

7   Key Risks

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

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

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

7.4   The impact on bed footprint as a result of Norovirus/Infection Control issues during winter.

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

8   Risk Register

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

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

9   Resource Implications

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

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

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

Neil Wilson
Unscheduled Care Manager
26 January 2015.
neil.wilson@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 2015

Director of Human Resources & Organisational Development

SUMMARY PAPER - CONSULTANT VACANCIES

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

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

• Consultant recruitment activity in NHS Lothian	3.1-3.4
• Vacancies as a % of the overall consultant workforce for NHS Lothian and comparative data for other Health Boards in Scotland	3.5
• Recruitment successes in Emergency Medicine	3.9
• Consultant terms and conditions framing the employment offer	3.10
• Review of international recruitment campaign in Paediatrics (2012)	3.11
• Global and local recruitment efforts	3.12
• Current advertising practice	3.13
• Partnership with Scottish Government, NES and other Health Boards	3.15
• Need to explore the benefits of regional appointments	3.16

Janis Brown
Associate Director of Human Resources
28 January 2015
Janis.brown@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 2015

Director of Human Resources & Organisational Development/Medical Director

CONSULTANT VACANCIES

1   Purpose of the Report

1.1   The purpose of this report is to update the Board on the management of Consultant vacancies over the last 12 months, actions taken to support recruitment activity and actions in process.

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

2   Recommendations

2.1   Note the number of Consultant vacancies under recruitment during 2014.

2.2   Recognise the Board's position relative to other Health Boards.

2.3   Support the actions being taken forward to support Consultant recruitment both locally and nationally.

3   Discussion of Key Issues

3.1   In the period 1 January 2014 to 31 December 2015 there were 140 Consultant vacancies in NHS Lothian (note the nationally determined definition of a consultant vacancy is "posts actively under recruitment", therefore this is the measure being used here).

3.2   Of the 140 vacancies under recruitment last year, 1 post was withdrawn, interviews for 19 of the posts are still to take place. Of the remaining 120 vacancies, 92 appointments have been made; representing a fill rate of 77%.

3.3   38 of the posts were locum appointments to cover a combination of maternity leave and substantive vacancies i.e. to fill the gap until the post is appointed to on a permanent basis.

3.4   There are currently 28 Consultant posts under recruitment.

3.5   Over the last 12 months vacancies as a percentage of the overall consultant workforce NHS Lothian has averaged 4.7%, which is significantly lower than the national average of 6.1%. This is lower than the other Boards in the South East region; the average within NHS Borders is 6.9% and 12.5% within NHS Fife. When compared with other Teaching Boards NHS Lothian is slightly higher than NHS Greater Glasgow & Clyde(4.2%) and NHS Tayside (3.6%), it is however substantially lower than NHS Grampian (9.4%). This data was sourced from ISD.

3.6   As previously reported to the Board the specialties which are difficult to recruit to are:- Obstetrics & Gynaecology, Opthalmology, Paediatrics, Anaesthetics, Medicine of the Elderly and Psychiatry.

3.7   Following a successful recruitment campaign led by the Clinical Director and supported by his Consultant colleagues, Emergency Medicine is no longer considered to be high risk.

3.8   The Workforce Risk Assessment report presented to the Board in December 2014 outlined the key actions taken or in process for each of the high risk specialties to ameliorate the risks to service sustainability.

3.9   Demonstrated through our successes in Emergency Medicine the key elements of any recruitment campaign are:-
- Local leadership and ownership of the campaign at Clinical Director and Consultant team level i.e. it has to be more than a transactional process administered by the HR function.
- Determine the drivers which will attract future applicants (eg working with renowned experts in the field, opportunities for development, to develop a particular specialism) to the service/team and those which will work against you (e.g poor trainee feedback, Royal College reports) and develop a plan to appropriately address these.
- Sell the service and the team, the opportunities for development, specialism etc informally through medical networks and more formally through recruitment materials and in the case of Emergency Medicine through a locally developed website. In other Health Board area's short films to sell the service/team/opportunities have been developed, particularly for GP's.
- Consider alternative medical roles such as Clinical Development Fellows, which in themselves highlight our commitment to developing the Medical Workforce and creating opportunities.

3.10   With regard to the package on offer to consultant staff, the Board is tied into nationally (UK) negotiated terms and conditions of employment, for example rates of pay. There has been considerable discussion about the balance of activities which make up the consultant contract between direct clinical care and supporting professional activities. A wide range of views have been expressed. The Scottish Governments position is that they wish to leave employers with flexibility to recruit and retain consultants in a way which best responds to service demands, and gives appropriate attention to patient care and safety, clinical leadership, and personal and service development. The Scottish Government issued a statement as follows "The contract of employment for consultant doctors in NHS Scotland is based on ten programmed activities. Employers are expected to use flexibility to ensure that the number and allocation of programmed activities reflect the nature of the individual's overall contribution to the NHS, through the job planning process". NHS Lothian complies with this position.

3.11   Havas (recruitment advertising agency) were commissioned to review our international recruitment campaign for Paediatrics (2012). The key findings from their research were that once medics were established in their positions it had to be a significant offer to entice them to a new role. Applicants would only look to move to a role that offered them something over and above what they already had, e.g. particular specialism. They were also driven by who they would be working with

(renowned experts in the field). Other factors that influence/block a move is relocation and the fact that many often have spouse/family commitments to consider, so the benefits of relocating have to far outweigh the difficulties in uprooting a whole family.

3.12 Whilst global recruitment undoubtedly is worth pursuing it does not preclude action locally, i.e. at Clinical Director and team level to determine drivers that will influence/potentially block recruitment. Supported by the Lothian Medical Workforce Group and the Recruitment Team.

3.13 All Consultant vacancies are currently advertised and promoted through a range of external websites. Recent recruitment campaigns, such as Anaesthetics have also been supported through microsites hosted on our existing internet supported by a promotional campaign involving google advertising and search functionality, targeted advertising to countries across the world and social media marketing through NHS Lothian's Twitter and Facebook pages. We operate a system whereby for hard to fill posts the Clinical Director can make a request to the Medical Director to have the vacancy advertised in the print media, usually the British Medical Journal (BMJ). To date no such request has been refused.

3.14 Work is underway to create a specific NHS Lothian Internet site for recruitment purposes.

3.15 The Board is 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:- strategy for Medical Recruitment Advertising, joint Board advertising and an international recruitment campaign.

3.16 Actions still to be taken include exploring the benefits of regional Consultant appointments. This is being taken forward by the Medical Director and Director of Human Resources and Organisational Development.

4   Key Risks

4.1 There are no significant risks attached to the recommendations in this paper.

5   Risk Register

5.1 The NHS Lothian risk register contains a 'Medical Workforce Sustainability' risk, which relates the risk that workforce supply pressures in conjunction with activity pressures will impact on service sustainability and /or NHS Lothian's ability to achieve its corporate objectives. The multi-factorial risk assessments that have been carried out will be reviewed and updated where necessary on a 6 monthly basis or where there are significant changes.

6   Impact on Inequality, Including Health Inequalities

6.1 The introduction of the medical workforce risk assessment process has been subject to a rapid impact assessment for which a report has been prepared.

7   Involving People

7.1   As this is an update paper, this section is not applicable.

8   Resource Implications

8.1   The are no resource implications attached to the recommendations in this paper.

Janis Brown
Associate Director of Human Resources
28 January 2015
Janis.brown@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 2015

Director of Scheduled Care

SUMMARY PAPER - WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

The key points of the paper are summarised here.

A total of 447 patients were beyond the treatment time guarantee at end of December with 427 treated in the month beyond the expected 12 weeks.	**3**
142 inpatient and daycase patients not covered by the treatment time guarantee were waiting over 12 weeks at the end of December.	**3**
Outpatients over 12 weeks numbered 2672 at the end of December.	**4**
18 week performance from referral to treatment for December remained stable at 86.3%.	**5**
Both 31 and 62 day performance against Cancer were above 95% across the final quarter of 2014 as whole.	**6**
An improvement in those difficulties experienced in cystoscopy capacity reduced the number waiting over 6 weeks for a diagnostic endoscopy at the end of December to 588. However it remained higher than earlier in the year. 68 radiology patients also exceeded this 6 week standard and predominately were waiting for an ultrasound scan.	**7**
End of December's surveillance endoscopy position saw 805 waiting beyond their due date. The numbers delayed for a review colonoscopy have increased whilst a decrease is evident in those overdue a check cystoscopy.	**8**
341 adult patients were waiting beyond the standards in place in audiology at the end of December.	**9**
The forthcoming standard for IVF continues to be met.	10
Numbers waiting in Child and Adolescent Mental Health over 18 weeks are reducing (December actual: 490), aiming to meet the standard – as described previously to the Board – by May.	11
Capacity issues continue to impact on Psychological Therapy performance. 1142 patients were identified over 18 weeks at the end of December.	12

NHS LOTHIAN

Board Meeting
4 February 2015

Director of Scheduled Care

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 during 2014. At the end of December 447 patients who had waiting more than 12 weeks remained on the waiting list with 427 treated in month beyond the guarantee (Table 2).

Table 1 – Treatment Time Guarantee Patients waiting beyond standard at month end[1].

Specialty	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Ophthalmology	61	88	146	42	60	38	31	24	32	16	15	10	11
Plastic Surgery	89	131	137	120	142	128	122	150	191	188	162	181	195
Maxillofacial	66	35	35	35	28	30	22	28	34	37	39	35	30
ENT	49	69	46	26	28	42	19	11	20	34	33	34	48
Colorectal/General	57	75	61	39	46	56	57	70	76	55	35	39	18
Urology	72	99	142	108	111	127	134	138	140	134	122	109	68
Paediatric ENT	16	20	22	7	9	20	12	13	16	19	21	15	14
Paediatric Plastic Surgery	12	12	5	1	8	7	10	10	8	4	3	3	1
Orthopaedic Surgery	5	12	32	13	28	28	32	20	42	34	51	64	49
Others	26	31	64	24	64	106	63	46	9	11	5	8	13
TOTAL	**453**	**572**	**690**	**415**	**524**	**582**	**502**	**510**	**568**	**532**	**486**	**498**	**447**

Table 2 – Treatment Time Guarantee Patients seen beyond 12 weeks[1].

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
TTG Patients treated over 12 weeks	252	473	528	574	443	533	476	388	402	467	448	397	427

3.2   As will be known, there are some patients admitted as inpatients and daycases who are not included within the Treatment Time Guarantee. The numbers of these patients waiting over 12 weeks is outlined in Table 3.

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[1] Source changed from Trak to Warehouse in July 2014, with impact of new calculation apparent from May.

Table 3 – Inpatients and Daycases not covered by Treatment Time Guarantee and waiting over 12 weeks

Specialty	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Diagnostic Procedure	3	6	2	2	1	1	2	34	51	58	69	77	53
Neurology - Videotelemetry	37	42	44	41	43	48	48	51	56	56	65	71	71
Scoliosis	19	21	27	25	32	26	26	23	17	14	11	9	8
Ophthalmology - Corneal Graft	11	11	11	8	5	6	7	1	2	3	4	5	8
Neurosurgery - Spine	29	33	41	53	61	48	27	12	6	1	1	2	1
Fertility and Rep Endocrine Centre	2	2											1
Neurosurgery - Diagnostic (biopsy)							1						
Orthopaedic Backs			2						1				
Plastic Surgery legacy	5	3	2	3	1	1	1						
Urology legacy													
Other legacy	1				1								
TOTAL	107	118	129	132	144	130	112	122	132	132	150	164	142

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 4 – List Size and Unavailability[2]

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total List Size (TTG)	10199	9884	9555	9445	9256	9252	9307	9534	9842	9841	9832	9961
Available	9169	8842	8400	8260	8016	7891	8000	8322	8697	8810	8733	8784
Unavailable	1030	1042	1155	1185	1240	1361	1307	1212	1145	1031	1099	1177
Percentage Unavailable	10%	11%	12%	13%	13%	15%	14%	13%	12%	10%	11%	12%
non-TTG	216	328	513	715	691	631	564	574	551	606	572	620

3.4 The position on choice codes is shown below.

Table 5 – Choice codes in Inpatients (December)

Specialty	Patient Request - wishes named consultant	Patient Request - wishes to be treated within Health Board	Grand Total
Urology	4	5	9
Orthopaedic Surgery	4	4	8
General Surgery	4	2	6
Ophthalmology	1	2	3
Plastic Surgery	1	1	2
Ear Nose and Throat		2	2
Gynaecology	2		2
Oral Surgery	1		1
Grand Total	17	16	33

4 Outpatients

4.1 Across NHS Lothian 2672 were over 12 weeks at the end of December. The position reflects the emphasis that was placed on focusing consultant and additional capacity on the treatment time guarantee during the holiday season whilst the decision of further funding of £4M discussed at the Board meeting in December was considered.

4.2 Figures on list size and unavailability are shown in the following table. As with inpatients, the use of unavailability and choice codes in Lothian remains low.

Table 6 – List Size and Unavailability[3]

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total List Size	40592	40691	40970	40808	42481	42480	43738	43091	42624	43955	43004	42639
Available	39725	39786	40021	39837	41357	41169	42320	41854	41441	42808	42085	41527
Unavailable	867	905	949	971	1124	1311	1418	1237	1183	1147	919	1112
Percentage Unavailable	2%	2%	2%	2%	3%	3%	3%	3%	3%	3%	2%	3%

4.3 The most recent position on choice codes is shown in the table below.

Table 7 – Choice codes in Outpatients (December)

Specialty	Patient Request - wishes named consultant	Patient Request - wishes to be treated within Health Board	Grand Total
Orthopaedic Surgery	1	7	8
Gynaecology	5		5
Gastroenterology	1		1
Plastic Surgery	1		1
Urology		1	1
Clinical Oncology		1	1
Medical Oncology	1		1
Grand Total	**9**	**9**	**18**

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 86.3% achievement during December.

Table 8 -Trend in 18 Week Performance and Measurement

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Patient journeys within 18 weeks (%)	87.2	85.4	84.7	85.2	86.0	86.4	85.9	86.1	86.0	86.1	87.3	85.9	86.3
Number of patient journeys within 18 weeks	10,857	12,670	11,861	12,797	12,552	12,742	13,178	12,947	12,573	13,415	13,877	13,042	11,811
Number of patient journeys over 18 weeks	1,594	2,174	2,135	2,217	2,044	2,003	2,164	2,098	2,044	2,163	2,014	2,137	1,873
Patient journeys that could be fully measured (%)	85.6	86.6	86.2	86.1	86.3	85.7	86.6	86.6	86.5	86.3	85.9	86.0	83.4

6 Cancer

6.1 Performance against cancer standards is shown in the following tables.

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.

Table 9 – 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 10 – 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. For scopes, cystoscopy remains responsible for most instances exceeding the national standard of 6 weeks although the reduction in the numbers waiting over 6 weeks at the end of December contributed to an overall improvement in the month.

7.2   In radiology, there was 68 patients were waiting over 6 weeks at the end of December, predominately for an ultrasound examination.

Table 11 –Numbers over 6 week standard for Key Diagnostic Tests (Endoscopy)

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Colonoscopy	15	28	8	9	10	17	7	24	37	42	47	49	25
Upper Endo	14	23	13	9	21	24	14	20	13	29	41	72	36
Flexi Sig	8	25	13	8	4	4	14	36	21	39	19	17	13
Flexi Cysto	48	149	31	45	42	57	129	294	442	485	603	602	514
Total	**85**	**225**	**65**	**71**	**77**	**102**	**164**	**374**	**513**	**595**	**710**	**740**	**588**

Table 12 – Numbers over 6 week standard for Key Diagnostic Tests (Radiology)

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
CT	0	0	1	0	0	0	0	1	0	0	0	0	0
MRI	0	11	5	2	1	0	1	4	2	0	1	0	1
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0
Ultrasound	1	0	0	0	0	0	0	0	0	1	7	21	67
Total	**1**	**11**	**6**	**2**	**1**	**0**	**1**	**5**	**2**	**1**	**8**	**21**	**68**

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. The recent rises in cystoscopy numbers have been reduced although those overdue a review colonoscopy are on the increase.

Table 13 – Surveillance and Review Patients overdue appointment

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Colonoscopy	169	160	118	105	82	89	81	83	108	113	96	191	301
Upper Endo	80	78	54	58	52	53	42	57	55	51	71	99	125
Flexi Sig	18	18	16	15	23	22	16	18	20	19	17	18	35
Flexi Cysto	265	255	226	257	199	219	234	180	190	269	334	324	282
Other	59	41	48	32	34	56	49	33	37	39	59	34	62
Total	**591**	**552**	**462**	**467**	**390**	**439**	**422**	**371**	**410**	**491**	**577**	**666**	**805**

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 December and at the end of the year 341 were exceeding the standards set in adult services.

Table 14 – Adult Audiology – Performance against Standard

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Patients waiting for audiology assessment (first contact)													
Number waiting 9 weeks and over	**82**	**80**	**2**	**11**	**17**	**14**	**38**	**11**	**3**	**0**	**0**	**0**	**111**
Total number waiting	1563	1565	1648	1730	1677	1619	1599	1735	1516	1608	1464	1662	1939
Patients waiting for fitting of hearing aid													
Number waiting 9 weeks and over	**57**	**48**	**4**	**21**	**33**	**33**	**108**	**45**	**3**	**1**	**0**	**26**	**215**
Total number waiting	922	942	842	901	944	1001	1051	931	983	995	1007	1024	978
Patients waiting for other treatment (excl. hearing aids)													
Number waiting 9 weeks and over	**7**	**8**	**1**	**0**	**2**	**0**	**2**	**4**	**4**	**4**	**0**	**8**	**15**
Total number waiting	146	108	113	105	105	42	92	126	96	67	84	116	121

Table 15 – Paediatric Audiology – Performance against Standard

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Patients waiting for audiology assessment (first contact)													
Number waiting 12 weeks and over	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total number waiting	198	187	240	228	220	264	216	142	144	101	168	238	189
Patients waiting for other treatment (excl. hearing aids)													
Number waiting 6 weeks and over	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Total number waiting	32	26	30	40	50	3	7	12	6	8	7	38	47

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 16 – IVF Waiting List

	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14
Numbers waiting	234	261	234	176	171	163
Numbers over 12 months	0	1	0	0	1	0

11 CAMHS

11.1 The waiting times and trajectory for CAMHS is detailed in Table 18. In December 52% children and young people seen for a first treatment were seen within 18 weeks. This level of performance against the target will remain similar in the first quarter of 2015 as the service continues to focus on those with the longest waits in order to reduce the number of children and young people waiting over 18 weeks and meet the target as planned by May 2015.

Table 17 – CAMHS Performance Trend

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Percentage <u>seen</u> within 18 weeks*	75%	67%	67%	67%	63%	69%	57%	52%	52%
Revised Trajectory – June 2014			67%	67%	67%	66%	69%	72%	75%
Trajectory for seen within 18 weeks	85%	85%	85%	88%	88%	88%	90%	90%	90%
Total waiting at end of month	1,537	1,542	1,547	1,553	1,565	1,724	1,792	1,734	1,776
Those waiting more than 18 weeks	462	503	508	514	601	623	626	527	490

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. The generic teams have achieved the agreed activity levels

in relation to new patient treatments each month. This is despite considerable impact on the ability of Edinburgh services to maintain capacity due to reduction in clinical space caused by need to decant the teams from their current accommodation between April and December.

11.3 The CAMH Service has continued to cleanse the TRAK waiting lists with support from the A12 Team. There is now confidence that data quality issues have been addressed.

Table 18 – CAMHS Generic Team Performance – Over 18 weeks

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Predicted	519	526	465	405	345
Actual	601	559	535	435	388

11.4 At the end of December there were 43 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 there were 189 more referrals than in the same period the previous year. The performance against the trajectory will continue to be monitored via the agreed capacity planning cycle with action being taken as required to ensure

12 Psychological Therapies

Table 19 – Psychological Therapise Performance Trend

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Percentage seen within 18 weeks*	59%	58%	52%	52%	**32%**	**52%**	37%	36%	35%
Revised Trajectory for seen within 18 weeks			52%	52%	57%	60%	62%	64%	64%
Initial Trajectory for seen within 18 weeks	77%	79%	81%	82%	83%	86%	88%	90%	90%
Total waiting at end of month	2357	2379	2438	2442	2542	2645	2800	3004	3068
Those waiting more than 18 weeks	787	644	800	802	814	859	1004	1069	1142

12.1 The waiting times and trajectory for Psychological Therapy services is detailed in Table 20. In December 35% of patients seen for a first treatment were seen within 18 weeks. This level of performance against the target will continue as the services focus on those with the longest waits. The number of patients waiting over 18 weeks has continued to increase from 787 reported in April 2014 to 1142 in December 2014.

12.2 The A12 Team continue to support services to improve the completeness and accuracy of the Psychological Therapies data. A number of additional measures have been put in place to accelerate the cleaning of the lists with an agreement that services will now formally sign off data their data in terms of accuracy.

12.3 Service improvements, as detailed in previous papers, continue to be progressed with additional capacity being released from existing resource. However, the capacity to provide psychological therapies, in most services continues to be inadequate to meet the demand.

12.4 The use of non-recurring funded posts has continued. However, there are clear limitations to the use of these posts due to the relatively limited additional capacity realised. A six month non-recurring post will only be able to allocate new treatment

slots for the first four months of their contract. Furthermore, the ability of staff employed to treat those patients with the longest waits is limited as these patients presentations are often the most complex.

12.5   A detailed business case is being prepared for consideration by the Corporate Management Team which, following the completion of a detailed demand and capacity analysis across all services, will outline the steps required for services to meet current demand and address current waiting list backlogs.

12.6   Initial demand and capacity calculations have been undertaken for Edinburgh services and West Lothian Psychological Therapy services. This has utilised the previous method used with East and Midlothian Psychological Therapy services as part of a national pilot. Further work is required to validate the metrics utilised but these initial calculations suggest that these services require around 19 wte staff the meet current demand. As a minimum, it is suggested that current non-recurring posts require to be substantiated.

Jim Crombie
Director of Scheduled Care
27 January 2015
j.crombie@nhs.net

NHS LOTHIAN

Board Meeting
4 February 2015

2.5

Medical 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% (4.8%) which appears to reflect seasonal variation.	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
13 January 2015
Jo.bennett@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 2015

Medical Director/Executive Nurse Director

QUALITY REPORT

1   Purpose of the Report

1.1   This report presents the Quality Report for December 2014, 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.

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 Apr-June 2014	Change from baseline
Scotland	1.00	0.81	-15.89%
RIE	0.87	0.63	-18.06%
St John's	0.88	0.75	-7.37%
WGH	0.74	0.59	-12.38%

3.1.3   Staff absence levels (Graph 6) are over 4% (4.8%) which appears to reflect seasonal variation.

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, Cancer 62 day waits and compliance with stroke standards which remain a challenge.

Quality Dashboard – December 2014 (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

3

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

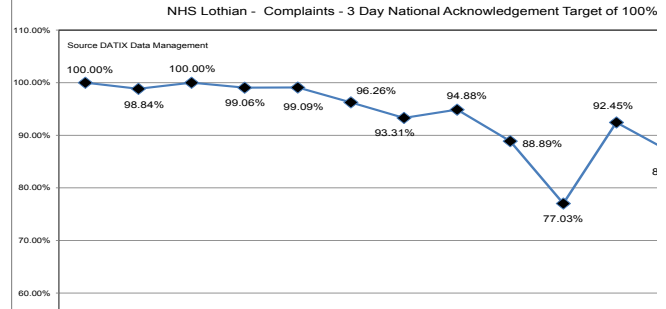**Process Measure**
20-Day Response Target across NHS Lothian
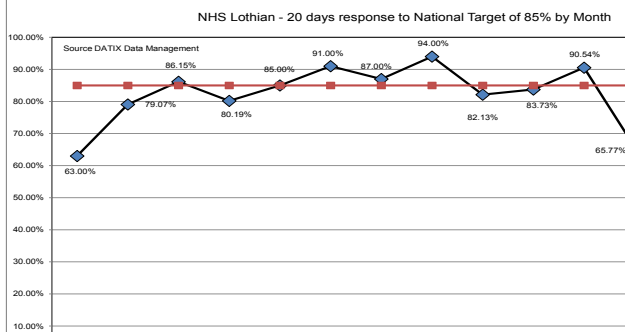
Data Source: Datix   Exec Lead: Alan Boyter

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
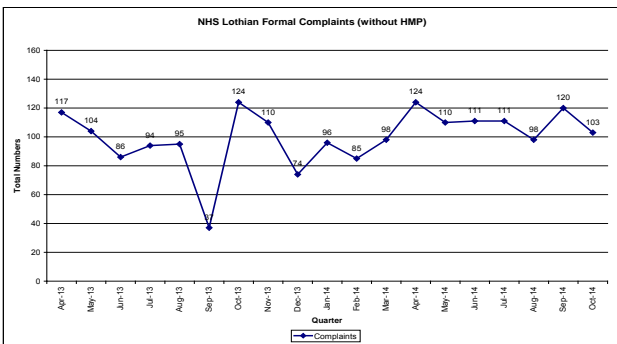
Outcome Measure

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
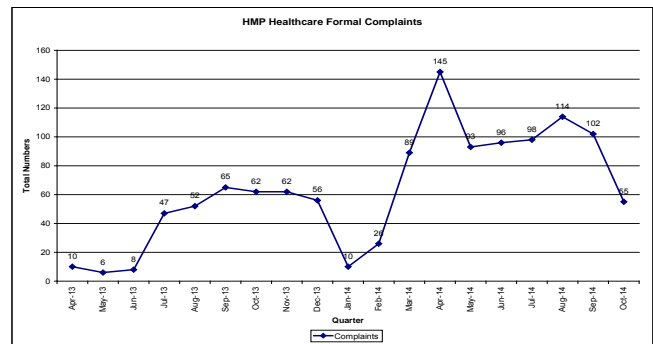
Data Source: Datix   Exec Lead: Alan Boyter

Title:	Delayed Discharges & Average Length of Stay (Graph 5)
Goal:	No patient waiting longer than 2 weeks for discharge, by April 2015

Process Measure
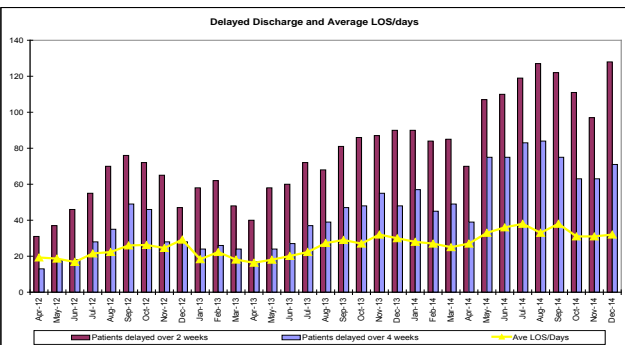
Data Source: Local data captured on EDISON shared data with Health & Social Care   Exec Lead: Melanie Johnson

Title:	Staff Absence Levels (Graph 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

Outcome Measure
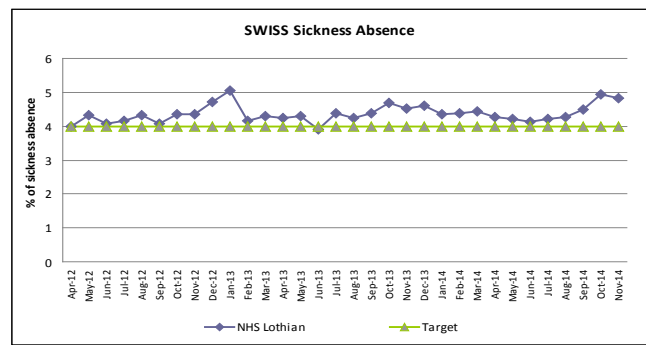
Data Source: Scottish Workforce Information Strategic Systems (SWISS)   Exec Lead: Alan Boyter

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	**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – June 2014	Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2014

Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in St John's Hospital, October 2006 – June 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.
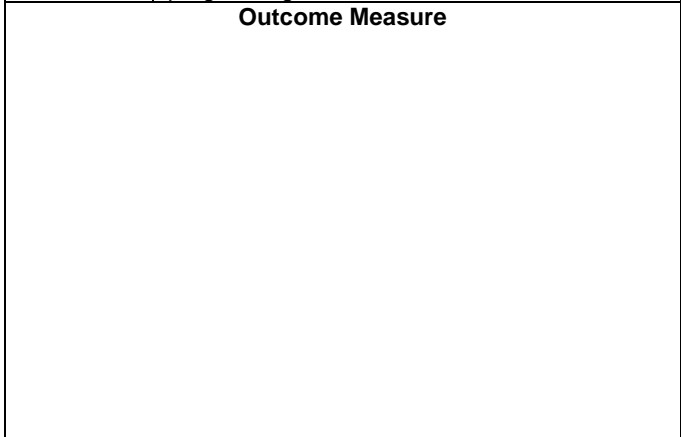
Title:	C. difficile associated disease against HEAT Target 2012-13 (Graph 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve 262 or fewer CDI by March 2015 as shown by trend line.

Outcome Measure	**Outcome Measure**
	Progress against HEAT Target for *C.difficile* Infection (CDI)

NHS Lothian Adverse Events Reported with Serious Harm

Serious Harm = Moderate or Major Harm or Death
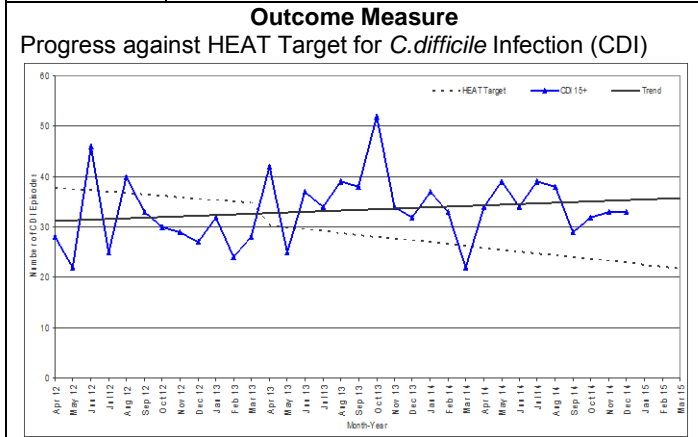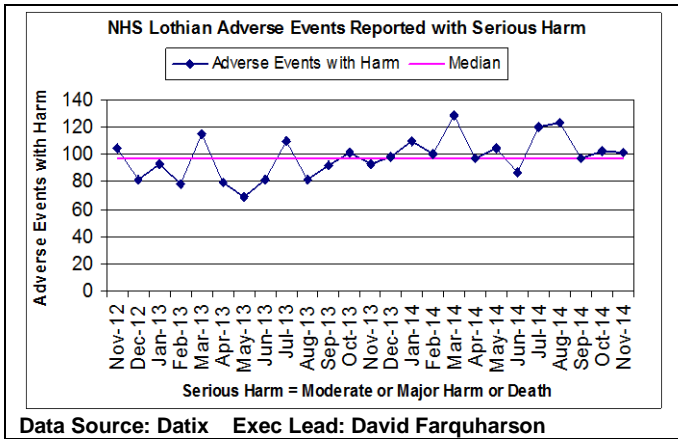
Data Source: Datix   Exec Lead: David Farquharson

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
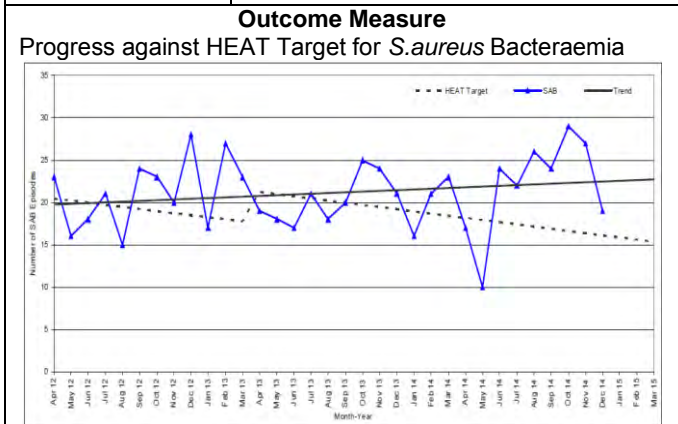
Title:	Number of Cardiac Arrests (Acute Wards) (Graph 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
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	

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	

Source Data: Local Audits (Resuscitation Officer Database)
Exec Lead: David Farquharson

Data Source: Datix   Exec Lead: Melanie Johnson
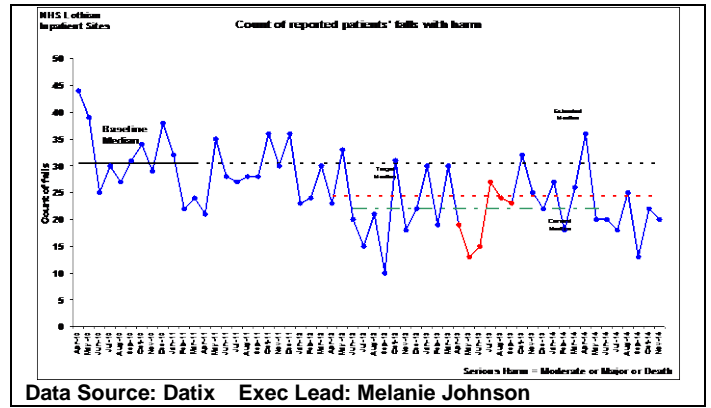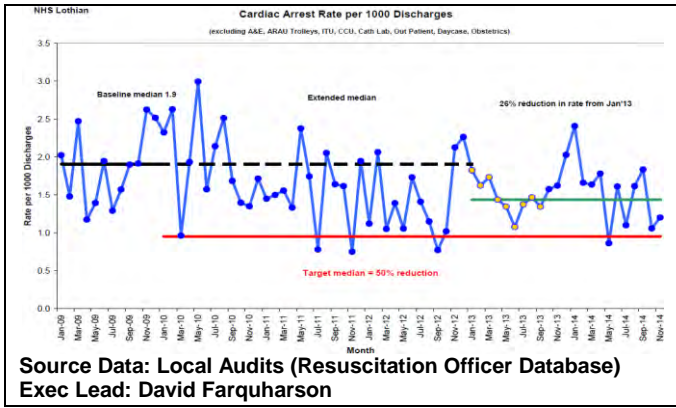
Title:	Number of Pressure Ulcers per month across NHS Lothian (Graph 16)
Numerator:	Number of Grade 2 or above pressure ulcers
Goal:	To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2015 (from one a day to none a day)

Outcome Measure

Data Source: Datix   Exec Lead: Melanie Johnson
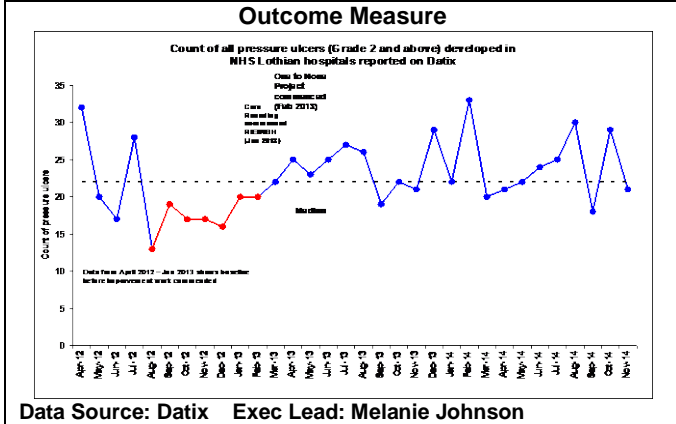
Effective

"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
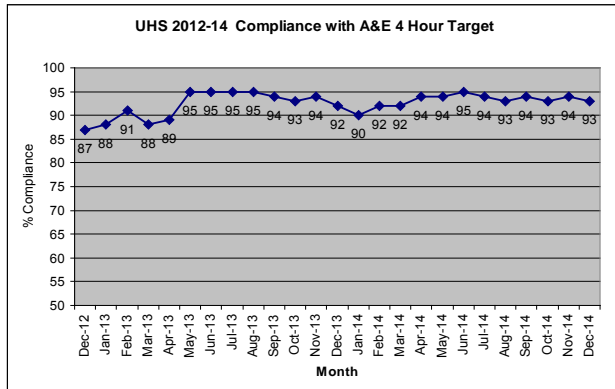
Data Source: Patient Administration System (TRAK)
Exec Lead: Melanie Johnson

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
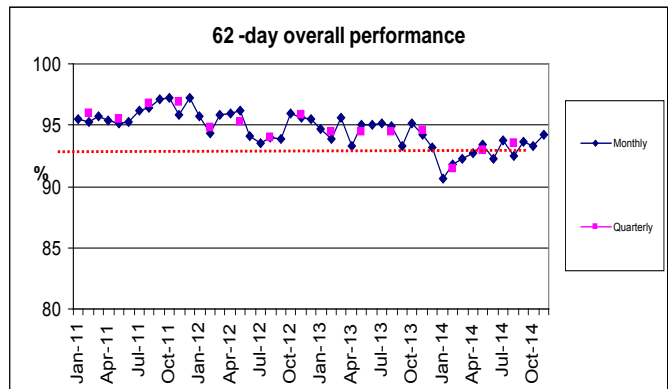
Data Source: SGHD Management Information
Exec Lead: Jim Crombie

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
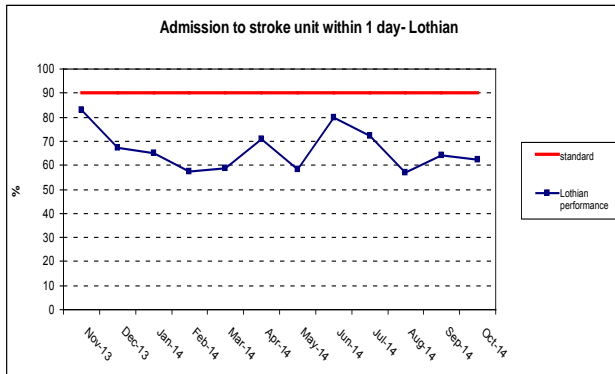
Data Source: ISD   Exec Lead: Melanie Johnson

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
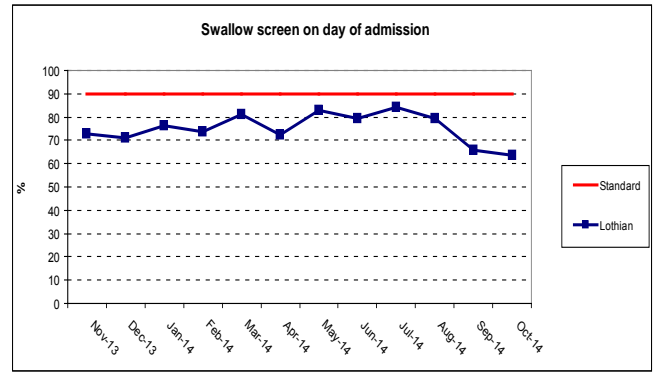
Data Source: ISD   Exec Lead: Melanie Johnson

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

Data Source: ISD   Exec Lead: Melanie Johnson

9
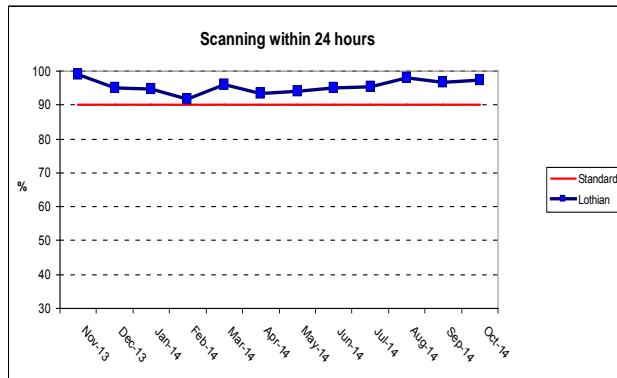
4   Key Risks

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. Patient Experience 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.

Jo Bennett
Clinical Governance & Risk Manager
13 January 2015
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Supporting Context and Technical Appendix

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

Board Meeting
4 February 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - STRATEGIC PLAN PROGRESS REPORT

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 purpose of this report is to recommend that the Board receives an update on the progress against the Strategic Plan "Our Health, Our Care, Our Future" post the consultation in the summer and autumn of 2014 and the subsequent discussions at the October Board and the January Board Development Session.	1.1
• The purpose of presenting the progress report is to provide the Board with information which will enable the Board members to make key decisions in relation to the development of the key propositions as set out in the attached report across primary, unscheduled and scheduled care.	1.2
The main recommendations are to: • Support the key recommendations as set out in section 10 of the attached report on page 32. If supported these propositions will be developed further into options or taken to option appraisal or to initial or full business case. Where appropriate consultation and engagement will also be built in to the process for each proposal.	2.1
• To agree to support further work in relation to the development of the 'policy choices' as set out in the paper on page 6.	2.2
• To note for information the Gantt chart setting out the anticipated timelines and interdependencies related to key work streams/propositions and the Property and Asset management Investment plan 2015/16-2019/20.	2.3

Alex McMahon
Director of Strategic Planning
2 February 2015
Alex.mcmahon@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 February 2015

Director of Strategic Planning, Performance Reporting & Information

OUR HEALTH, OUR CARE, OUR FUTURE

1   Purpose of the Report

1.1   The purpose of this report is to recommend that the Board receives an update on the progress against the Strategic Plan "Our Health, Our Care, Our Future" post the consultation in the summer and autumn of 2014 and the subsequent discussions at the October Board and the January Board Development Session.

1.2   The purpose of presenting the progress report is to provide the Board with information which will enable the Board members to make key decisions in relation to the development of the key propositions as set out in the attached report across primary, unscheduled and scheduled care.

1.3   The attached progress report covers in more detail the process of developing this work; its connectivity with the finance agenda and the inter relationship with the integration agenda and the development of the clinical leadership agenda.

1.4   This progress report and the proposed key developments sit within the context of the Boards overall financial position. It should be noted that through the Corporate Management Team a process has been put in place to ensure a balanced budget can be presented to the Board as part of its Local Delivery Plan (LDP) by 31 March.

1.5   A Core Steering Group has been established which is overseeing the development of propositions and ideas for delivering financial balance and all of the propositions within this progress report sit within this context and process.

1.6   Much of the content of the progress report and the actions which are being presented will also feature within the Boards LDP submission and within our corporate objectives for 2015/16, subject to agreement by the Board.

1.7   The Board is expected to submit its first cut of its financial plan for 2015/16 LDP by Friday 13 February.

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

2   Recommendations

2.1   To receive the progress report and support the key recommendations as set out in section 10 of the attached report on page 32. If supported these propositions will be developed further into options or taken to option appraisal or to initial or full business case. Where appropriate consultation and engagement will also be built in to the process for each proposal.

2.2   To agree to support further work in relation to the development of the 'policy choices' as set out in the paper on page 6.

2.3   To note for information the Gantt chart setting out the anticipated timelines and interdependencies related to key work streams/propositions and the Property and Asset management Investment plan 2015/16-2019/20.

3   Discussion of Key Issues

3.1   Our Health, Our Care, Our Future is NHS Lothian's draft strategic plan was signed off by the Board in April 2014. The plan was then taken out to public and staff consultation during the summer and autumn of 2014. From there information was brought back to the Board and the Strategic Planning Committee in relation to the key issues that were raised and Board support was sought and agreed in relation to the need to develop the work plan further.

3.2   At the same time NHS Lothian's financial position for 2014/15 and 2015/16 raised concern and this was also discussed at the October and December Board meetings. Further work is being progressed to address financial sustainability, part of which is identifying the key propositions that we need to progress in order to meet short, medium and longer term sustainability as well as delivering recurring LRP, whilst ensuring the delivery of safe and effective care and treatment.

3.3   During the consultation process one of the key issues raised was access to and capacity within primary care. This was stated by both the public and through responses from our GP community.

3.4   Since the consultation phase senior officers within the Board have worked very closely with the Chair of the GP Sub Committee and the wider GP community to develop a strategic narrative around the key issues that need to progress in order for primary care to be developed and for a sustainable position to be found. This translated into a Board Development Session on 14 January where GP's from across Lothian attended and took part in the Board presentation and discussion. A number of key areas were discussed and further action has been taken to translate these issues into the attached progress report. Amongst the key issues are the need to develop primary care facilities but also capacity. It has been acknowledged that this requires not a review of GP numbers but a broader workforce and skill mix review. At the same time sustaining out of hours capacity is key, particularly around sustaining scheduled and unscheduled care and a further key action is investment in IM&T within general practice.

3.5   Key actions to reflect this are captured in the progress report.

3.6   At the same Board Development session in January further updates were provided on the key strategic propositions in relation to scheduled and unscheduled care. Work to develop these has been progressed and the actions now proposed are set out in the progress report.

3.7   Attached with the Strategic plan is a Gantt chart providing information on the key milestones, and dependencies for delivery, as well as the current Property and Asset management Investment plan 2015/16-2019/20.

3.8 In progressing this agenda senior officers of the Board are developing the plans that will see the establishment of four Integration Joint Boards in Lothian (IJB's). These IJB's will take the lead for strategically planning for all community, primary and unscheduled care services whilst also influencing strongly the strategic planning of acute scheduled care. The above propositions need to be seen in the context of the transition that will take place in terms of 'strategic planning responsibility' during 2015/16. Good progress is being made in respect of both the establishment of the IJB's and also the development of the initial draft strategic commissioning plans. Further development of a number of the key actions set out in the attached progress report, will going forward sit within this new planning context and process.

3.9 Clinical leadership has been discussed throughout the process of developing the strategic plan. Although there has been significant clinical engagement in all aspects of the plan a proposed Clinical Change Cabinet has been developed to enhance clinical engagement in the delivery of service change.

3.10 This forum will engage senior clinical leaders in identifying and driving forward the changes needed to deliver financially sustainable services and care models. The 'Cabinet' will also support the Board and the Corporate Management Team to deliver its strategic objectives in line with the national 2020 vision and the triple aims around improved quality, improved health and value and financial sustainability.

The idea of this proposal is that we engage clinicians and seek their support in leading change and developing new models of care or developing new policy choices, some of which are set out in the progress report.

The 'Cabinet' might meet several times a year i.e. three or four and would be primarily led by the Chief Executive and senior clinical colleagues and as appropriate Board Directors and other senior managers would also attend and participate.

3.11 The first meeting of the Cabinet is on 27 February and the agenda will potentially cover policy and practice issues relating to how we eradicate boarding; better manage discharges and the development of a programme around 'choosing wisely' in relation to management of long term conditions and end of life care.

4   Key Risks

4.1 The risk to NHS Lothian is that we do not achieve financial balance nor meet our LDP objectives around delivering against performance targets. There are individual corporate risks and as appropriate these have been placed on the NHS Lothian Corporate Risk register but the intention of this plan and the proposed key actions is to assist NHS Lothian and the soon to be established IJB's to achieve financial balance whilst maintaining and where possible improving our performance against targets and delivering safe and effective care and treatment.

5   Risk Register

5.1 The further development of this plan and the key actions are part of our work to ensure we mitigate against a number of key corporate risks such as not achieving financial balance; sustaining patient safety and patient experience as well as managing infection control and delivery of the treatment time guarantee.

6　Impact on Inequality, Including Health Inequalities

6.1　An impact assessment has not been carried out in relation to this progress report and the set of key propositions being put forward to the Board. Impact assessments will however be required for each proposition as they progress from statements of ambition to option appraisal and business case to final recommendations.

7　Involving People

7.1　The development of this plan and the key actions has involved a wider range of people both in the consultation period and subsequently in terms of the further development of the key propositions and this was highlighted at the Board Development Session on 14 January 2015.

8　Resource Implications

8.1　The resource implications are significant in the context of our £74m gap to deliver financial balance in 2015/16 whilst meeting performance targets and treatment time guarantees. This work needs to be seen within the overall financial sustainability of the Board and the IJB's going forward. That is why further steps need to be taken to ensure that each agreed action has a costed plan but also sets out clear metrics in relation to what the impact will be and also the improvement in performance. The Board would wish to consider all of these factors in agreeing any final investment. From this perspective the Strategic Planning Committee and the Finance and Resources Committee will play a strong role in overseeing the development of key actions and also in endorsing recommendations to the Board.

Professor Alex McMahon
Director of Strategic Planning, Performance Reporting and Information
2 February 2015
Alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1:　Our Health, Our Care, Our Future - NHS Lothian Strategic Plan 2014-2024

Our Health, Our Care, Our Future

NHS Lothian Strategic Plan 2014-2024

Summary Progress Report

on Key Propositions

30 January 2015

Unique ID:NHS Lothian Strategic Plan 2014-2024	Author (s) Libby Tait , Martin Hill, Alex McMahon
Category/Level/Type: Strategic Plan	Authorised By: Director of NHS Lothian: Strategic Planning, Performance Reporting and Information
Status: Final Draft	Version: 1:9a 02 Feb 2015
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Date added to Z:\SPD\Board Committees\2015\Board NHS Lothian\4 February 2015 folder: 30 Jan 2015	Keywords: Financial Context Primary Integrated Care Services, Workforce Integration.
Comments: • Appendix 2 added	

Content

Appendices: Schedule of Key Milestones

Capital and Asset Management Programme

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1. <u>Background</u>

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. This Report summarises progress in the development and implementation of some of the key propositions in the Plan, along with emerging propositions in areas such as the management of acute medicines and key elements in the savings plan.

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.

In providing the first of a regular series of updates to the Board on progress with implementation of the Plan, this paper also presents specific recommendations for the Board's approval.

2. **Financial Context**

The financial outlook presented to the Board in December 2014, following discussion at the Finance and Resources Committee 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 initial assessment of the financial plan for 15/16 identified a potential recurring gap of circa £74m. With a savings and efficiency improvement local reinvestment programme (LRP) which had delivered around £25m in each of the previous two years, it was agreed that a balanced financial plan could not be presented at that stage and that further and more intensive review of the options were required to close the gap.

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 costs, which are also skewed to the hospital sector.

This compounds the financial pressure already generated across our Acute Hospitals from;

- A much higher level of supplementary staffing, particularly nursing, due to an increasing intolerance to compromising patient safety/quality as a consequence of staff absence/vacancies.
- 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

4

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 £47m, 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 workstreams 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 require 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.

3. <u>Policy Choices</u>

Successful delivery of the strategic ambitions in this plan is promulgated on the Board's adoption of a number of fundamental policy choices, including:-

- 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

4. <u>Introduction to Progress Report</u>

Through an explicit process of prioritisation, effort has been concentrated on an initial programme of change which is designed to improve the quality and efficiency of healthcare that is safe, patient-centred and that consistently meets the needs of a growing and ageing population. This also means delivering waiting times and other mandatory targets, at the same time as shifting the balance of care from hospital to community and home care, in the face of rising patient demand for complex care and a legacy of financial deficits.

Although the following propositions are described in resource terms, changes and improvements are being clinically led and informed by analyses of patient pathways to ensure that the changes will improve the patients' experience and health outcomes.

In prioritising the role of primary care, considerable effort is being spent, in close liaison with the Lothian GP Sub-Committee in identifying how best to reinforce primary care to deliver wider access to patients and the capacity to more effectively manage patient demand which would otherwise lead to hospital admission and longer lengths of hospital stay.

While investment in improving the capacity and access in primary and community care is expected to more effectively manage demand on acute hospital services, by shifting the balance of care, this will not happen overnight and parallel actions are required in acute hospital services to meet immediate waiting time and other care standards for patients.

So far as acute hospital care is concerned a site-masterplanning approach is being taken to ensure long term viability of each site and to present a revised specialty configuration which makes strategic sense in serving the needs of the Lothian population.

Underpinning all of these changes is a rapid process of organisational integration of health and social care which, taken together with a stronger primary care sector, is expected to provide new opportunities to address health and care inequalities and to provide new impetus and leverage for shifting the balance of care.

"Our Health, Our Care, Our Future" presented a large number of propositions for change and improvement, each described individually. However, the reality is that there are significant relationships and interdependencies amongst the propositions and these are reflected in the following progress report and timelines. In other words, little can be done in one part of such a complex system without it impacting upon others.

Pathway Redesign – Lothian House of Care

Within the original strategic plan we development 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 Hannah patient pathway work being undertaken to inform the further development of the NHS Lothian's Strategic Plan. In addition, the Scottish Government offered Lothian funding to support early adoption of the house of care.

The £70,000 funding offered by the Scottish Government to support early adoption in Lothian has been confirmed and will transfer to the Thistle Foundation imminently. NHS Lothian and the Thistle Foundation have entered into a partnership to take this forward.

In October 2014, a paper was submitted to NHS Lothian Board recommending that the House of Care approach 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 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.

The paper outlined actions which included establishing:

- A programme board and 3 work streams to oversee the strategic coherence;
- An operational group and a learning group to support early adopter sites

The house of care approach is also being considered by the four Integrated Joint Boards. Potential early adopter sites have been identified in each of the four areas and there are varying degrees of strategic endorsement. 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.

5. **Progress with Key Propositions**

This section is in two parts, a narrative describing the projects coming forward in this part of the strategic programme and, in an appendix, a schedule of key milestones and projected timelines.

6.1 **Primary and Integrated Care Services**

6.1.1 **Primary and Community Care Access and Capability**

Project Objectives and scope

This major project 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.

Project Deliverables

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.

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.

Benefits
The benefits expected as a result of this project relate to:

- 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.

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*
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.*

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Deliverable / Milestone	Expected Delivery Date
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.*
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*

6.1.2 <u>Integrated Care Services</u>

"Our Health, Our Care, Our Future" 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).

Integrated Care Facilities (ICF's)

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

Current	Future
	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, 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.
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.

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Current	Future
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 **St Michaels Hospital –** 30 beds **Maple Villa –** 30 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.
Corstorphine Hospital – service reprovided	Beds re-provided on the Royal Victoria hospital; main hospital now closed and subject to disposal.

6.1.3 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

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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. Business case for enhanced ELSIE model covering patients with dementia and 7/7operation 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.

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 on: discharge process review; Royal Victoria Care home project- Oct 16 target; interim integrated care home commencing admissions from January 15; work underway to evaluate step down facilities -December 14;Plans to expand care home, care at home, re-ablement, intermediate care capacity – by March 15.

6.2 Acute Services

Current	Future
St John's Hospital – 259 beds, plus 20 paediatric beds and 63 maternity (inc SCBU) beds	**St John's Hospital** – • New MRI scanner installed Site master planning potential includes: • creation of capacity for business continuity • remodelling front door to improve patient flow • additional surgical capacity for plastic surgery, ENT, hand surgery and Oral Maxillo-facial surgery, including additional operating theatres • Consider as one of the options for elective orthopaedics • Review Maternity provision, including potential for more midwife-led and home births, in line with recent NICE review • Day hospital and ambulatory care for frail elderly people to West Lothian community
Western General Hospital – including RVB there are 675 beds (including critical care beds) plus 40 winter beds currently open	**Western General Hospital, Edinburgh's Surgical and Cancer Care Centre** This is a complex estate of mixed structures, the redevelopment of which will require significant capital investment which is unlikely to be available in the foreseeable future. However, site master planning is underway. • Redesign of the "Front Door" has been completed to increase access to medical day care, direct GP admissions and surgical assessment. This is phase one of a longer term review of unscheduled care services across NHS Lothian, including designation of RIE as centre for unscheduled care and WGH as Edinburgh's Surgical and Cancer Care Centre • Rheumatology and dermatology redesign being progressed, delivering more care on day patient basis • Site release from transfer of DCN beds to RIE in 2017

Current	Future
	• Consider redeveloping Regional IDU at RIE/Bioquarter • Consider as one of the options for elective orthopaedics • Additional Day surgery capacity • Development of Cancer Centre, including additional radiotherapy capacity and the potential of collocating gynaecology (from RIE) • Significant review of current estate and reorganisation of current services to maximise capacity and accommodation.
Royal Infirmary of Edinburgh – 729 beds plus 165 maternity (inc SCBU) beds	**Royal Infirmary of Edinburgh, Edinburgh's Emergency, Medical and Major Trauma Centre** Site master planning potential includes: • Consider potential to develop acute medical receiving for Edinburgh and beyond using expanded footprint at the Bioquarter. • Plan to expand medical assessment capacity to improve flow • Regional Major trauma service by end 2016 • Children's Hospital and DCN transfer in 2017 • Further development of care of older people through the enhancement of the Compass outreach model and increased comprehensive geriatric assessment • Consider as option for Elective Orthopaedic Surgery service with WGH and SJH • Creation of an integrated stroke unit supported by the transfer of beds from Liberton • Consider central pathology services • Review current outpatient capacity as potential bed capacity
Royal Hospital for Sick Children – beds	**Royal Hospital for Sick Children –** replaced in new RHSC on RIE site, which also incorporates the CAMHS unit from REH site.

Current	Future
Royal Edinburgh Hospital – 364 beds	**Royal Edinburgh Hospital, fully redeveloped** Future will be a multipurpose site providing acute mental health, learning disability, substance misuse, neuro and brain injury services as well as continuing care and potential integrated care facility for the south side of the city. Review of in-patient complex care beds for old age psychiatry underway as part of city wide review.
Liberton Hospital – 130 beds	Services will be re-provided in modern, purpose-designed facilities i.e. stroke beds to RIE, re-patriation of patients to Midlothian and East Lothian. Potential for 90-120 care home beds at Royal Edinburgh Campus in proposed South Edinburgh Integrated Care Facility. All of this will enable the closure and disposal of the Liberton Hospital site.

6.3 Specialty-Specific Propositions

6.3.1 Eye Care Redesign & Modernisation

Project Definition and Strategic Context

The project objectives are to identify the optimal site for the Princess Alexandra Eye Pavilion re-provision and redesign of patient pathways and processes to improve efficiency and ensure that the patient is treated in the right place by the right person and at the right time. This programme of work will map current service model and patient pathways and, using peer review from other organisations, research based options and whole system intelligence, define a new model of care that will cross from primary care into acute and back.

The Princess Alexandra Eye Pavilion (PAEP) building was opened in 1969 and consists of five floors (3500m2) of clinical and supporting office accommodation. The current building fabric and infrastructure is no longer fit for purpose, and does not support efficient patient flows or provide the necessary space for service development and expansion. Ophthalmology is a multi-professional service with staffing resources of 148.02 WTE and an annual budget of £11.1million.

Progress to date

The Programme Board have commissioned some Test of Change Redesign Projects along with some infrastructure investment to optimise patient pathways and flows. As a consequence of this work the following options are being put forward for consideration:

Scope	Option	Description	Scope
Less Ambitious	**Re provision of PAEP to Lauriston building**	Relocation of PAEP services to the Lauriston building.	Enables re provision of service in city centre location but does not address clinical adjacencies or access requirements. Would require some existing services to be re located to allow full service fit.
Preferred way forward	**Re provision of PAEP to RIE / Bio quarter campus**	Relocation of PAEP services to RIE/Bio quarter site	Provides collocation of service with acute clinical capability and adjacencies with front door services and in patient services
More Ambitious	**Alternative new build (Edinburgh city centre)**	Provision of a new build that would be of a bespoke design	Would address all location and access, accommodation requirements. Potentially housing other day surgery / outpatient activity.

Taking account of the proposed profile of service (activity, physical footprint, finance and workforce), it is proposed that all current PAEP out-patient, day case and in-patient services are located within a single site, with a layout that reflects key clinical adjacencies to optimise efficiency and flow.

The initial conceptual design of the space required is significantly larger than the current space occupied. There are three main drivers for this:-
- Service expansion both in terms of volumes and range of services provided.
- Future proofing provision of sustainable expansion space. (New treatments for previously untreatable eye conditions have driven a requirement to provide clean room facilities for intravitreal injections, a requirement to provide frequent and long term follow up)
- Compliance with current legislation and guidance for clinical service provision and patient flow.

Strategic Impact – Patient Care

• Patient care required in secondary care will be delivered from compliant premises with modern, fit for purpose accommodation which will improve access to services, flow and efficiency, improving the patients overall experience.
• Care will be delivered as close to home as clinically appropriate through optimising use of modern technologies and skills and capacity within community optometry.
• Care will be delivered by the most appropriate health professional releasing consultant capacity to support high complexity work and virtual clinics.
• Through investment in service as agreed through Delivering for Patients and service redesign, activity will be repatriated from external providers and delivered within agreed access targets.

6.3.2 Outpatient Services Redesign

This project will radically change the delivery of outpatient services to ensure all patients are seen by the person with the appropriate skills, in a timescale that meets their needs and at a location which is most convenient to the patient.

Historically, outpatient services have been delivered on several acute sites across NHS Lothian, using a traditional speciality-based management model. The management responsibility lies with the individual site or speciality, resulting in a variety of operational structures within the model. This has led to a silo approach to the management of outpatient services and does not cultivate innovative working, promote change in practice, nor deliver efficient and effective services. Healthcare is now so reliant on quality data to advise management of activity trends, resource utilisation and overall clinic productivity, that the current delivery model is unable to provide the detail needed.

The new model will see outpatient services managed as a central function across all sites which is a similar model to that in place for theatres. Outpatient services will become the responsibility of an individual General Manager, supported by a full management team, just like any other clinical service. This will enable cross-specialty vision and will support the need for standardised processes and functions throughout the service, irrespective of the specialty. These teams will have full responsibility for delivering quality outpatient services, including the management of resources, activity and budget, implementation of standard processes, monitoring progress through standard datasets and building robust relationships with primary care, the Integration Joint Boards and social services.

Key objectives

- To establish standardised processes within all outpatient services, for booking, time allocation for appointments, consultant workplans etc.
- To establish service and department-specific data to inform specialties of activity against capacity plans.
- Identify areas of good practice which can be rolled-out internally.
- To develop and establish monitoring processes for utilisation of facilities similar to that provided by ORSOS for theatres.
- To explore, plan and implement alternative forms of delivering care to patients which avoids them having to travel to hospital.
- For patients who must travel to hospital, plan reasonable clinic times and identify appropriate transport solutions to enable patients to attend these appointments.
- To redesign the outpatient function to provide the most appropriate care/advice for the patient or primary care professional and where possible, avoiding the need for face-to-face consultation and the disruption to the patients routine that this causes.
- To investigate the benefits of cutting-edge technology and seek to explore and implement systems such as digital self check-in, real-time advice screens in clinics and electronic patient-focussed booking for follow-up appointments.
- To work closely with the operational teams to standardise models of care across all sites and implement appropriate staffing levels and skill mix. Creative but robust job planning will ensure that clinical time is optimised and that appropriate clinic accommodation is always available.
- To implement plans that will ensure that outpatient clinics are no longer the first choice for cancellation during periods of holidays or absence and that core capacity will be utilised to the full, reducing the reliance on waiting time initiatives and the use of the independent sector.
- To deliver patient-centred care, enhanced by involving patients, carers and other service users throughout the project.

A more efficient, standardised and streamlined service in outpatients will contribute significantly to NHS Lothian's achievement of national and local targets. In addition to national goals, such as reducing DNA rates for new outpatients to an average 7% by April 2016, NHS Lothian intends to introduce local targets, such as a 20% reduction in follow-up appointments for the top 10 specialities generating return activity. Other local Key Performance Indicators will be developed over time.

Progress
- The transfer of the management of outpatient services in agreed areas is underway in a phased plan with realignment of staff and budgets to be complete 31st March 2015.

- An Invest to Save proposal for Service Directory/Refhelp development has been submitted, which would support referral protocol development between primary care and hospital services.
- Initial focus on ENT outpatient system redesign commenced January 15, delivery of new model expected in April 15.
- Rheumatology system redesign to follow from February 15.

6.3.4 Orthopaedic Services Redesign

Acute Orthopaedics

The Orthopaedic unit at RIE is the largest in Scotland and one of the three busiest in the UK. All trauma and elective in-patient orthopaedic surgery is centralised at this site along with a large proportion of orthopaedic day case surgery. Some day case surgery (mainly foot and ankle) is performed at St John's hospital (SJH).

Outpatient clinics are run at RIE/SJH/Lauriston buildings (LB) and Roodlands (RH). Royal Hospital of Sick children (RHSC) is also supported by a cohort of (adult) orthopaedic surgeons who cover on call and clinics at RHSC site.

Currently, orthopaedics is endeavouring to deliver a number of access targets; the 48 hour hip fracture target by March 2015, the Treatment Time Guarantee for elective in-patients, and the 12 week standard for out-patients. Available theatre sessions and current in-patient facilities are inadequate in capacity for current service delivery and for future needs. This in turn constrains patient flow and efficiency, practice development and expansion of services.

The principal issues to address are:

- Inadequate access to trauma theatres
- Inadequate MOE support for trauma orthopaedic patients
- Lack of flow of patients to Orthopaedic Rehabilitation Beds – this is highlighted in the Orthopaedic Rehabilitation DCAQ Strategic Paper
- Re-streaming of non operative fracture patients
- The need for additional in-patient, DOSA and theatre capacity within Lothian to meet National Waiting times target and be able to dis-invest from use of the Private Sector.
- The requirement for this work to be addressed in order to accommodate the National Major Trauma Redesign in 2016.

In addition, there is also an increasing recognition that the capacity at the RIE site is limited and orthopaedics along with other services may be required to review the services they deliver from the RIE site and look for opportunities to deliver services from other NHS Lothian sites.

Objectives

The project objectives are to:

- Develop a Business Case for a redesign of Orthopaedic Trauma Services that will address improving performance against the National Hip Fracture target, improving Medicine of the Elderly support for Trauma Orthopaedic patients, increased access to trauma theatres and preparedness for the impact of the National Major Trauma Redesign in 2016.
- Develop a service model for the elective orthopaedic service that provides the sustained delivery of the Treatment Time Guarantee for Orthopaedic inpatients with the service being delivered principally within NHS facilities and minimal use of non NHS facilities.

Progress to date

The Programme Board have made significant progress in two key workstreams:

(a) The development of a business case for the trauma inpatients service, that seeks to increase the overall capacity to treat orthopaedic trauma patients at the RIE site in order to meet the Scottish Government 48 hour hip fracture target and reduce the impact on elective patient cancellations.

The work on further developing this Business Case in ongoing, but needs to be linked closely to the proposals for the future provision of the elective orthopaedic service.

(b) An options appraisal on the Elective Orthopaedic Service has taken place, involving the clinical staff from within the service and other services linked to it, as well as partnership and patient representation. This option appraisal covered a number of options for the future provision of the elective service.

The options were:-

Option	Description
Option 1a **Status quo**	Elective and trauma orthopaedic service is continued to be delivered from the RIE site.
Option 1b **Status Quo plus**	As above but with further improvements to existing service including extended day working.
Option 2 **Move day surgery off site for all specialties**	Elective and trauma orthopeadic service is continued to be delivered from the RIE site. Additional capacity is created by removing all RIE day surgery to an alternative NHS Lothian site.

Option	Description
Option 3 **Move elective orthopaedic surgery to an alternative NHS Lothian site**	Only the trauma orthopaedic service is continued to be delivered from the RIE site with elective procedures carried out from an alternative NHS Lothian site.
Option 4 - **Increase use of external capacity**	Additional elective procedures are sent to the Golden Jubilee Hospital, other NHS Board or private sector suppliers to free up capacity on the RIE site.
Option 5 - **Provide additional elective orthopaedics procedures on another NHS Lothian site**	This option would involve an additional NHS Lothian site undertaking elective procedures (in a similar manner to that currently being undertaken at the Murrayfield hospital).

Major Trauma Unit

The Royal Infirmary if Edinburgh will be one of four new major trauma units to be established across Scotland. The expected date for opening is the end of 2016.

This development will bring additional numbers of trauma patients to the RIE site. In order to accommodate this development there will require to be capital investment at the 'front-door' to support the immediate management of such patients. This will also require revenue investment for staffing in medical, nursing and allied healthcare professional capacity.

Key issues related with the development include the ability to discharge or repatriate patients to other Boards for their rehabilitation. The inability to do this may impact on NHS Lothian's ability to meet 4 hour; delayed discharge and treatment time guarantee commitments, which are already compromised.

Initial costed plan required by March 2015.

Orthopaedic Rehabilitation

- Orthopaedic rehabilitation for over 65s from South Edinburgh, Midlothian and East Lothian moved from AAH to Liberton Hospital in October 2014. A pan-Lothian ortho-rehab clinical collaborative has been established, with subgroups on each site which provides orthopaedic services - RIE, Liberton, St John's and Royal Victoria Building at WGH.
- Improvement methodology is being used with a strong therapy led focus.
- Early data shows significant reduction in length of stay particularly for the Liberton based service.
- There is also a focus on community therapy in-reach and discharge to assess in collaborative approach.
- This service provides more local rehabilitation at RVB (for North Edinburgh) and St John's. 3 wards occupied at Liberton (44 beds) and would need alternative bed based provision in step-down rehabilitation facilities if Liberton was to close.

General Rehabilitation will be progressed subsequent to orthopaedic workstream above, and discharge to assess "tests of change" planned at RIE and St John's Hospital.

6.3.5 Stroke Services Redesign

- Consultation events have confirmed that the preferred model is to provide an integrated stroke unit on RIE site, mirroring the services already in place at WGH and St John's Hospitals. This requires capacity for stroke rehabilitation beds to transfer from Liberton to RIE, with potential to reduce length of stay through avoiding handoffs.
- Proposition is for specialist stroke ward of 15 beds at RIE by August 2015.
- Thrombolysis treatment which must be delivered with 1 hour will be delivered via A&E Departments at St John's and RIE.
- Delivering this change requires release of bed capacity at RIE and plans are under development to achieve this.
- This will close one ward at Liberton Hospital.

6.3.6 Implementing Laboratory Strategy

The 'Labs Renew' change management programme will continue the work started in 2011 to implement efficient and fit for purpose service models through workforce reshaping, process automation and delivery of increased productivity while maintaining quality and safety.
Key deliverables:
- Introduction of automation within Microbiology, which will concentrate all processing capacity at RIE, allowing the service to cope with the expected growth in demand in a modernised cost-efficient way

- Redesign of the blood sciences workforce into a single staff resource, retaining rapid laboratory processing capacity at three acute sites with phased workforce efficiencies over 2/3 years.
- Development of potential options for collaboration with partner agencies in the medium term.
- Delivery of circa £4m recurrently in efficiency and productivity benefits across the lifespan of the programme
- Developing further efficiency programmes in line with the NHS Scotland National Healthcare Science Delivery plan – namely in Demand Optimisation, Point of Care Testing, Extended scientific roles

The physical location of laboratory medicine functions is detailed below taking into consideration the best use of space, technology, adjacencies, centralisation and alignment with NHS Lothian's Clinical Strategy:

- RIE: Blood Sciences (Biochemistry, Haematology, some blood-based Virology and Specialist paediatric services), Cell sciences (Infection, Microbiology, Category 3 containment labs and Pathology) and Gene sciences (Molecular Diagnostics comprising infection, molecular pathology and haemato-pathology, NEQAS)
- WGH: Blood sciences (Biochemistry, Haematology, Blood Transfusion and some specialist services including nationally funded programmes) and Gene sciences (Clinical, Molecular and Cyto-Genetics)
- SJH: Blood sciences (Biochemistry and Haematology) and the Training school
- Other: the service will explore opportunities for co location of certain laboratory medicine functions, including Pathology and Mortuary services, with local partner agencies at appropriate locations, such as the BioQuarter.

6.3.7 Ambulatory Care (day surgery)

Data gathering and analysis underway on day surgery rates and opportunities to improve these in specialties.

The delivery of this workstream is linked to and dependent on the preferred options and DCAQ requirements of all surgical specialities including orthopaedics, plastic surgery, and ophthalmology.

The options for additional day surgery capacity include:

- Introducing extended days and weekend working on a routine basis to increase productivity of current facilities
- Developing additional day surgery theatres and day bed areas at WGH or St John's Hospital.

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6.3.8 Maternity Services

The Maternity Services Programme Board has agreed a comprehensive action plan to improve patient flow and management in Maternity services across Lothian, maximising the efficient use of existing facilities at the Simpsons Centre for Reproductive Health, Royal Infirmary and at St John's. A Project Manager is in place to support this and a progress report is going (went to) to the Programme Board on 11 February 2015.

The next phase of the supporting Midwifery and Nursing workforce plan and the Medical Workforce plan, including proposals for 24/7 Labour Ward staffing at the Royal Infirmary were also reported to the February Programme Board.

An invited joint visit by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives is due to take place on 18 and 19 February and the report from that will be used to inform the further work of the Programme Board.

The recently published NICE guidelines, December 2014, which highlight the safety of Midwife Led units and home births for women who are low risk and recommends that women should be made fully aware of this and their choices, will also need to be taken into consideration in planning for the future development of Maternity services in Lothian and the South East region.

6.3.9 Cancer Services Redesign and Edinburgh Cancer Centre

The increasing incidence of cancer means that Lothian as a regional cancer centre requires to plan to meet the growing treatment and care needs. The Revised Cancer Strategy was approved by the Health Board in December 2015. A regional group chaired by the Director of Strategic Planning has been established to progress cancer pathway redesign and cancer centre redevelopment.

Specific workstreams are in place focussing on: Accommodation, Workforce, radiotherapy, pathway mapping by tumour group.

An intensive review (deep dive) is proposed and has been supported by Boards across the region and planning for this is now underway with recently appointed Clinical Director taking a lead role.

Planning sufficient radiotherapy capacity is an immediate challenge and an action plan is being finalised which will require a number of short and medium term changes to sustain service delivery. Proposals are expected by March 2105.

This project is a core part of the WGH site masterplanning work and the Initial Agreement for this is being developed to include the Cancer Centre re-development options as one of the key components.

The initial focus of the work needs to be the fabric of the in patient wards; the radiotherapy capacity and the review and development of cancer pathways, which will be followed by the deep dive to then inform the redevelopment of the cancer centre which may be opened in around 2020/21.

7.0 Workforce

As set out in this progress report the model of delivery 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.

8.0 Planning Processes

Clinical Leadership Model for Service Transformation- Clinical Change Cabinet

The aim of this innovative approach to leadership is to establish a forum and process within NHS Lothian to engage senior clinical leaders in identifying and driving forward the changes needed to deliver financially sustainable services and care models. The 'Cabinet' will also support the Board and the Corporate Management Team to deliver its strategic objectives in line with the national 2020 vision and the triple aims around improved quality, improved health and value and financial sustainability.

The idea of this proposal is that we engage clinicians and seek their support in leading change and developing new models of care or developing new policy choices. Examples from elsewhere support such an approach. The 'Cabinet' might meet several times a year (i.e. three or four) and would be primarily led by the Chief Executive and senior clinical colleagues and Board Directors and other senior managers would also attend and participate, as appropriate.

Early themes to address may include, for example:

- Eradicating Boarding - introducing a policy of discharging from the right beds rather than boarding in to the wrong beds, ring fencing elective capacity, avoiding inappropriate admissions etc;

- Improving discharge arrangements – implementing Estimated Date of Discharge, Discharge to Assess, Criteria-Led Discharge, Reducing LOS, Discharge earlier in the day, use of discharge lounges, management of patient and family expectations around support for discharge, ward round protocols etc;
- Managing end of life care – including policy around end of life interventions, diagnostics, medicines and technologies, appropriate admission avoidance at end of life etc.

The first session of the Cabinet will be held on Friday 27 February 2015.

9.0 Integration

Finalise draft integration plans

Much of the agenda set out above will become the responsibility in strategic planning terms of the four new integration joint boards during 15/16 and certainly fully from 16/17. The NHS Lothian Board and the four councils have approved the draft integration schemes and these are out for consultation and have to be agreed and submitted to the Cabinet Secretary by 31st March 2015. Work is underway to review what corporate support will be required by the new IJB's as well as setting an agreed opening financial budget. Work in establishing the membership of the IJB's as well as work to develop their strategic commissioning plans is also underway.

A significant piece of work is the operational and governance capacity required to ensure that planning for unscheduled and scheduled care is done in tandem between the four IJB's and the acute service. An interface group of senior managers i.e. Joint Directors, Directors of Scheduled and Unscheduled Care Director of Finance and the Director of Strategic Planning have been established to support the planning process and the use of agreed data sets and data sources.

Work in relation to developing the children's integration agenda is also progressing.

10.0 <u>Summary of Recommendations</u>

- Support the process and the development of the propositions set out in this progress report

- Agree that the plan and the propositions set out are considered within the Boards financial sustainability and financial planning process

- Support the adoption and further development of the policy choices as set out on page 6

- Support further work being undertaken to re-profile our workforce in line with proposed policy choices and models of care as set out on page 29-30

- Support the continued development of the 'House of Care' concept in developing new models of care and in developing the strategic commissioning plans

- Support the development of the primary care actions and project benefits set out in order to support 'shifting the balance of care' through building primary care capacity – pages 11-12

- Support the developments as set out under 'integrated care facilities' and the proposed future as relating to the estate – pages 13-15

- Support the direction of travel and the developments in relation to 'future' acute hospital sites as set out in pages 16-19

- Support the development and testing out of the speciality specific propositions in relation to the re-provision of the Eye Pavilion; elective and orthopaedic rehab; redesign of outpatients; stroke as well as work on the laboratory strategy; maternity services; the re-provision of the cancer centre and the work on increasing day care and the development of the major trauma centre as set out on pages 19-28

Key Milestones		(yellow)
Consultation		(cyan)
Capital Investments		(purple)
Property Disposals		(orange)

Financial Year	2014/15	2015/16		2016/17		2017/18		2018/19		2019/20		2020/2021
	4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter
Primary Care												
Primary care access capability												
Review GP practice requirements		£3million		£5 million		£5 million		£5 million		£5 million		
Scheduled Care Priority Projects												
Eye Service Modernisation / PAEP Reprovision												
PAEP Reprovision	Initial Agreement approved (March 15)	Outline business case development (March - October 15)		Full business case complete	Business case approved	Construction underway				New facility commissioned		
Consultation and engagement												
Out-patient Redesign												
Transfer of Outpatient services in agreed areas to Corporate Improvement Team	Complete March											
DHI digital options event	30/31 March											
ENT (pilot) system redesign		Complete May										
Rheumatology Redesign		Start Feb	Complete August									
Further phases of redesign (provisional timeline only)			Future phases prioritising services with out-patient capacity gaps									
Ambulatory Care (day surgery)			Initial agreement prepared		Additional capacity developed							
Gynaecology/Obstetric pathway redesign opportunities		Service redesign underway										
		TOP Service redesign	Release Bruntsfield Suite for Obstetrics	Create Obstetric day assessment unit								
RHSC & DCN												
new Facility commissioned		Enabling work underway	Construction underway				Commissioned (September 17)					
Royal Hospital for Sick Children				Marketing anticipated			Disposal anticipated					
					Potential to dispose peripheral units prior to main hospital site							
Orthopaedics redesign		Business case prepared	(cyan)		Additional elective capacity developed (dependent on outcome of option appraisal)			Elective service transfers??				
Plastic surgery		Part of business case for day surgery capacity								Repatriation of external capacity		

Financial Year	2014/15	2015/16		2016/17		2017/18		2018/19		2019/20		2020/2021
	4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter
Laboratory Strategy		Microbiology of automation SBC prepared	Automation implemented									
Blood sciences redesign		Blood sciences review										
Pathology Options				Review Pathology Options								
Unscheduled Care and Flow Priority Projects												
Cancer pathways and ECC reprovision		Initial pathways complete										
Intensive Review/Deep Dive		PID prepared	Review reports	Pathway redesign across region								
Radiotherapy Capacity Plan	By end March					Additional Linacc capacity in place						
Cancer Centre Reprovision										Capital Project Underway		
Stroke Modernisation Creation of integrated stroke unit RIE		Thrombolisis pathway confirmed	15 beds from Liberton move to RIE (September 15)									
Major Trauma Unit including trauma orthopaedic capacity		Regional impact assessment complete April 14	Modelling of capacity: acute and rehab			Create additional capacity RIE. Full MTU capacity (September 17)						
Orthopaedic Rehabilitation	Joint Collaborative workshop (March 15)	Improvement collaborative reduce LOS	redesign pathway to									
General Rehabilitation			Spread collaborative methodology									
WGH Master Planning		Full master plan (June 15)										
Remodelling WGH Front Door	Complete											
RIE Service Redesign			closure of 15 MOE beds (due to reduced LOS)									
Additional Acute Medicine Assessment Capacity	Business case for additional beds agreed (March 15)			Phase 1, 8 additional AMU beds		Phase 2, 13 additional AMU beds						
St John's Service Redesign	Site master planning capacity development. IA to F&R (March 15)											
Hospital Closures / Site Disposals/Relocation												
Liberton		Stroke beds transfer - ward 10 closes						Transfer capacity to ELCH/MCH?			Transfer to ICF - Edinburgh	
Astley Ainslie		Upgrade Balfour Pavilion	Transfer services from Charles Bell Unit to Balfour Pavilion	Marketing of North Section		Partial Disposal Anticipated				Marketing of South Section	Specialise rehab transfer to REH campus	

Financial Year	2014/15	2015/16		2016/17		2017/18		2018/19		2019/20		2020/2021
	4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter
Corstorphine		Marketing and disposal anticipated										
Herdmanflat		Hopetoun site disposal						Marketing of site	disposal of site			
Community Capacity Developments												
Redesign of LUCS		Service change consultation	Service change implemented									
REH Campus Development		phase 1 construction			Phase 1 complete	Phase 2 construction					Transfer rehabilitation from AAH.	South Edinburgh Integrated Facility
					Mackinnon House refurbishment begins	work starts on facilities management building	Facilities Management building complete	Mackinnon House refurbishment complete	Integrated rehab work begins		Integrated rehab work complete	
Mental health services redesign												
Learning disability service redesign												
Older People Capacity development plans												
East Lothian Community Hospital/ Integrated Care Facility development		Business Case prepared			Phased Development of ELCH			ELCH commissioned				
West Lothian Older People's frailty pathway		PID prepared	Pathways analysis to improve pathway opportunities	Pathway redesign across region								
North Edinburgh Integrated Care facility (RVH)	Strategy Approval(March 15).	Accept quotations (May 15)	Demolition (November 15). Site Clearance (December 15)									
RVH Site	66 DD and winter beds closed by March 15. Transfer 56 IPCC beds to Gylemuir house.											
Midlothian	7 additional step down beds available in Highbank - 14th February 15											
Whole systems pathway												
Hannah		House of care collaborative and practice pilots underway										
Scott		Engagement with partnerships /acute services - older people planning										
Callum		Recommendations to follow from stakeholder events 1 and 2										

Financial Year	2014/15	2015/16		2016/17		2017/18		2018/19		2019/20		2020/2021
	4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter	3rd Quarter + 4th Quarter	1st Quarter + 2nd Quarter
Sophie		Steering group established, clinical lead appointed and in process of developing plans. Event to take place before summer 15.										
IJB Development		Integration schemes approved . Draft IJB strategy plans to be prepared										
Innovation		Review of design opportunity for early implementation - target May 15										

	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m
Rolling Programmes					
Backlog maintenance	5.00	2.50	2.50	2.50	2.50
Medical Equipment	10.50	14.77	10.09	10.25	10.25
Strategic Priorities (E-Health)	2.00	2.00	2.00	2.00	2.00
Service Redesign Projects Under £250k	1.50	1.50	1.50	1.50	1.50
Other	0.10	0.10	0.12	0.12	0.12
	19.10	**20.87**	**16.21**	**16.37**	**16.37**
Primary Care Sites					
Modernisation of GP and dental premises	3.00	5.00	5.00	5.00	5.00
Firhill Partnership Centre	0.01	0.47	0.00	0.00	0.00
Blackburn Partnership Centre	0.02	0.33	0.00	0.00	0.00
North West Edinburgh Partnership Centre	0.02	1.03	0.00	0.00	0.00
Bundle Sub Debt Investment	0.00	0.00	0.00	0.00	0.00
Ratho Health Centre	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.38	0.19	0.00	0.00
	3.06	**7.21**	**5.19**	**5.00**	**5.00**
Integration					
East Lothian Community Campus	0.86	2.50	6.05	0.00	0.00
Royal Victoria Hospital Integrated Care Facility	5.00	20.00	5.00	0.00	0.00
Balfour Pavillion Improvements	1.50	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00
	7.36	**22.50**	**11.05**	**0.00**	**0.00**
Royal Edinburgh Campus					
Masterplanning & Infrastructure Works	0.00	0.00	0.00	0.00	0.00
Royal Edinburgh Hospital Phase 1	0.06	6.39	0.00	0.00	0.00
REH Sub debt investment	0.00	0.31	1.48	0.19	0.37
Royal Edinburgh Hospital Phase 2 (Mackinnon House)	0.00	3.78	11.36	2.17	0.00
Royal Edinburgh Phase 2 DBFM	0.00	1.11	0.87	0.08	0.16
Orchard Clinic Redwood	0.00	0.00	0.00	0.00	0.00
E&P enabling	1.00	0.50	0.00	0.00	0.00
	1.06	**12.09**	**13.71**	**2.44**	**0.53**
Edinburgh Bioquarter Campus					
Royal Hospital for Sick Children and DCN	6.84	7.13	32.91	0.00	0.00
RIE Lifecycle Costs	4.79	4.87	4.96	5.05	5.14
Endoscopy Decontamination Unit	1.15	0.00	0.00	0.00	0.00
Additional Assessment Beds	0.80	2.50	0.50	0.00	0.00
Other	0.00	0.00	0.50	0.00	0.00
	13.58	**14.51**	**38.87**	**5.05**	**5.14**
Western General Campus					
Edinburgh Cancer Centre and Enabling	0.50	4.00	5.00	15.00	15.00
Radiotherapy - Linear Accelerator Replacement	2.60	0.87	2.55	1.80	0.00
Endoscopy Decontamination Unit	1.96	1.01	0.00	0.00	0.00
Aseptic Pharmacy Modernisation	0.78	0.00	0.00	0.00	0.00
Expansion of Colorectal Capacity (Ward 58)	1.00	0.00	0.00	0.00	0.00
Capacity Developments	0.00	1.00	6.00	6.50	0.00
CT Scanner	1.20	0.00	0.00	0.00	0.00
Other	0.50	0.00	0.00	0.00	0.00
	8.54	**6.87**	**13.55**	**23.30**	**15.00**
St John's Campus					
Dental Decontamination Unit	0.36	0.00	0.00	0.00	0.00
Masterplanning & Infrastructure Works	0.70	0.00	0.00	0.00	0.00
SJH Critical Care Centralisation	0.78	0.00	0.00	0.00	0.00
Residencies Modification	0.55	0.00	0.00	0.00	0.00
Theatre Capacity SJH	0.10	10.00	10.00	2.90	0.00
Reprovision of Non Clinical Space (SJH)	0.00	1.00	0.00	0.00	0.00
Ward 20	0.75	0.00	0.00	0.00	0.00
Other	0.05	0.00	0.00	0.00	0.00
	3.29	**11.00**	**10.00**	**2.90**	**0.00**
Lauriston Campus					
Masterplanning & Infrastructure Works	0.00	0.00	0.00	0.00	0.00
Edinburgh Dental Institute	0.30	0.50	0.00	0.00	0.00
Reprovision of Eye Pavillion Services	0.00	10.00	8.00	0.00	0.00
Capacity Developments (Lauriston)	0.00	0.00	0.00	0.00	0.00
	0.30	**10.50**	**8.00**	**0.00**	**0.00**
Other Schemes					
Microbiology Automation	2.00	2.00	0.00	0.00	0.00
Regional Learning Disabilities & Autism Unit	0.00	2.90	0.00	0.00	0.00
Laboratory Strategy	0.01	0.10	0.50	4.39	10.00
Dental Decontamination	0.00	0.00	0.00	0.00	0.00
Catering Strategy	2.00	1.50	0.00	0.00	0.00
Asset Management & Development - PFI	0.00	0.00	0.00	0.00	0.00
Opthalmic Service	0.00	0.00	0.00	0.00	0.00
Transfer of Woodburn House	0.00	0.00	0.00	0.00	0.00
Closed Codes	0.00	0.00	0.00	0.00	0.00
Vale of Leven Recommendations	0.00	0.00	0.00	0.00	0.00
Schemes in development	0.00	0.00	0.00	0.00	5.00
	4.01	**6.50**	**0.50**	**4.39**	**15.00**
Gross Expenditure	**60.30**	**112.05**	**117.06**	**59.45**	**57.03**

NHS LOTHIAN

Board Meeting
<u>4 February 2015</u>

Director of Finance

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SUMMARY PAPER - FINANCIAL POSITION TO DECEMBER 2014

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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 reporting an overspend of £5.556m at the end of December. This reflects an underspend of £0.966m in the month.	3.1
• The current assessment of the year end is that breakeven is still deliverable provided there is no further deterioration in our financial performance and the actions taken to reduce expenditure have the required impact.	3.5
• In the first 9 months, £18.3m of savings has been delivered against a target of £26.6m, a shortfall of £8.3m.	8.2
• In order to achieve the forecast in year LRP there will be a requirement to achieve a further LRP of £9.8m from Month 10 to the year end.	8.7
• An analysis of the reserves position is incorporated in the report.	10.1 10.2
• With the forecast position there are a number of risks and assumptions that have been made. These are regularly reviewed to ensure no detriment to the forecast.	3.6 & Appendix 6

Susan Goldsmith
<u>Director of Finance</u>
<u>28 January 2015</u>
<u>Susan.Goldsmith@nhslothian.scot.nhs.uk</u>

NHS LOTHIAN

Board Meeting
4 February 2015

Director of Finance

FINANCIAL POSITION TO DECEMBER 2014

1   Purpose of the Report

1.1   The purpose of this report is to provide an overview of the financial position for period 9 and the latest forecast outturn position of 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 £966k is reported in December against the Revenue Resource Limit (RRL), bringing the year to date position to a £5,556k overspend, including unachieved LRP.

- LRP is reporting an in-month delivery of £2,862k against a target of £3,620k, leading to a shortfall of £758k in December. For the year to date, savings of £18,351k have been achieved against a target of £26,615k, bringing the year to date shortfall to £8,264k.

- A further £1.1m of reserves has been released in the month of December, (£9.9m year to date) in relation to the £13.2 non recurrent LRP requirement that was put in place to underpin the operational position.

- The operational position and the forecast outturn estimate has required a further review of all corporately held reserves and available flexibility and this has resulted in a further £9,348k being identified to support the position, of which £1,558k has been released in month 9, reflecting a pro-rata share for the second half of the year (£4,674k year to date).

- Expenditure of £24.5m has been incurred year to date against the capital programme budget of £52.4m. The Property and Asset Management programme for the year is discussed in further detail within section 12 of this report.

- The current assessment of the year end is that breakeven is still deliverable provided there is no further deterioration in our financial performance and the actions taken to reduce expenditure have the required impact.

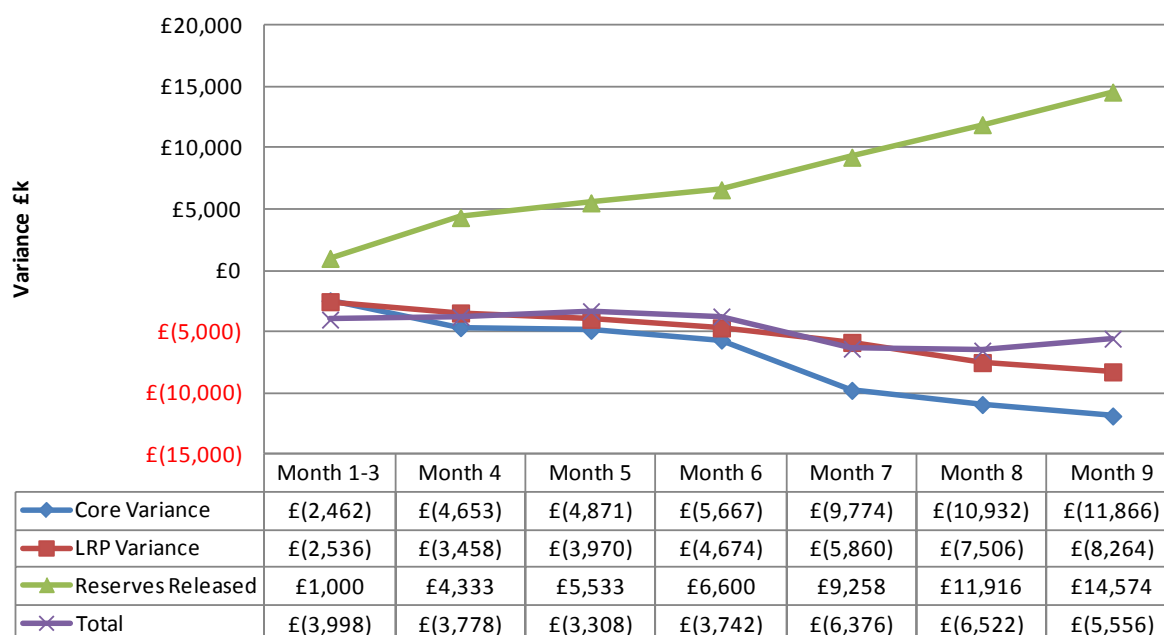**3   Discussion of Key Issues**

Overall Position

3.1   At period 9 of this financial year, NHS Lothian has overspent by £5,556k 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 31st December 2014

	Pay £k	Non Pay £k	Income £k	YTD £k	In Month £k
Baseline position	(2,341)	(12,334)	2,809	(11,866)	(934)
Outstanding efficiency savings		(8,264)		(8,264)	(758)
Non-Recurring Corporate LRP		9,900		9,900	1,100
General Reserves Flexibility		4,674		4,674	1,558
Net operational position	(2,341)	(6,024)	2,809	(5,556)	966

3.2 In the month, NHS Lothian underspent in total by £966k. An overspend of £1,692k arising from a baseline overspend of £934k and undelivered LRP of £758k is offset by the additional £1,100k flexibility arising from the monthly share of the £13.2m non-recurrent LRP achievement, and a further £1,558k additional general reserves funding released to underpin the position, identified as required following the mid year review. The total identified of £9,348k is being released over the second half of the year. This breakdown is detailed further in section 11.

3.3 Table 2 below shows the cumulative run rate of the core position, variance against LRP Targets and the increasing level of reserves that have been released to support this financial position.

Table 2: Cumulative Run Rate

	Month 1-3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
Core Variance	£(2,462)	£(4,653)	£(4,871)	£(5,667)	£(9,774)	£(10,932)	£(11,866)
LRP Variance	£(2,536)	£(3,458)	£(3,970)	£(4,674)	£(5,860)	£(7,506)	£(8,264)
Reserves Released	£1,000	£4,333	£5,533	£6,600	£9,258	£11,916	£14,574
Total	£(3,998)	£(3,778)	£(3,308)	£(3,742)	£(6,376)	£(6,522)	£(5,556)

3.4 A number of cost reducing actions have been agreed by the Corporate Management Team and have been actioned in order for the health board to return to a trajectory of breakeven by year end. In addition some further funding (£1.6m) has been received from the Scottish Government for acute medicines.

3.5 A review of the forecast outturn position has been undertaken based on expenditure to December 2014. This confirms breakeven remains achievable, provided there is no further deterioration in our financial performance and the actions taken to reduce expenditure have the required impact.

3.6   Within this revised forecast position there are a number of risks and assumptions that have been made to achieve outturn position. These include issues for which no costs have been assumed that may well impact before the year-end and are detailed in Appendix 6. These are reviewed regularly to ensure there is no detriment to the forecast.

4   PAY

Overview

4.1   Overall, pay expenditure is reporting an underspend of £165k in the month taking the year to date position to an overspend of £2,341k. This equates to 0.3% of the cumulative pay budget.

4.2   The overspend rate on nurse staffing shows an improvement against the annual trend but continues to be the most significant area of pressure, with a £4.7m overspend for the year, of which £0.3k is the reported overspend in the month. £1.7m has been incurred on nursing bank costs in the month (excluding the admin charge which is reported within non-pay) and a further £382k on nursing agency for the month. Nursing agency and bank costs are presenting a reduction in expenditure levels from last month of 14% in both areas, however the expenditure levels on both are consistent with the same period last year, suggesting the reduction may be a seasonal effect.

4.3   Support Services remains the other significant overspending staffing group, reporting an overspend of £1.2m (3.3%) against year to date budget. The in month position of £73k favourable represents a significant improvement on the trend to date specifically within Scheduled Care and Facilities & Consort areas.

Workforce

4.4   Table 3 below shows the WTE figures for nursing, medical staff and all other staff compared to the funded staffing levels. These figures incorporate the use of supplementary staff from the Staff Bank and show a continued level of Medical and Other Staff vacancies. Nursing establishments in December are reporting the lowest period WTE for the financial year. Note that there are no WTE statistics included in these actual WTE figures for any agency staff utilised. The level of agency hours utilised in the month would equate to an additional 45 WTE staff. This is a reduction of 19 WTE on previous month's agency equivalent of 64 WTE.

Table 3 – Comparison of funded staff with staff in post as at Month 9

	YTD Budgeted Staff WTE	YTD Actual Staff WTE	YTD Variance Staff WTE	Period WTE
Medical Staff	2,339.14	2,182.38	156.76	2,238.11
Nursing Staff	10,061.76	10,015.27	46.49	9,894.23
Other Staff	8,636.95	8,293.77	343.18	8,324.28

5   NON PAY

Overview

5.1   Excluding LRP, non-pay expenditure is reporting a year-to-date overspend of £12,334k against budget for the year to date. This represents a further deterioration of £963k in the month.

GP Prescribing

5.2   Primary Care Prescribing is reporting an overspend of £3,344k to date which represents an adverse movement of £411k in the month. Despite signs of slowing volume growth and marginally reducing average price levels, prescribing continues to be a significant overspend for the CHPs and is the main cause for the adverse movement on the forecast outturn position for them. Average prices remain higher than budgeted, principally due to short supply issues. Lothian's prescribing spend growth is 4% this year compared to last year and higher than the Scottish average of 3%. An emerging concern is LRP delivery, and it is now unlikely that the full £4.3m prescribing target will be achieved in year. The estimated shortfall is £0.8m, leading to a forecast overspend on Prescribing of £4.3m including this LRP shortfall. Table 4 below shows the breakdown of the baseline prescribing position and the variance on the LRP target for Prescribing.

Table 4 : Primary Care Prescribing as at Month 9

	YTD Baseline Variance £k	YTD LRP Variance £k	YTD Total Variance £k
Edinburgh CHP	(1,783)	(120)	(1,903)
East Lothian CHP	(501)	(28)	(529)
Mid Lothian CHP	(389)	(22)	(411)
West Lothian CHP	(736)	(50)	(786)
Prescribing Other	43	0	43
GP Prescribing	**(3,366)**	**(220)**	**(3,586)**
Other FHS Prescribing	22		22
Prescribing Total	**(3,344)**	**(220)**	**(3,564)**

Other Drugs

5.3   Drug expenditure (excluding GP Prescribing) is reporting a variance in the month of £423k overspent taking the year to date position to £428k overspent. There are a number of pressures reported across the Business Units in the month that require further investigation to identify the key driver in each of the areas and whether there is available funding to offset the reported pressure. However, due to the pressure on available resources within the Drug Reserve it is unlikely that any newly identified pressures will attract additional funding for this year and the overspend will continue.

5.4   Within the overall drug position there is an assumption that all Individual Patient Treatment Requests (IPTRs) within Cancer will be funded by savings made from the Pharmaceutical Price Regulation Scheme (PPRS) currently held by the Scottish Government. The costs within Lothian anticipated as being funded for this financial year total £2,644k.

Medical Supplies and Equipment

5.5   A year to date overspend of £4.3m on Medical Supplies represents a further £677k deterioration in period 9. Equipment is a further £120k adverse in the month taking the year to date overspend to £2.2m. These represent the main ongoing areas of non-pay pressure. Ongoing levels of expenditure are despite the business units attempts to reduce levels in order to achieve forecast outturn positions.

Other Non Pay

5.6   Other non pay areas that continue to show an in month deterioration are maintenance costs (now £1.1m overspent to date), transport costs (£1.3m overspend to date), and other non pay showing a £1.2m overspend. These areas of overspend are this month offset by a significant underspend on Property Costs due to rebates received on energy (£848k underspent in the month and £1.4m favourable variance to date).

6   INCOME

6.1   Income is reporting a shortfall in month 9 of £137k bringing the overall year to date income position to £2.8m favourable.

7   Cost Drivers – Additional Information

Bed Usage

7.1   In December a further £403k of reserves supported all the additional beds open across RVH, WGH and St Johns Hospital in line with agreed plans. The plan supports the funding of these beds until the end of the year, and assumes the reduction of the beds over a planned period in the new year.

Table 5: Additional Beds Funded

Additional Beds funded in Month 9		
	No of Beds	£k
RVH Ward 2	11	56
RVH Ward 5	22	111
RVH Ward 6	22	78
SJH Ward 25	6	25
WGH Ward 15	26	108
WGH Ward 54	6	25
Total	93	403

Delayed Discharges

7.2   The continued use of additional beds is due in the main to the level of delayed discharges within the system. At the end of December there were 258 delayed discharges recorded, which is second highest for the year and a significant increase on last month. For the same period in 2013/14 there were 203 delayed discharges recorded.

Activity

7.3   In recognition of the impact on cost arising from changes to activity, a summary of acute activity for the year to date is provided in appendix 3.

7.4   The figures represent the number of inpatient and day case discharges from acute sites for the calendar year.

7.5   Inpatient and Day Case admissions show a 6% increase in December against the previous months reported activity. There is a reduction of 14% in Waiting List admissions for December due to the the festive period. Bed occupancy over the last month is up by 1.6%.

8   Efficiency & Productivity

8.1   The total LRP to be delivered in 2014/15 on a recurring basis is £39.4m. As at the end of December only £34.6m of plans have been identified by the Business Units, leaving an in year gap of £4.8m for plans identified.

8.2   In the first 9 months, £18.3m of savings have been delivered against a target of £26.6m, a shortfall of £8.3m, which equates to an average slippage of £922k per month, further detail is provided in Appendix 4.

8.4   Of the £8.3m slippage year to date, £3.6m relates to the total gap on plans, currently equating to £4.8m for the year as previously stated. The balance of £4.7m relates to slippage on schemes which are part of the planned £34.6m delivery, and contributes to the forecast year end under delivery for additional funding.

8.5   In Month 9 £2.9m of savings was achieved against the £3.6m target leaving a shortfall of £0.76m, which is an improvement of £0.89m on the previous month's shortfall and reflects an increased delivery against the higher monthly LRP targets that are phased in the latter part of the year.

8.6   The Quarter 3 Review has been undertaken across the organisation to give a robust year end forecast of delivery against target. In total, recurring LRP of £23.2m is expected to be delivered in the full year, a shortfall of £16.2m against the 2014/15 LRP target of £39.4m. This is an adverse movement of £1.1m from the Mid Year Review. In year a shortfall of £11.3m is forecast, which is a deterioration of £1.9m on Mid Year Review. The main movements are in acute services. In Scheduled Care the level of savings from theatres supplies has not materialised and in Unscheduled Care the actual savings delivered from identified schemes have been lower than anticipated.

8.7   In order to achieve the forecast in-year LRP, there will be a requirement to achieve a further £9.8m LRP delivery from months 10 to the year end.

9   Waiting times

9.1   For the 9 months to date, £19.4m has been spent on waiting times against available resources of £20.4m. In month expenditure is £3.1m, an increase of £0.8m against previous month. This includes retrospective costs anticipated in the forecast relating to use of other health board capacity.

9.2   Funding continues to be allocated in line with reported spend however the projected deficit will begin to impact on the monthly financial performance of the Scheduled Care

division from January onwards. The Mid Year Review identified the requirement for a funding of a further £4m on the basis of projected expenditure to the end of March, and this has been incorporated into year end planning. Discussions are ongoing with SGHD colleagues regarding options for further funding which may be available, however it is anticipated that there will be a requirement that this delivers additional activity above current forecast.

9.3   Table 6, below, summarises expenditure against main categories of spend.

Table 6 – Waiting Times Expenditure against Plan

Source of Funds		CYE £k
Financial Plan 13/14 - FYE		2,319
Financial Plan 14/15 - Delivering for Patients	R	8,552
Financial Plan 14/15 - DFP Independent Sector	NR	9,000
SGHD - (Spinal Surgery)	NR	500
Total Funds Available		**20,371**

Application of Funds		CYE £k	M01 £k	M02 £k	M03 £k	M04 £k	M05 £k	M06 £k	M07 £k	M08 £k	M09 £k	YTD £k
Internal	R	9,462	174	223	367	338	310	323	463	376	791	**3,365**
Independent Sector & Other Contracts	NR	9,500	1,606	1,839	1516	1,730	1,756	1,761	1,597	1,919	2,177	**15,901**
Other NHS	R	1,409	0	0	0	0	2	2	2	18	129	**153**
Total Application of Funds		**20,371**	**1,780**	**2,062**	**1,883**	**2,068**	**2,068**	**2,086**	**2,062**	**2,314**	**3,097**	**19,419**

10   Financial Reserves Position

10.1   Appendix 7 provides detail around the level of financial reserves held centrally and the level of service and other commitments against these. The table also shows the flexibility being released to the position to help offset the operational position.

10.2   Reserves currently held to date total £29.1m, but of this amount £5.6m have commitments due against these between now and the year end. This leaves a balance of £23.5m of which £22.5m (£13.2m and £9.348m) is being evenly phased into the overall monthly position to offset the operational overspend. This leaves approximately £1m potential flexibility against the available reserves.

11   Property and Asset Management

11.1   Expenditure of £24.5m has been incurred to the end of December and the detailed programme for the year is shown in Appendix 5. Detail on the programme is routinely considered by the Finance and Resources Committee as is a review of all Business Cases.

12   Key Actions

12.1   Given the level of operational overspend reported to date and the ongoing pressures showing minimal improvement in the monthly position, it is vital that the additional actions agreed by CMT and Business Units are delivered in order to achieve agreed forecast outturn positions.   This must also be supported by robust financial management across the organisation.

12.2   The risks and assumptions that underpinned the forecast outturn position will require ongoing scrutiny to ensure that any changes do not impact on that position.

12.3　Focus is required to ensure both delivery of the agreed in year LRP plans and the development of additional schemes to ensure the target is delivered in full both in-year and on a recurrent basis. It is of concern, the level of continued slippage against monthly LRP targets, which are increasing as we progress towards the year end. Even to meet the quarter 3 forecast of £11.2m unachieved requires the delivery of a further £9.8m savings to the year end.

12.4　Any further deterioration to the financial position in year will impact on the Board's ability to deliver a break even position in this financial year and also has implications for the 15/16 financial plan.

13　Risk Register

13.1　There is nothing further to add to the Risk Register at this stage.

14　Health and Other Inequalities

14.1　There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

15　Involving People

15.1　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.

16　Resource Implications

16.1　The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
28 January 2015
susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1 - NHS Lothian Income & Expenditure Summary 31 December 2014
Appendix 2 - NHS Lothian Summary by Operational Unit to 31 December 2014
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NHS Lothian Income & Expenditure Summary to December 2014

Description	Annual Budget £k	YTD Budget £k	YTD Actuals £k	YTD Variance £k	Period Variance £k
Medical & Dental	224,502	166,952	166,499	452	(83)
Nursing	365,552	271,014	275,676	(4,662)	(298)
Administrative Services	78,994	58,665	58,500	165	81
Allied Health Professionals	60,199	44,655	43,842	813	179
Health Science Services	37,549	27,414	26,757	657	78
Management	11,033	8,383	7,562	821	68
Support Services	49,581	37,307	38,525	(1,218)	73
Medical & Dental Support	7,212	5,389	5,295	94	54
Other Therapeutic	24,296	18,328	17,462	866	90
Personal & Social Care	2,966	2,204	2,004	200	52
Other Pay	(7,510)	(6,408)	(5,892)	(515)	(127)
Emergency Services	3	3	18	(15)	(2)
Pay	**854,377**	**633,905**	**636,246**	**(2,341)**	**165**
Drugs	94,854	88,593	89,021	(428)	(423)
Medical Supplies	81,202	61,416	65,736	(4,319)	(677)
Maintenance Costs	5,615	4,235	5,345	(1,109)	(193)
Property Costs	39,556	27,911	26,482	1,429	848
Equipment Costs	26,296	20,375	22,545	(2,170)	(120)
Transport Costs	9,233	7,062	8,393	(1,331)	(53)
Administration Costs	157,700	53,775	52,281	1,494	265
Ancillary Costs	15,124	12,149	12,299	(150)	(278)
Other	(12,258)	(10,866)	(9,619)	(1,247)	(59)
Service Agreement Patient Serv	93,308	75,697	76,763	(1,065)	236
Non-Pay	**510,630**	**340,350**	**349,246**	**(8,896)**	**(455)**
Other Payments/Reimbursements	18	18	18	0	0
Gms2 Expenditure	114,590	85,443	85,419	24	(90)
Ncl Expenditure	3	2	(6)	8	0
Other Primary Care Expenditure	0	0	69	(69)	(7)
Pharmaceuticals	130,438	94,842	98,187	(3,344)	(411)
Primary Care	**245,049**	**180,305**	**183,686**	**(3,381)**	**(508)**
Bad Debts	4	4	60	(56)	0
Fhs Non Discret Allocation	(1,986)	(1,494)	(1,494)	0	0
Other	**(1,982)**	**(1,490)**	**(1,434)**	**(56)**	**0**
Total Non-Pay	**753,698**	**519,165**	**531,498**	**(12,334)**	**(963)**
Income	**(1,652,250)**	**(200,018)**	**(202,827)**	**2,809**	**(137)**
Sub Total Core Basline Position	**(44,176)**	**953,052**	**964,917**	**(11,866)**	**(934)**
Savings Target Non-Pay	(17,153)	(8,264)	0	(8,264)	(758)
N/R Corp Savings LRP	13,200	9,900	0	9,900	1,100
Additional Reserve Flexibility	9,348	4,674	0	4,674	1,558
TOTAL	**(38,781)**	**959,362**	**964,917**	**(5,556)**	**966**

NHS Lothian Summary by Operational Unit to December 2014

| 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	218,889	387,432	76,364	303,167	52,057	118,860	135,848	88,366	(1,380,983)	(0)
Medical & Dental	457	(426)	2	273	(32)	72	0	196	(89)	452
Nursing	(1,738)	(1,517)	(31)	(1,179)	94	(159)	(27)	(103)	(2)	(4,662)
Administrative Services	74	542	(31)	(20)	(62)	(83)	82	(350)	13	166
Allied Health Professionals	(132)	(514)	40	84	119	109	(4)	63	1,047	813
Health Science Services	177	301	10	178	3	75	0	(86)	0	657
Management	53	59	1	94	(29)	11	32	603	(3)	821
Support Services	(14)	(386)	(43)	(13)	(0)	19	(798)	17	0	(1,218)
Medical & Dental Support	(19)	(216)	0	0	0	304	0	26	0	94
Other Therapeutic	25	71	88	40	(18)	330	0	330	0	866
Personal & Social Care	1	(41)	(12)	64	3	0	20	164	0	200
Other Pay	(303)	(151)	(0)	(29)	0	0	(17)	(15)	0	(515)
Emergency Services	0	0	0	0	0	(10)	(5)	0	0	(15)
PAY	(1,419)	(2,279)	23	(509)	78	669	(716)	846	967	(2,341)
Drugs	(273)	(307)	(2)	(161)	(1)	(83)	(2)	151	249	(428)
Medical Supplies	(584)	(2,753)	(83)	(679)	45	(34)	(38)	(191)	(2)	(4,319)
Maintenance Costs	(160)	(251)	(42)	(114)	(20)	(30)	(437)	(55)	(0)	(1,109)
Property Costs	7	(25)	(38)	126	17	(64)	1,443	(36)	(0)	1,429
Equipment Costs	(1,067)	(638)	(56)	(315)	(4)	(106)	91	(25)	(49)	(2,170)
Transport Costs	(75)	(461)	(136)	(228)	(89)	(7)	(202)	(126)	(7)	(1,331)
Administration Costs	(389)	(7)	273	259	92	239	(7)	859	174	1,493
Ancillary Costs	(11)	85	(4)	22	(11)	41	(251)	(21)	(0)	(150)
Other	(435)	(418)	(383)	(447)	(199)	(88)	45	678	0	(1,247)
Service Agreement Patient Serv	(41)	(5)	(88)	(43)	7	(64)	(0)	13	(845)	(1,065)
NON PAY	(3,027)	(4,782)	(559)	(1,579)	(163)	(196)	642	1,247	(481)	(8,896)
Gms2 Expenditure	0	(10)	(43)	74	(5)	10	(0)	(2)	0	24
Ncl Expenditure	6	0	2	0	0	0	0	(0)	0	8
Other Primary Care Expenditure	0	(69)	0	0	0	0	0	0	0	(69)
Pharmaceuticals	(1)	(0)	(522)	(1,746)	(373)	(703)	(0)	1	0	(3,344)
Primary Care	5	(78)	(563)	(1,672)	(379)	(693)	(0)	(1)	0	(3,381)
Fhs Non Discret Allocation	0	0	7	(14)	0	(2)	0	9	0	0
Bad Debts	(5)	(51)	(4)	(0)	0	(1)	(2)	3	4	(56)
Other	(5)	(51)	3	(14)	0	(3)	(2)	12	4	(56)
SUB TOTAL NON PAY	(3,027)	(4,911)	(1,118)	(3,265)	(542)	(892)	640	1,258	(476)	(12,334)
INCOME	208	1,707	58	(117)	1	(57)	425	437	146	2,809
CORE POSITION	(4,238)	(5,483)	(1,037)	(3,891)	(462)	(281)	349	2,541	636	(11,866)
Savings Target Non-Pay	(2,106)	(3,853)	(189)	(1,633)	18	(39)	(279)	(338)	155	(8,264)
N/R Corp Savings LRP	0	0	0	0	0	0	0	0	9,900	9,900
Additional Reserves Felixibility	0	0	0	0	0	0	0	0	4,674	4,674
TOTAL	(6,344)	(9,336)	(1,226)	(5,524)	(444)	(320)	70	2,203	15,365	(5,556)

NHS Lothian Activity to December 2014

SUMMARY ACTIVITY BY SPECIALTY AND MONTH

Source: TRAK, NHS Lothian

NB: New outpatient figures include all activity for clinics under the SMR00 & ISD(S)1 data schemes, and may therefore include some activity that is not part of the waiting times standard e.g. nurse-led activity

	2014											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Waiting List Daycases	2,837	2,697	2,874	2,624	2,542	2,378	2,464	2,412	2,483	2,662	2,496	2,208
Waiting List Inpatients	2,002	1,944	2,140	2,008	2,389	2,470	2,235	2,156	2,325	2,517	2,280	1,895
Waiting List Inpatient Bed Days	6,751	7,068	7,864	7,602	8,131	8,047	7,551	7,598	8,139	8,276	7,709	7,703
All Other Daycases	2,649	2,458	2,586	2,680	2,562	2,608	2,903	2,573	2,932	3,072	2,799	3,128
All Other Inpatients	8,873	7,998	8,741	8,469	8,733	8,464	8,509	8,469	8,587	8,740	8,546	8,950
All Other Inpatient Bed Days	72,389	65,519	72,788	69,047	70,327	67,126	69,177	69,435	67,416	70,443	69,105	70,199

INPATIENT ACTIVITY BY TYPE OF ADMISSION AND MONTH
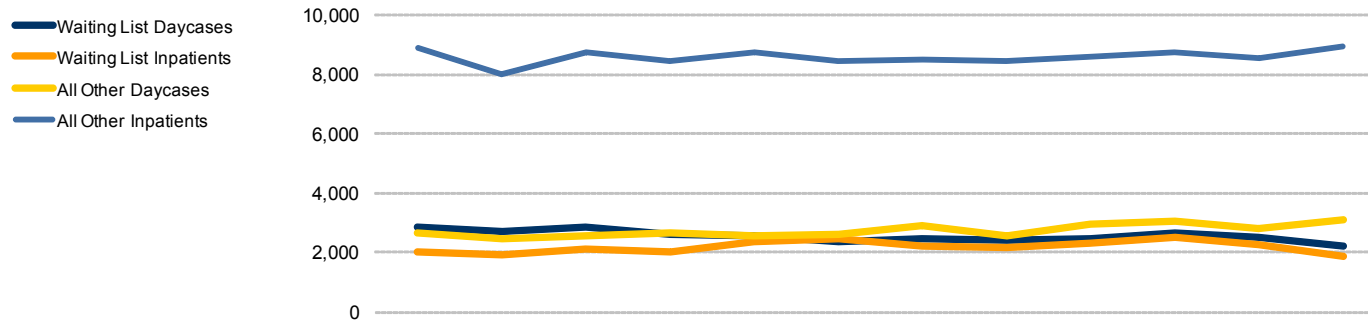
OCCUPIED BED DAYS BY TYPE OF ADMISSION AND MONTH

11
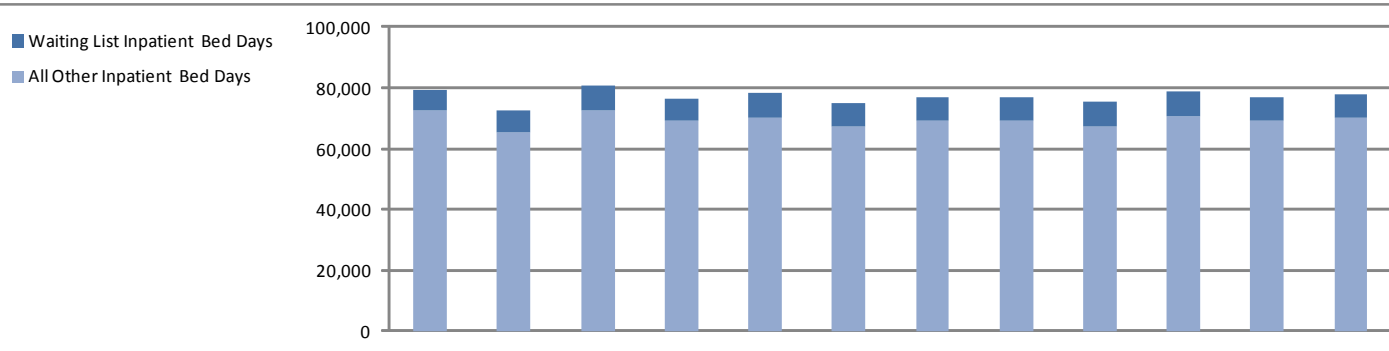
NHS Lothian Efficiency & Productivity – December 2014/15

Business Unit	Total Recurring Target £k	Current Year Plans £k	Gap on In Year Plans £k	In Year Position					
				Dec-14			April - December		
				Target Delivery £k	Actual Delivery £k	Slippage £k	Target Delivery £k	Actual Delivery £k	Slippage £k
East Lothian Chp	(1,426)	(1,200)	(226)	(119)	(54)	(65)	(587)	(426)	(161)
Midlothian Chp	(564)	(477)	(87)	(5)	(47)	42	(283)	(323)	40
Edinburgh Chp	(5,107)	(4,412)	(695)	(374)	(455)	81	(3,571)	(2,058)	(1,513)
West Lothian Chp	(1,632)	(1,648)	16	(126)	(127)	1	(1,169)	(1,180)	11
Prescribing	(4,303)	(4,303)	0	(414)	(304)	(110)	(3,062)	(2,842)	(220)
Scheduled Care	(13,663)	(12,140)	(1,523)	(1,422)	(832)	(590)	(9,409)	(5,556)	(3,853)
Unscheduled Care	(6,982)	(5,562)	(1,420)	(668)	(642)	(26)	(4,768)	(2,662)	(2,106)
Facilities & Consort	(2,284)	(2,096)	(188)	(252)	(137)	(115)	(1,528)	(1,249)	(279)
	(35,961)	(31,838)	(4,123)	(3,379)	(2,598)	(782)	(24,377)	(16,296)	(8,081)
Corporate Services									
Chief Executive	(25)	(25)	0	(2)	(2)	0	(19)	(19)	0
eHealth	(517)	(167)	(350)	(74)	(28)	(46)	(294)	(248)	(46)
Finance & Capital Planning	(505)	(536)	31	(44)	(29)	(15)	(357)	(400)	43
Human Resources & Communications	(699)	(410)	(289)	(71)	(61)	(10)	(427)	(433)	6
Medical Director	(104)	(79)	(25)	(9)	(8)	(1)	(78)	(81)	3
Nursing	(246)	(253)	7	9	0	9	(160)	(240)	80
Pharmacy	(639)	(421)	(218)	(53)	(1)	(52)	(479)	(78)	(401)
Planning	(147)	(147)	0	(12)	(12)	0	(110)	(110)	0
Public Health	(401)	(300)	(101)	(31)	(119)	88	(317)	(294)	(23)
	(3,283)	(2,338)	(945)	(287)	(260)	(27)	(2,241)	(1,903)	(338)
Strategic Programmes	(525)	(744)	219	16	(5)	21	(259)	(152)	(107)
Strategic Other	350	350	0	29	0	29	262	0	262
	(39,419)	(34,570)	(4,849)	(3,621)	(2,863)	(759)	(26,615)	(18,351)	(8,264)

NHS Lothian Property & Asset Management Investment Programme – December 2014/15

	Agreed Programme £000	Expenditure to M9 £000	Remaining Anticipated Expenditure £000
INCOME			
SGHSCD Specific Funding	22,798		
SGHSCD Formula Funding	29,624		
SGHSCD Funding	**52,422**		
EXPENDITURE			
Rolling Programmes			
Projects Under £250k	1,638	385	1,253
Medical Equipment	4,721	1,492	3,229
Strategic Priorities (Ehealth)	2,000	23	1,977
Backlog Maintenance	5,000	2,129	2,871
Digital Radiology	85	85	0
Donated Schemes	523	125	398
NSD Schemes	270	28	242
SGHSCD Cancer Schemes	228	0	228
	14,465	**4,266**	**10,199**
Primary Care Sites			
West End Medical Practice	0	(404)	404
Tranent Health Centre Extension	619	632	(13)
Blackburn Partnership Centre	261	35	226
Firhill Partnership Centre	864	29	835
North West Edinburgh Partnership Centre	888	93	794
Bundle Sub Debt Investment	497	0	497
Ratho GP Reprovision	50	7	43
Modernisation of GP Premises	500	114	386
Westerhailes Healthly Living Centre	0	(529)	529
	3,678	**(24)**	**3,702**
Integration			
Astley Ainslie Hospital Improvements	300	44	256
East Lothian Community Hospital	161	22	139
Liberton Quality Improvements	100	79	21
RVH Continuing Care	310	238	72
Care Village RVH	296	251	46
Corstorphine Decommisioning	0	0	0
Rvh Lucs Works	0	145	(145)
	1,168	**779**	**389**
Royal Edinburgh Campus			
REH Master Planning	520	456	64
REH Infrastructure Investment	1,223	1,188	34
REH Sub Debt Investment	1,360	0	1,360
Royal Edinburgh Hospital Phase 2	100	0	100
Orchard Clinic Redwood Upg Reh	380	0	380
	3,582	**1,644**	**1,938**
Edinburgh Bioquarter Campus			
Consort Life Cycle Costs Rie	4,192	3,145	1,047
Rhsc Reprovision	0	(1)	1
LEPP RIE	460	427	33
RIE Additional Assessment Beds	212	137	75
Endoscopy Decontamination Unit RIE	150	59	91
RIE Additional Beds Wards 120/220	0	13	(13)
	19,091	**12,208**	**6,884**

NHS Lothian Property & Asset Management Investment Programme – December 2014/15 (contd)

	Agreed Programme £000	Expenditure to M9 £000	Remaining Anticipated Expenditure £000
Western General Campus			
Endoscopy Decontamination Unit WGH	50	(4)	54
WGH Expansion Of Ward 58	100	0	100
Aseptic Pharmacy Modernisation	579	66	512
WGH Front Door	3,245	1,776	1,469
WGH Masterplanning	65	61	4
Traffic Management (WGH)	200	0	200
CT Scanner WGH	12	2	10
Radiotherapy Phase 9	2,467	170	2,297
Rvh Ward 7 Recommission	0	5	(5)
Edinburgh Cancer Centre	200	0	200
	6,918	**2,075**	**4,842**
St Johns Campus			
MRI Scanner St Johns	2,259	2,134	125
Labour Ward St Johns	145	147	(2)
Burns Unit St Johns	0	0	0
Special Care Baby Unit St Johns	1,288	635	653
St Johns Hospital Masterplanning	450	15	435
Dental Decontamination St Johns	580	70	511
	4,723	**3,001**	**1,721**
Lauriston Campus			
Lauriston Masterplanning	20	14	6
Capacity Developments Lauriston	0	0	0
	20	**14**	**6**
Other Schemes			
Opthalmic Service	170	0	170
Woodburn House	1,166	1,160	6
Laboratory Strategy	0	0	0
Microbiology Automation	80	0	80
Completed Schemes	(570)	(644)	74
Completed Schemes	12	68	(55)
Dental Decontamination	(13)	(13)	0
Total Gross Capital Expenditure	**54,491**	**24,479**	**30,012**
	0	0	
Donated Asset Capital Income	523		
Net Book Value of Receipts	2,750		
Total Net Capital Expenditure	**51,219**		
Total (Over) / Under Commitment	**1,203**		

Risks and Assumptions

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.
Parental and Adoption Leave	High	The implementation of paid parental leave until the child is 14 years has been modelled with various scenarios. No cost has been included in the forecast position but may need to be accrued for by the year end.
Rates Rebates and Property Sales	Medium / High	The ongoing rateable value appeal of the GMS properties could generate substantial backdated rebates.
Prescribing	Medium	A sustained level of short supply has been included in the year end forecast and this has deteriorated further following quarter 3 review.
Changes to the IPTR process	High	Changes to the process have not yet fully bedded down, however based on the year to date the financial impact has been assessed at £2.6m to NHS Lothian. 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 usage of the new Hep C drug (Sofosbuvir) is greater than originally anticipated. A £3m overspend in year is forecast
Changes to pay terms & conditions including discussions with Consort on the full implication of the Two Tier Agreement	Medium	These issues can't at the moment be fully quantified. The financial consequence will be monitored as the year progresses
Equal Pay	High	Discussions are continuing with CLO and Audit Scotland with regards to the treatment of this potential financial exposure.

NHS Lothian Reserves Position

	Available Reserves at period 9 £k	Committed to Service £k	Balance Available £k	Month 9 offset to Operational Position £k	YTD offset to Operational Position £k	Additional Committed Feb - Mar £k	Total Offsetting Operational Position £k	Reserves Flexibility £k
N/R Savings Target	£13,200	£0	£13,200	£1,100	£9,900	£3,300	£13,200	£0
General Reserves	£10,868	£(557)	£10,311	£1,558	£4,674	£4,674	£9,348	£963
Financial Plan - Current Year	£3,723	£(3,723)	£0	£0	£0	£0	£0	£0
Financial Plan - Prior Years	£257	£(257)	£0	£0	£0	£0	£0	£0
Drugs Reserve	£552	£(552)	£0	£0	£0	£0	£0	£0
Junior Medical	£569	£(569)	£0	£0	£0	£0	£0	£0
£29,169	**£(5,658)**	**£23,511**	**£2,658**	**£14,574**	**£7,974**	**£22,548**	**£963**