BOARD MEETING

DATE: **WEDNESDAY 4 OCTOBER 2017**

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

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

Members are reminded that they should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. It is also a member's duty under the Code of Conduct to ensure that any changes in circumstances are reported to the Corporate Services Manager within one month of them changing.

AGENDA

Item		Lead	
	Welcome to Members of the Public and the Press		
	Apologies for Absence		
1.	**Items for Approval**		
1.1.	Minutes of the Previous Board Meeting held on 2 August 2017	**BH**	*
1.2.	Running Action Note	**BH**	*
1.3.	Corporate Risk Register	**AMcM**	*
1.4.	Finance and Resources Committee - Minutes of 12 July 2017	**MH**	*
1.5.	Staff Governance Committee – Minutes of 26 July 2017	**AM**	*
1.6.	Audit & Risk Committee – Minutes of 28 August 2017	**MA**	*
1.7.	Strategic Planning Committee – Minutes of 10 August 2017	**BH**	*
1.8.	Acute Hospitals Committee – Minutes of 29 August 2017	**KB**	*
1.9.	Edinburgh Integration Joint Board - Minutes 11 August 2017	**AJ**	*
1.10.	Midlothian Integration Joint Board - Minutes 15 June 2017	**CJ**	*
1.11.	East Lothian Integration Joint Board - Minutes 29 June 2017	**CJ**	*
1.12.	Appointment of Members to Committees	**BH**	*
1.13.	Schedule of Board and Committee Meetings for 2018	**BH**	*
2.	**Items for Discussion** (subject to review of the items for approval)		
2.1.	Quality Management System – Next 5 Years	**SW**	*/p
2.2.	Quality and Performance Improvement	**SW**	*
2.3.	Integration Joint Boards' Annual Performance Reports 2016/17	**JC**	*
2.4.	Financial Position to August 2017 and Year End Forecast	**SG**	*

3.	**Resolution To Take Items in Closed Session**	**BH**	**v**
4.	**Minutes of the Previous Private Meeting held on 2 August 2017**	**BH**	**®***
5.	**Matters Arising**	**BH**	**v**
6.	**Any Other Competent Business**	**BH**	**v**

7. Next Development Session:
Wednesday 1 November 2017 at 9:30 a.m. at the Scottish Health Service Centre, Crewe Road South, Edinburgh EH4 2LF

8. Next Board Meeting:
Wednesday 6 December 2017 at 9:30 a.m. at the Scottish Health Service Centre, Crewe Road South, Edinburgh EH4 2LF

Board Meetings in 2017

6 December 2017	Scottish Health Service Centre

Board Meetings in 2018

7 February 2018	Scottish Health Service Centre
4 April 2018	Scottish Health Service Centre
27 June 2018*	Scottish Health Service Centre
1 August 2018	Scottish Health Service Centre
3 October 2018	Scottish Health Service Centre
5 December 2018	Chancellor's Building RIE

** Annual Accounts Meeting*

Development Sessions in 2017

1 November 2017	Scottish Health Service Centre

Development Sessions in 2018

10 January 2018	Scottish Health Service Centre
7 March 2018	Scottish Health Service Centre
16 May 2018	Scottish Health Service Centre
18 July 2018	Scottish Health Service Centre
12 September 2018	Scottish Health Service Centre
7 November 2018	Scottish Health Service Centre

DRAFT **1.1**

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 2 August 2017 in the Carrington Suite, Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mrs K Blair; Cllr R Henderson; Mr M Hill; Ms C Hirst; Ms F Ireland; Cllr J McGinty; Mrs A Mitchell; Cllr D Milligan; Cllr F O'Donnell; Mr J Oates and Mrs L Williams.

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

In Attendance: Mr G Perks (Clinical Development Fellow, Orthopaedics RIE) and Mr C Graham (Secretariat Manager).

Apologies for absence were received from Mr A Joyce; Mr P Murray; Mr M Ash; Dr R Williams; Miss T Gillies; Professor M Whyte and Mr D Weir.

Welcome and Introduction

The Chairman welcomed members of the public and press to the Board meeting. The Chairman introduced Mr Gruffydd Perks, who was currently shadowing the Chairman at various meetings.

The Chairman also welcomed the Board Members present and the newly appointed local authority Board Members, namely Councillor Derek Milligan (Midlothian Council); Councillor John McGinty (West Lothian Council); Councillor Fiona O'Donnell (East Lothian Council) and Councillor Ricky Henderson who was returning to the Board from Edinburgh Council.

The Chairman also reported that three new Non Executive Lay Board Members had been appointed and would commence their terms in September. These were Professor Tracy Humphrey; Mr Martin Connor and Mr Angus McCann.

The Chair added that given the significant turnover of Board Membership part of the September Board Development Session would be an induction type event that would be for all Board Members, given the new added complexity that was now being dealt with. The Chief Executive would cover this in more detail during the Board's Private Session.

Declaration of Financial and Non-Financial Interest

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

22. Items for Approval

22.1 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated "For Approval" paper without further discussion:-

22.2 Minutes of the previous Board meeting held on 21 June 2017 - Approved.

22.3 Running Action Note – Approved.

22.4 Corporate Risk Register – The Board acknowledged the corporate risks undergoing review to improve the expression of risk, controls and actions and accepted the significant assurance that the Corporate Risk Register contains all appropriate risks. The Board also accepted that as a system of control, the Governance Committees have all confirmed they are assessing the levels of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

22.5 Healthcare Governance Committee – Minutes of 11 July 2017 – Endorsed.

22.6 Acute Hospitals Committee – Minutes of 4 July 2017 – Endorsed.

22.7 Staff Governance Committee – Minutes of 31 May 2017 – Endorsed.

22.8 Strategic Planning Committee – Minutes of 8 June 2017 – Endorsed.

22.9 Audit and Risk Committee – Minutes of 19 June 2017 – Endorsed.

22.10 West Lothian Integration Joint Board – Minutes of 27 June 2017 – Endorsed.

22.11 Edinburgh Integration Joint Board – Minutes of 16 June & 14 July 2017 – Endorsed.

22.12 Midlothian Integration Joint Board – Minutes of 29 April 2017 – Endorsed.

22.13 Reference Committee Chair – The Board agreed that the Chairman will take Chair's action to appoint a Non-Executive Director as Chair of the Reference Committee on the earliest possible occasion. If a Reference Committee were necessary before completion of the appointment process, the Chairman will either take on this role or identify a Non-Executive to undertake this function under a formal appointment is approved by the Board.

Items for Discussion

23. Scheduled Care Access Performance, 2017/18 Trajectories and Allocation of Funding

23.1 The Board noted the reported updated position on NHS Lothian's Outpatient (OP) and Inpatient and Daycase (IPDC) Treatment Time Guarantee (TTG) performance, at end June 2017. The detail of Outpatient and In-patient/Day case Trajectories for 2017/18 and the update on the process of clinical risk assessment of specialties, and the use of this process to allocate non recurring access performance funding from the Scottish Government was also noted.

23.2 The Board discussed the current performance in outpatients and In-patients/day case performance. It was discussed that in some specialties, namely orthopaedics and vascular, general surgery improvements had been made in their in-patient/day case performance. This was due in part to improved access to theatres, recruitment of consultants, Scottish Government allocation of funding and prioritisation of how the funding would be spent.

23.3 There was discussion on the use of external providers to provide additional capacity. The Board acknowledged that there was ongoing work within procurement to look at best volumes, prices and national capacity. It was accepted that local providers would not be able to provide all the capacity required hence the reliance on national procurement.

23.4 There was further discussion on trajectories and whether putting sufficient investment into areas of worsening trajectory such as endoscopy was actually helpful. Mrs Campbell stated that this was a service of higher clinical risk, and would have resources allocated on that basis. Dr Watson added that the endoscopy pathway was one of Quality Improvement Programmes with focus on the patient journey and non attendance.

23.5 Mrs Campbell clarified that as part of the procurement process approval was being sought to switch back on private sector use for high risk services paid for with ringfenced Scottish Government funding specifically for that purpose.

23.6 Mrs Mitchell asked if other Health Boards were doing anything differently that could be learnt from. Mrs Campbell stated that other Boards were not doing anything particularly different. NHS Lothian is working in partnership with NHS 24 to pilot a 'keeping in touch' process with longer waiting patients. This pilot will focus on GI. A concurrent pilot will be undertaken with endoscopy to see if a selected group of return patients could be managed via a different pathway to reduce demand.

23.7 The Chief Executive outlined that as a Board there had been a struggle to consider individual parts of systems in context of the whole and the strategic position and financial challenge around this. As a Board there was a need to generate 7% recurring savings annually. Moving forward there will be greater challenges for example ring fencing of primary care and mental health budgets and of Integration Joint Boards, so effectively increasing the recurring savings challenge to 15%. The inclusion of shifting the balance of care costs and investment along with resource transfer would make the challenge more like 30%.

23.8 The Board agreed to the detailed investment profile against the available non recurring funding from the Scottish Government, along with the anticipated impact on performance recognising that this was not a sustainable solution. However the Board recognised the challenges involved.

24. Paediatric Programme Board Update

24.1 The Chairman stated that the Board would recall the circumstances around the current situation within paediatric services.

24.2 The Board received the update on the St John's Hospital (SJH) paediatric inpatient out of hours service and noted the revised interim remit of the Paediatric Programme Board (PPB). The Board also considered the proposed format of the review of the actions taken against the Royal College of Paediatrics and Child Health (RCPCH) recommendations provided to NHS Lothian in 2016, in relation to a sustainable 24/7 workforce model.

24.3 The Chairman informed the Board that there had been a recent meeting with West Lothian Council to provide information and background on the decision that had been made to suspend the 24/7 paediatric inpatient access at St John's Hospital. The meeting had allowed for co-operative discussion about the issues involved and how the effect could be mitigated in order to get back to a position where all involved wanted to be.

24.4 The Board remained committed to 24/7 service provision although a service with an ongoing risk of collapse was deemed unacceptable. The Board noted that the children's ward was running as an assessment unit, Monday to Friday 8am to 8pm. Support of the Clinical Team at St John's had now seen this extended across 7 days and this was being reviewed on a weekly basis. This arrangement had been in place since 07 July 2017 and there was currently sufficient staffing to enable this to continue.

24.5 It was acknowledged that parents of children in West Lothian would not have to do anything different and children would continue to be referred by General Practice; attend prearranged appointment or be assessed in the emergency department as before. There continued to be a paediatric consultant on site 12 hours a day and on call 24/7. The only change would be for any children requiring to be admitted as they would now be transferred to the Royal Hospital for Sick Children. The Board noted that the number of children transferred between 07 July and 24 July 2017 had been thirty, an average of 1.7 children per day, which was in line with numbers seen during the previous temporary closure. Maternity and Neonatal services at St John's Hospital remained unaffected.

24.6 Mr Hill informed the Board that due to the current situation it had been deemed appropriate to amend the Paediatric Programme Board (PPB) remit for an interim period of time as outlined in appendix 1 of the Board Paper. This approach had been endorsed by the Board's Acute Hospitals Committee (AHC) and the Programme Board would continue to receive ongoing governance from the AHC. It was also timely to review progress against the Royal College of Paediatricians and Child Health (RCPCH) recommendations one year on.

24.7 The Paediatric Programme Board provided the AHC with two options for consideration at the 04 July 2017, regarding a review:

- Option A - The RCPCH alone would be asked to review the PPBs progress against their recommendations using the terms of reference for the review. Input would be required from someone with the knowledge and understanding of current Scottish paediatric workforce challenges. The output of this review would then immediately be fed back to NHS Lothian Board and Scottish Government.

- Option B - The PPB would review their progress against the RCPCH recommendations in line with the terms of reference for the review along with additional input from; representation from the RCPCH, a paediatrician with current or recent experience of medical management in paediatrics from another Scottish Health Board out with the South East region, a national workforce planning expert, and contribution from Finance colleagues. The output of this review would then be scrutinised by the Acute Hospitals Committee, NHS Lothian Board and then Scottish Government.

24.8 Mr Hill stated that the AHC had decided for Option B. The wider external review had been commissioned and the RCPCH agreed to participate in this review. This included interviewing staff in service at St John's Hospital and Royal Hospital for Sick Children along with senior nursing staff and the management teams. The RCPCH report would then be considered by the PPB along with a Paediatrics Director from out with the South East Region; Workforce Planning and a senior staff member from the finance team. Mr Hill added that the PPB was now meeting monthly to review the situation and that whenever the criteria are met and the service deemed safe and sustainable it would be re-established.

24.9 Mrs Goldsmith made it clear that despite the Board's current financial position it had not held back resource in trying to resolve the issue at St John's Hospital.

24.10 The Board discussed the current staffing situation and accepted that currently there was not enough staff in place to sustain and deliver a safe service due to gaps in the rota. Two Consultant posts had been advertised and would be interviewed for in September.

24.11 Cllr McGinty asked about current staffing gaps and actions taken. Mrs Campbell reported that against the recommendation of eight new consultants there were two vacancies which were currently being advertised with a planned interview date in September 2017. In addition part of the solution to the workforce gap was to recruit and train advanced paediatric practitioners (APP). No trained APPs had been recruited but two trainees had been recruited and were undertaking the appropriate competencies at this time. There were also problems with long term sickness absence. Mr Crombie added that there was a lack of commitment to resident on call from some existing consultants which added to pressures. The Board also noted that two members of staff return to work in August but will not be able to contribute to the out of hours rota.

24.12 Mr Hill stated that in relation to consultant appointments, it was hoped to make new consultant appointments from staff who had previously contributed to rotas at a junior level.

24.13 Cllr McGinty asked for clarity around the new review. The Chief Executive clarified that Board policy remained committed to a continuing 24/7 service at St John's Hospital provided this could be made safe and sustainable, as would be the case for any service. The Chief Executive also reminded members that in terms of total hospital provision the policy was to shift the balance of care away from hospitals. He further suggested that the term "down grading" was not helpful; in fact if the policy was successful then there would be fewer inpatient services as more services would be supporting people in their own homes.

24.14 Cllr McGinty proposed an additional statement in relation to recommendation 2.1 in the report. This was to support the reinstatement of 24/7 paediatric services at St John's Hospital at the earliest date possible after July 2017. Mrs Mitchell stated that in terms of governance she was uncomfortable redrafting papers at the Board meeting. Cllr Milligan suggested that the proposed additions to the recommendations did not impact on what they were actually saying.

24.15 The Board agreed to accept the proposed additions to the paper as they did not effectively change the substance of the recommendations:

- Recommendation 2.1 to read "Note" rather than "Support".
- To add "To support to reinstatement of a 24/7 paediatric service at St John's Hospital at the earliest date possible after July 2017 subject to assurance of a safe and sustainable solution" in accordance with recommendation 2.1. With a caveat around clinical safety as outlined in the Chief Executive's statement at 24.13 above.
- To add that the outcome of the review will be made publically available under recommendation 2.3.

24.16 The Board also agreed that it was critical to support the "interim" remit of the PPB as endorsed by the Acute Hospitals Committee as well as supporting the review format of against the RCPCH recommendations, again as endorsed by the Acute Hospitals Committee.

25. 2017/18 Financial Performance - 30th June 2017

25.1 Mrs Goldsmith introduced the report covering Month 3 based on the latest financial information. The draft had been considered at the Board's Finance and Resources Committee in July. The Board noted that the report did not cover all the 5 Year Financial Strategy and this would be covered at a future Board Development Session.

25.2 The Board considered the financial position as at June 2017 which reported a deficit of £5.7m, after phasing in three months of the £10m reserves identified in the Financial Plan.

25.3 The Board noted that the month 3 position as reported is in line with previous years and against trajectory looks marginally better although this is not consistent across different parts system. There was only 1 month of GP prescribing data available so this was based on estimates. The drivers of overspend were highlighted in the report.

25.4 Mrs Goldsmith added that main effort would now be directed to quarter one review and time would be spent with directors and senior teams to see what could be done to improve the position. The Quarter 1 review would be taken to the September Finance and Resources Committee Meeting.

25.5 The Board discussed risks within the Acute Sector and the relationship between Integration Joint Board (IJBs) and the Acute Sector in terms of set aside budgets. It was noted that dialogue between the Board and the IJBs had started and that Mr Hill would be meeting with IJBs in his role as Chair of the Finance and Resources Committee.

25.6 Professor McMahon asked what provision was being put in place to ensure that risk was appropriate against safe staffing levels. Mrs Goldsmith stated that control was across the piece with service managers and general managers being asked to continually balance safe staffing levels against financial pressures.

25.7 Cllr O'Donnell asked about financial control for set aside and hosted services budgets. Mrs Goldsmith assured the Board that the Quarter 1 review would be the result of the Board's engagement with managers and that there was a rigorous mechanism put in place for finance control of spends, overspends and pressures.

25.8 There was also discussion on GP prescribing and efficiencies. Mrs Goldsmith stated that partnerships were being asked to work closely with cluster quality leads to look at different approaches to prescribing and a Quality Improvement approach to managing variation and reducing waste was being considered but the benefits of this would not be realised until later in the year.

25.9 The Chief Executive added that whilst there would be no compromise on safety of services there was an endeavour to reduce reliance on costly agency staff and look to service to reduce spend. The Board noted that Miss Gillies and Professor McMahon were looking at examples of agency spend and considering how reconfiguring the provision of services could improve this.

25.10 Professor McMahon made the point that last year there had been a £2M less spend on nursing agency. There had been a regional piece of work undertaken with NHS Fife and NHS Borders to make sure that agency nurses were only working in their own board areas. This was an effort to encourage take up of full time nursing posts.

25.11 The Board noted the report and accepted that the reported overspend is slightly lower than the financial plan trajectory but that this is not consistent across the Business Units. The Board acknowledged that ongoing actions were being progressed to reduce the predicted financial plan deficit in order to achieve a year-end balanced position; however only limited assurance could be agreed in relation to the achievement of breakeven at this time.

26. Quality and Performance Improvement

26.1 Dr Watson introduced the report updating the Board on the most recently available information on NHS Lothian's position against a range of quality and performance improvement measures.

26.2 The paper described performance on a range of metrics and key performance indicators. The Board noted that following previous discussion around how the data was to be presented the report now used less narrative and was more of a high level summary. The paper also separated out detailed graphs and now used hyperlinks to a 'self service' pack of more detailed data and narrative. Dr Watson added that the eventual aim was the development of a digital dashboard for the Board Members to use and interrogate. There was also to be review of the report at the September Board Committee Chair's Group.

26.3 Mrs Mitchell stated that whilst she was supportive of the direction of travel it would be helpful to have a little more narrative to highlight particular issues of interest or concern.

26.4 The Board approved the "lighter documentation" approach to the reporting of quality and performance improvement and accepted that performance on the 14 measures considered across the Board are currently met with 19 not met. It was noted that it was not possible to assess performance on Dementia Post-Diagnostic Support or Complaints stage 1 or 2. The Board also accepted that the Board Governance Committees are continuing with the enhanced programme of assurance as agreed.

27. Next Development Session

27.1 The Board noted that the next Board Development Session would be held on Wednesday 6 September 2017 at 9.30am at the Scottish Health Service, Crewe Road South, Edinburgh EH4 2LF.

28. Date and Time of Next Meeting

28.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 4 October 2017 in the Scottish Health Services Centre, Crewe Road, Edinburgh.

29. Invoking of Standing Order 4.8

29.1 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.

1.2

LOTHIAN NHS BOARD MEETING

RUNNING ACTION NOTE

Action Required	Lead	Due Date	Action Taken / Outcome	Outcome
Delayed Discharges				
• Provide more detail on the lack of availability of care packages, particularly identifying if the problem was a recruitment or a budget issue	**AMcM**	Ongoing	*For IJB Chief Officers to address*	
Person Centred Culture				
• The Nurse Director would arrange for the Internal Audit department to bring focus to complaints as part of the improvement process, this to be included in the work programme for the Internal Audit department in the forthcoming year.	**AMcM**	2018/19 Plans	*Action Plan being progressed*	
Reference Committee Chair				
• The Board agreed that the Chairman will take Chair's action to appoint a Non-Executive Director as Chair of the Reference Committee on the earliest possible occasion. If a Reference Committee were necessary before completion of the appointment process, the Chairman will either take on this role or identify a Non-Executive to undertake this function under a formal appointment is approved by the Board.	**BH**	04/10/17	*Proposal to appoint Martin Connor as Reference Committee Chair on October Agenda*	

1.3

NHS LOTHIAN

Board
4 October 2017

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

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

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

2 Recommendations

The Board is recommended to:

2.1 Acknowledge the corporate risks are undergoing review to improve the expression of risk, controls and actions.

2.2 To approve the Management of Deteriorating Patients risk which is the key risk associated with the delivery of the Scottish Patient Safety Work programme.

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

2.4 Accept that as a system of control, the Governance committees of the Board have confirmed they are assessing the levels of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

3 Discussion of Key Issues

3.1 The Board in June 2017 accepted a number of changes to the risk register which are illustrated in Appendix 1. These include:-

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

All the corporate risks are undergoing review which includes the above and will be completed by October 2017. The aim of the review is to improve clarity of expression of risks, controls and actions to maximise effectiveness of the process which was an Audit & Risk Committee agreed risk management objective for 2017/18. Table 1 below illustrates progress with this review.

Table 1

Datix ID	Risk Title	
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	Risk has been reviewed and approved by the Finance & Resources Committee in July 2017
3203	Unscheduled Care: 4 hour Performance	Risk to be reviewed
3726	Timely Discharge of Inpatients (Previously Unscheduled Care: Delayed Discharge)	Risk agreed at June 2017 Board
3829	GP Workforce Sustainability	Risk agreed at June 2017 Board
3211	Access to Treatment – Organisation Risk (Previously Achievement of National Waiting Times)	Risk agreed at June 2017 Board
4191	Access to Treatment Risk – Patient (New Risk May 17)	Risk agreed at June 2017 Board and also reviewed by HCG in July 2017
3454	Management of Complaints and Feedback	Risk reviewed and grading reduced. Supported by September HCG Committee
1076	Healthcare Associated Infection	Risk to be reviewed
3480	Management of Deteriorating Patients in Acute Inpatient Settings (previously Delivery of SPSP Work Programme)	Risk reviewed and approved at September HCG Committee prior to submission to October Board.
3527	Medical Workforce Sustainability	Risk reviewed
3189	Facilities Fit for Purpose	Risk to be reviewed
3455	Management of Violence & Aggression	Risk to be reviewed
3828	Nursing Workforce – Safe Staffing Levels	Risk reviewed to be approved at Staff Governance Committee
3328	Roadways/ Traffic Management	Risk to be reviewed

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

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

1. The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge *
2. Achieving the 4-Hour Emergency Care standard *
3. Timely Discharge of Inpatients *
4. General Practice Sustainability
5. Access to Treatment (organisational risk)
6. Access to Treatment (patient risk)

* Outwith risk appetite as illustrated in Table 3.

3.3.1 The Board and Governance committees of the Board need to assure themselves that adequate improvement plans are in place to attend to the corporate risks pertinent to the committee. These plans are set out in the Quality & Performance paper presented to the Board and papers that are considered at the relevant governance committees. Governance Committees continue to seek assurance on risks pertinent to the committee and level of assurance along with the summary of risks and grading is set out below in Table 2.

3.3.2 The Patient Experience risk – Management of Complaints & Feedback has been reviewed. This includes a reduction in risk grading from Very High 20 to High 16 due to moderate assurance being accepted by the Healthcare Governance Committee (HCG) in March and July 2017, and improved performance in 11 out of 12 months prior to a new complaints process being implemented. The September 2017 HCG approved the revised risk and a reduction in grading.

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

Table 2

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. **(Finance & Resources Committee)**	March 2017 No assurance with respect to financial balance 2017/18. July F&R considered the revised risk and accepted limited assurance.	High 12	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017
3203	Unscheduled Care: 4 hour Performance **(Acute Services Committee)** (Set out in Quality & Performance Improvement Report)	February 2017 Moderate Assurance; Members approved the recommendations laid out in the paper and accepted moderate assurance, but asked for more detail in the next paper on the greater impact of the measures taken to manage unscheduled care. Paper received and moderate assurance accepted due to performance over the last 4 quarters.	High 10	Very High 20	Very High 20	Very High 20	Very High 20
3726	Timely Discharge of Inpatients (Previously Unscheduled Care: Delayed Discharge) **(HCG Committee)** (Set out in Quality & Performance Improvement Report)	January 2017 Limited assurance. No clear improvement plans in place to mitigate the risk. A plan was presented to the September 2017 HCG committee who accepted limited assurance and ask for regular updates from the Chief Officers..	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	GP Workforce Sustainability **(HCG Committee)**	March 2017. Limited assurance. No clear improvement plans in place at March 2017. Plans presented in May 2017. September 2017 HCG continued to accept limited assurance, but more confident that the plans in place will mitigate this risk over time and asked for regular updates.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3211	Access to Treatment – Organisation Risk (Previously Achievement of National Waiting Times) **(Acute Services Committee)** (Set out in Quality & Performance Improvement Report)	July 2017. Limited Assurance. The Committee was impressed with the work in progress but also disappointed that performance remained of concern with the volume of patients waiting over 12 weeks. Recognition that systems of control were in place was accepted. Update provided to HCG in July 2017.	High 12	High 16	High 16	⇧ Very High 20	Very High 20
4191	Access to Treatment Risk – Patient (New Risk May 17) (Acute Services Committee)	Considered at HCG July 2017. Continues to be limited assurance and update to come regularly.	Very High 20				Very High 20
3454	Management of Complaints and Feedback **(HCG Committee)** (Set out in Quality &	July 2017. Moderate assurance with respect to a plan being in place, but need assurance that the plan will lead to an	High 12	High 16	Very High 20	Very High 20	⇩ High 16

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017
	Performance Improvement Report)	improvement and asked for an update every 2nd meeting. Next update to November 2017 HCG.					
1076	Healthcare Associated Infection **(HCG Committee)** (Set out in Quality & Performance Improvement Report)	July 2017. Overall moderate assurance due to SAB infections, but significant with respect to CDI HEAT target achievement. Committee asked for the risk grading to be reviewed in light of current performance. Incorporated into the Risk Review process.	High 12	High 16	High 16	High 16	High 16
3480	New Title - **Management of Deteriorating Patients in Acute Inpatients** (previously Delivery of SPSP Work Programme) **(HCG Committee & Acute Services Committee)** (Set out in Quality & Performance Improvement Report)	July 2017 Significant assurance received with the exception of the management of deteriorating patients. Committee in March. Review presented to HCG July 2017. Significant assurance re robustness of the review, limited as actions agreed that will lead to an improvement as changes not tested at scale.	High 16	High 16	High 16	High 16	High 16
3527	Medical Workforce Sustainability **(Staff Governance Committee)**	March 2017 Moderate Assurance that all reasonable steps are being taken to address the risks. Paper requested for 26th July meeting.	High 16	High 16	High 16	High 16	High 16
3189	Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015) **(Finance & Resources Committee)**	To be assessed.	High 15	High 16	High 16	High 16	High 16
3455	Management of Violence & Aggression. (Reported at H&S Committee, **via Staff Governance Committee**)	March 2017 Limited Assurance. Pending the review of the management of violence and aggression commissioned by Medical Director. Findings of review to be considered by Staff Governance on 26th July 2017 and inform the management of this risk.	Medium 9	High 15	High 15	High 15	High 15
3828	Nursing Workforce – Safe Staffing Levels **(Staff Governance Committee)**	March 2017 Moderate assurance that systems are in place to manage this risk as and this	High 12	Medium 9	Medium 9	Medium 9	Medium 9

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017
		risk will be regularly reviewed particularly with respect to District nursing.					
3328	Roadways/ Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee, **via Staff Governance Committee**)	March 2017 Moderate Assurance that issues are regularly reviewed, managed and improvements developed as supported by recent audits. Further report requested for 26th July meeting.	High 12	High 12	High 12	High 12	High 12

3.4 Risk Appetite Reporting Framework

NHS Lothian's Risk Appetite Statement is:-

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

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

Table 3

	Current Status	Current Position	Data Report
Corporate Objective 3 – Improve Quality, Safety & Experience Across the Organisation (LDP 2016-17 - 2.3 Deliver Safe Care) **Low Risk Appetite**			
• Scotland target to reduce acute hospital mortality ratios by 10% with a tolerance of 15-20% by Dec 2018 [1] All sites within HS limits & <=1	Green	0.87	Quality & Performance Improvement Report (HCG Committee)
• Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015	Green	99.9%	Patient Safety Programme Annual Report (Jan 2017) (HCG Committee)
• Achieve 184 or fewer SAB by March 2018 with a tolerance of 95% against target. n=193 to 184	Green	83	Quality & Performance Improvement Report (HCG Committee)
• Achieve 262 or fewer C.Diff by March 2018 with a tolerance of 95% against target. n=275 to 262	Green	67	Quality & Performance Improvement Report (HCG Committee)
• Reduce falls with harm by 20% with a tolerance of 15-20% by March	Green	53%	Quality & Performance Improvement Report

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

	Current Status	Current Position	Data Report
2017			(HCG Committee)
Corporate Objective 3 – Improve Quality, Safety & Experience Across the Organisation (LDP 2016-17 - 2.4 Deliver Person-centred Care) **Low Risk Appetite**			
• Patients would rate out of 10 their care experience as 9, with a tolerance of 8.5	Amber	8.90	Quality & Performance Improvement Report (HCG Committee)
• 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%	Red	74%	iMatters first report. Frequency of reporting to be confirmed. (Staff Governance Committee)
• Staff absence below 4% with a 5% tolerance (4.2%)	Amber	4.71%	Quality & Performance Improvement Report (Staff Governance Committee)
Corporate Objective 3 – Improve Quality, Safety & Experience Across the Organisation (LDP 2016-17 - 2.7 Scheduled Care & Waiting Times) **Low Risk Appetite**			
• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Red	79.4%	Quality & Performance Improvement Report (Acute Hospitals Committee)
• 95% of patients have a 62-day cancer referral to treatment with a tolerance of 90-95%	Red	85.3%	Quality & Performance Improvement Report (Acute Hospitals Committee)
Corporate Objective 3 – Improve Quality, Safety & Experience Across the Organisation (LDP 2016-17 - 2.8 Appropriate Unscheduled Care) **Low Risk Appetite**			
• 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%	Amber	95.1%	Quality & Performance Improvement Report (Acute Hospitals Committee)
• No patients will wait more than 14 days to be discharged by April 2015 with an appetite of 14 days, and a tolerance of 15 days *	Red	218	Quality & Performance Improvement Report (HCG Committee)
• No of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle, with an appetite of 80% and a tolerance of 75%.	Red	74.4%	Quality & Performance Improvement Report for management actions (Acute Hospitals Committee)
Corporate Objective 1 – Protect & Improve the Health of the Population. **Medium Risk Appetite**			
• Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas, with a 10% tolerance (36-40%). (Target = 293 minimum per quarter).	Green	303	Quality & Performance Improvement Report (HCG Committee)
• At least 80% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation, with a 10% tolerance (69.3-77%)	Green	Lowest SIMD is SIMD 4 – 91.6%	Quality & Performance Improvement Report (HCG Committee)

	Current Status	Current Position	Data Report
Corporate Objective 5 – Achieve Greater Financial Sustainability & Value (LDP 2016-17 – 3.1 Financial Planning) **Medium Risk Appetite**			
• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Green	£459k overspend at period 5 equating to 0.4%	Period 5 Finance Report (Finance & Resources Committee)
• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%	Red	£6,627k overspend for the year-to-date, equating to 1.2%	Period 5 Finance Report (Finance & Resources Committee)

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

3.4.1 The above table reporting would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set and where medium appetite has been set.

4 Key Risks

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

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

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

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

7.1 This paper does not consider developing, planning and/or designing services, policies and strategies.

8 Resource Implications

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

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13 September 2017
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List of Appendices

Appendix 1: Summary of Corporate Risk Register

Corporate Risk Register

Appendix 1

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3600	3: Secure Value & Financial Sustainability	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	There is a risk that the Board does not systematically and robustly respond to the financial challenge to achieve its strategic plan. This could be due to a combination of: uncertainty about the level of resource availability in future years, the known demographic pressure which brings major potential service costs and increasing costs of new treatment options, e.g. new drugs, leading to a reduction in the scale or quality of services. NOTE: During the last few years, NHS Lothian has been reliant on non-recurring efficiency savings, which has exacerbated the requirement to implement plans which produce recurring savings.	The Board has established a financial governance framework and systems of financial control. Finance and Resources Committee provides oversight and assurance to the Board. Quarterly review meetings take place, where acute services COO, site/service directors in acute, REAS and joint directors in Primary Care are required to update the Director of Finance on their current financial position including achieve delivery of efficiency schemes. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.	Risk reviewed and approved at July 2017 Finance & Resource Committee As at 19 June 2017, NHS Lothian has submitted a 2017/18 LDP (Local Delivery Plan) to the Scottish Government with a £22m funding gap. The medium term financial plan will have a renewed focus on the national opportunities identified via the national Value and Sustainability work streams. The positive impact on finance from the Quality initiatives work on reducing unwarranted variation and waste will also be reflected in the plan. The Board has agreed to produce a medium term strategic financial plan, with the specific aim of identifying a plan for the Board to return to recurring financial balance. The National Health and Social Care Delivery Plan has requested that Regional service models are enhanced to support delivery of recurring financial balance. The Board is committed to working with regional partners to deliver this aim. Risk Grade/Rating remains Very High 20	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Director of Finance	Deputy Director of Finance	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	There is a risk that patients are not seen in a timely manner that require emergency care as required by the Emergency Care standard of 95% resulting in sub optimal care experience and outcome.	A range of governance controls are in place for Unscheduled Care notably: - Bi monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. -The bi-monthly Acute Hospitals Committee as well as formal SMT meetings. Both are chaired by Chief Officer; NHSL University Hospitals & Support Services.. - The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis. - Monthly SMG and SMT meetings in place for acute services in Lothian - Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, SJ H NHS Lothian's Winter Planning Project Board is now established as NHS Lothian Unscheduled Care Committee in collaboration with the Integrated Joint Boards to promote sustainability of good performance all year round 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 - Delayed Discharge (see Corporate Risk ID 3726) - Boarding of Patients - Winter Planning - Length of Stay (LOS) - Cancellation of Elective Procedures - Finance Adherence to national guidance/ recommendations Plethora of work now focussed around the Scottish Government's *6 Essential Actions* initiative to support achievement of 95% target (stretch target of 98%) for 4 hour performance.	Risk Reviewed for period April-June 2017. (Normal Quarterly Update, Overall Risk still be reviewed) Updates highlighted below Risk Grade/Rating remains Very High/20 Work continues in line with the Scottish Governments 6 Essential Actions initiative. Boards now involved in taking forward set of actions (per site) to support a step change in performance. Priority interventions will focus on: • Clinical Leadership • Escalation procedures • Site safety and flow huddles • Workforce capacity • Basic Building blocks models • Proactive discharge • Flow through ED/ Acute Receiving • Smooth admission/ discharge profiling • Effective capacity and Demand models being developed re in /out , BBB methodology • Patients not beds principle • Daily Dynamic Discharge/check, chase, challenge methodology rolled out across the acute sites • Plan to roll out across the whole system and partnerships campus's The above has been absorbed as part of approach to winter planning, led by NHSL UCC Committee. The approved Winter Plan outlined the approach to supporting performance over the winter period and beyond. This reflected a number of actions namely: • Winter Readiness plans established for each site • Plans focused on discharge capacity as well as bed capacity • Clear measures in terms of escalation procedures • Measures to counter any demand unmatched to support winter and patient flow • A focus on DD and POC to ensuring sustainable performance throughout the winter period liaising closely with IJB partner organisations. • Weekly teleconference with IJBs • Each partnership has trajectories in place to support reduction in DD • Agreed data set to assist with developing a wider capacity plan across all health & social care areas Winter Planning Board has been changed to NHSL UCC Committee and will meet monthly throughout the calendar year. Winter Preparedness will be on the Agenda seasonally, however notable improvements through planning will be embedded as systems to promote sustainable access performance and mitigate risk. This year's process was developed following a 2015/16 winter planning de-brief which is the platform for the next iteration of winter planning during 2016-17 and debrief from winter is planned for May 2017. NHS Lothian achieved 94% performance against the standard for the quarter January-March 2017. The Winter Planning Board was established 2016/17 as NHS Lothian Unscheduled Care Committee to enhance performance as a collaborative response all year round.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Chief Operating Officer (Acting)	To be confirmed	Acute Services Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates/Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3726	2: Improve the quality and safety of health care	Timely Discharges of Inpatients	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	A range of management/governance controls are in place for Unscheduled Care notably: NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings. Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON NHS Lothian's Winter Planning Project Board is now established as the NHSL Unscheduled Care Committee in collaboration with the Integrated Joint Boards Integrated Joint Boards will report via the Deputy Chief Executive to Scottish Government on the delivery of key targets which include Delayed Discharges and actions in response to performance. Delayed discharges are examined and addressed through a range of mechanisms by IJBs which include: • Performance Management. Each Partnership has a trajectory relating to DD performance and these are reported through the Deputy Chief Executive • Oversight of specific programmes established to mitigate this risk for example Edinburgh Flow Board and/or Strategic Plan Programme Board (East Lothian)	Risk reviewed and approved at June 2017 Board Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include: • Criteria led discharge pilots • Downstream hospitals to have admission and discharge quotas similar to main acute sites. • A capacity and demand exercise is being implemented re hours of care at home required across the City of Edinburgh and other councils • Locality based Services (hubs) being developed to support pulling patients out of hospital and promoting prevention of admission and reducing delayed discharges • Evidence Based Daily Dynamic Discharge is rolled out across the whole system in collaboration with Scottish Government Improvement Team • Extending Hospital to Home and HAH capacity • Additional capacity to support weekend discharge (diagnostic, pharmacy, AHPs, transport etc) • Twice daily Teleconference to plan and match transfer of care to right place for patients • Weekly teleconference with the IJB Chief Officers, chaired by WLH&SCP Chief Officer and Deputy Chief Executive • Joint Venture with CEC to create additional models of interim care capacity – Gylemuir/Liberton • Discharge Hubs in the Royal Infirmary of Edinburgh, the Western General Hospital and St John's Hospital • Orthopaedic Pathway Review The Winter Planning Board/ NHS Lothian Unscheduled Care Committee are overseeing the necessary actions in support of sustained performance during the winter period and beyond. Lothian's approved Winter Plan sets out the key requirements in supporting service delivery and access performance during winter and beyond. Actions include: • Development of robust site winter readiness plans • Focus on Capacity and Demand in relation to beds and hours or care requirements • Clear measures in terms of escalation procedures • Counter any demand as a result of the extended 4 day break during the festive period. • Focus on DD and POC liaising with IJB Partner organisations to support patient flow and sustainable performance throughout the winter period. • Agreed Trajectories in place for each partnership and being monitored to support capacity to meet demand • Agreed data set to assist with developing a wider capacity plan that covers all health and social care areas • Further planning capabilities have been enhanced following the 2015/16 winter de-brief process • Health and social Care Partnerships are embracing the Integration agenda and working collaboratively to mitigate risk to patients due to poor performance and have put joint plans in place to support	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 9	Deputy Chief Executive	Director of West Lothian H&SCP/Chief Operating Officer (Acting)	Acute Hospitals Committee in partnership with IJBs

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3829	2: Improve the quality and safety of health care	GP Workforce Sustainability	There is a risk that the Board will be unable to meets its duty to provide access to primary medical services for its population due to increasing population combined with difficulties in recruiting and retaining general practitioners, other staff and premises difficulties (e.g. leases). This may affect: • ability of practices to accept new patients (restricted lists); • patients not being able to register with the practice of their choice; • ability to cover planned or unplanned absence from practice; • ability to safely cover care homes; and difficulties in one practice may impact on neighbouring practices/populations, occur at short notice with the result that practices are unable to provide services in their current form to existing patients; • other parts of the health and social care system e.g. secondary care, referrals, costs As a result of these pressures practices may choose to return their GMS contracts to the NHS Board who may in turn not be able to successfully fill practice vacancies or recruit sufficient medical staff to run the practice under 2c (direct provision) arrangements	Governance and performance monitoring • Regular updates reported to Healthcare Governance Committee • NHS Lothian Board Strategic plan, HSCP primary care transformation plans and reports to Board and Strategic Planning Committee. • Establishment of the Primary Care Investment and Re-design Board which will oversee implementation of local plans and measure associated improvement across NHS Lothian. • The risk is highlighted on all HSCP risk registers with local controls and actions in place and on the East Lothian IJB risk register as host IJB for the Primary Care Contractor Organisation (PCCO) Core prevention and detection controls • PCCO maintain a list of restrictions to identify potential and actual pressures on the system which is shared with HSCPs and taken to the Primary Care Joint Management Group (PCJMG) monthly. • PCJMG review the position monthly with practices experiencing most difficulties to ensure a consistent approach across the HSCPs and advise on contractual implications. • Ability to assign patients to alternative practices through Practitioner Services Division (PSD). • "Buddy practices" through business continuity arrangements can assist with cover for short-term difficulties. Rationale for Adequacy of Controls - remains inadequate as HSCP transformational plans are still at developmental stage and GP retention and recruitment is a national issue (see Medical workforce risk. Risk grading therefore remains very high/20).	Risk reviewed and approved at June 2017 Board • Healthcare governance committee received an update in May 2017 and confirmed limited assurance. An update will be presented to NHS Lothian Board in June 2017. • All HSCPs developing transformational plans for Primary Care based on agreed, joint priorities and a second Lothian-wide Primary Care summit was held on 4 May and reported to May HCG. • NHS Lothian proposed investment of £5m over three years from 2017/18 to address the key pressures are reflected in HSCP integration plans along with the additional national funding in 2017/18 for Primary Care Transformation, funding to increase provision of clinical pharmacist posts in General Practice to provide alternatives to GP consultations for medicines and prescribing related issues. • Further work on GP recruitment including: ➢ Testing the recruitment market (using Google clicks or a social media campaign to identify where GPs might come from before running a more visible, targeted campaign to recruit) ➢ Promotion of Edinburgh and Lothians as good place to work ➢ Provision of local contacts to discuss job opportunities ➢ GP practice recruitment micro site	Inadequate; control is not designed to properly manage the risk and further controls and measures are required.	Very High 20	High 16	Medical Director	Joint Director, East Lothian H&SCP	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3211	2. Improve patient pathways and shift the balance of care	Access to Treatment Risk – Organisation Risk (Previously Achievement of National Waiting Times)	There is a risk that NHS Lothian will fail to achieve waiting times targets for inpatient / day case and outpatient appointments, including the overall Referral To Treatment target, due to a combination of demand significantly exceeding capacity for specific specialties and suboptimal use of available capacity, resulting in compromised patient safety and potential reputational damage.	Governance & performance monitoring • Weekly Acute Services Senior Management Group (SMG) meeting • Monthly Acute Services Senior Management Team meeting- monthly outturn and forecast position • Performance reporting at Corporate Management Team (CMT) • NHS Lothian Board Performance Reporting • Performance Reporting and Assurance to Acute Hospital Committee • Monthly access and Governance Committee, to ensure compliance with Board SOPs relating to waiting times. Core prevention and detection controls • Establishment of the Delivering for Patients Group to monitor performance and work with individual specialties to delivery efficiency improvements against key performance indicators on a quarterly basis • Scope for improvement identified with recommendations made to specialties e.g. target of 10% DNA rate; theatre session used target of 81 %, cancellation rate 8.9%; for every 10 PAs recommendation of 6 DCCs directly attributed to clinic or theatre. Rational for adequacy of controls Some controls are in place and additional controls currently being designed and as such, overall control is inadequate. Controls and actions are now being reviewed quarterly at Acute SMT to ensure any areas of concern are highlighted and actioned. Risk remains high while demand continues to exceed available capacity.	Risk reviewed and approved at June 2017 Board <u>Ongoing Actions</u> • Weekly Acute SMG monitors TTG, RTT, long waits, cancer performance, theatre performance and recovery options on a weekly basis, with monthly deep dives into theatre and cancer performance. • Monthly Acute SMT has sight of Access & Governance minutes, to monitor ongoing actions and escalate as appropriate. • Performance is also reported to, and monitored by, Acute CMT. • Performance is also monitored by the Board and Acute Hospitals Committee, using the Quality & Performance pro forma format. A considerable amount of work is being undertaken by the Performance Reporting team, in conjunction with Acute divisional management, to streamline the pro formas making them easier to use and improving their relevance to the performance improvement process at service level. <u>Additional Actions</u> • Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams (Pre-assessment, HSDU, Booking and Scheduling, Workforce) to improve theatre efficiency. • Establishment of an Outpatient Programme Board that focuses on demand management, clinic optimisation and modernisation. Risk Grade/Rating is Very High/20	Inadequate – control not designed to properly manage risk; further controls required	Very High 20	Medium 4	Deputy Chief Executive	Chief Operating Officer (Acting)	Acute Services Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
4191	2. Improve patient pathways and shift the balance of care	Access to Treatment Risk - Patient	There is a risk that patients will wait longer than described in the relevant national standard due to demand exceeding capacity for in-patient / day case and outpatient services within specific specialties. Clinical risk is identified in two dimensions: 1) the probability that due to length of wait the patient's condition deteriorates; 2) the probability that due to the length of wait significant diagnosis is delayed.	• Service developed trajectories, that are used to monitor performance, early indications of pressures, and opportunities to improve efficiencies/productivity. • A re-invigorated Delivering for Patients (DfP) programme provides a framework for learning and sharing good practice through a programme of quarterly reviews. • New referrals are clinically triaged, a process which categorises patients as Urgent Suspicion of Cancer (USOC), Urgent or Routine. Within each of these categories, patients are triaged into the most appropriate sub-specialty queue, each of which is associated with a different level of clinical risk. • A revised communications strategy has been established to ensure that both patients and referrers are appropriately informed of the length of waits. • If the patient's condition changes, referrals can be escalated by the GP by re-referring under a higher category of urgency. There is an expectation that the GP would communicate this to the patient at the time of re-referral. • Specific controls are in place for patients referred with a suspicion of cancer. Trackers are employed to follow patients through their cancer pathways, with reporting tools and processes in place which trigger action to investigate / escalate if patients are highlighted as potentially breaching their 31-day and / or 62-day targets. Trackers undergo ongoing training, and have access to clear escalation guidance on how to deal with (potential) breachers. Rational for adequacy of controls Some controls are in place and additional controls currently being designed and as such, overall control is inadequate. Controls and actions are now being reviewed quarterly at Acute CMG to ensure any areas of concern are highlighted and actioned. Risk remains high while demand continues to exceed available capacity.	New Risk May 2017. Approved at June 2017 Board. <u>Ongoing Actions</u> • DfP quarterly reviews are supported by more regular meetings with service management teams and clinicians to develop and implement improvement ideas, and to facilitate links to the Outpatients and Theatre improvement programmes. Running action notes are kept at each service meeting, and regularly reviewed by service management teams and the DfP core group. • Significant redesign and improvement work is being undertaken through the Outpatient Programme Board and through the Theatre Improvement Programme Board, to help mitigate some of the increasing waiting time pressures and clinical risks. • Revised communications strategy includes an "added to outpatient waiting list" letter, which informs patients that their referral has been received, and that some service waits are above the 12-week standard. Current waiting times are also published on *RefHelp*, making them available to GPs at the time of referral. It has been agreed (March 2017) that a link to *RefHelp* waiting time information will be included in letters to patients, allowing them to check service waiting times regularly. • Information on the projected length of wait throughout a patient's pathway is communicated clearly to patients at clinical appointments throughout their cancer journey. <u>Additional Actions</u> • There are some ongoing issues with resilience with regard to cross-cover among trackers during periods of absence and / or annual leave and these are being addressed robustly with, in the first instance, an in-depth review of current cancer tracking arrangements. • Executive Medical Director and Interim Chief Officer have developed risk matrix for specialties under waiting time pressures, and will work with NHS Grampian to develop a clinician led framework for risk analysis to help prioritise resources. Risk is very high while demand exceeds available capacity and as such Risk Grade/Rating is Very High/20	Inadequate – control not designed to properly manage risk; further controls required	Very High 20	Medium 4	Deputy Chief Executive	Chief Operating Officer (Acting)	Acute Services Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	There is a risk that learning from complaints and feedback is not effective due to lack of reliable implementation of processes (for management of complaints and feedback) leading to the quality of patient experience being compromised and adverse effect on public confidence and expectation of our services. It is also acknowledged that a number of other corporate risks impact on this risk such as the processes and experience of unscheduled care, patient safety, primary care and waiting times.	<u>Governance and performance monitoring</u> • Routine reporting of complaints and patient experience to every Board meeting • Regular reports to the Healthcare Governance Committee - complaints and patient experience reports. • Additional reports are submitted to the Audit and Risk Committee • Monthly quality and performance reporting arrangements include complaints and patient experience <u>Core prevention and detection</u> • The complaints improvement project board, chaired by the Executive Nurse Director oversees implementation of the new complaints handling model for management and learning from complaints as part of a wider improvement project to improve patient experience • Feedback and improvement quality assurance working group meets monthly, chaired by Non-executive Director and is overseeing implementation of the SPSP action plan • Corporate Management Team and Executive Nurse Directors group review and respond to weekly/monthly reports Complaints management information available on DATIX dashboard at all levels enabling management teams to monitor and take appropriate action. Weekly performance reports on complaints shared with clinical teams. Patient experience data is fed back on a monthly basis at service and site level to inform improvement planning and is available via Tableau Dashboard. Rationale for inadequate controls: Governance processes and improvement plans are in place but yet to be fully implemented.	Risk Reviewed A new complaints handling procedure is in place from 1 April 2017 which introduces a 3-stage approach: 1) front line resolution, 2) Investigation and 3) SPSO. • Complaints Improvement Project Board now in place chaired by the Executive Nurse Director. • Stakeholder engagement from across the organisation seeking feedback on a new delivery model to support the new CHP. • Feedback & Improvement Quality Assurance Working Group meet monthly chaired by Non Executive and has overseen the implementation of SPSO action plan. Further meeting with the new Ombudsman update on progress – 26 July 2017. • Complaints and patient experience reports was given moderate assurance by the HCG committee – Jan '17. • Discussions are being undertaken with independent contractors to explore how new model can be implemented in Primary Care • Ongoing support, training and awareness raising within services to increase confidence and capability in managing complaints • Work ongoing to support the complaints and feedback systems within the 2 prisons encouraging early resolution. • Services are being supported to test a range of approaches including Care Opinion, Tell us 10 things and Care assurance standards • Tell us Ten things questionnaire has been aligned with "5 must dos with me" and is being tested in 3 acute sites with adults, children and young people Risk Grade/Rating reduced from Very High/20 to High/16 Rationale for this – moderate assurance given at March and July HCG committee. Performance improved 11 out of the last 12 months (before the new CHP was implemented). SPSO cases reduced by half – currently 31 (28.06.17) Complaints Improvement Project Board in place. Blended approach to patient feedback (TTT , Care Opinion / CAS)	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Executive Director Nursing, Midwivery & AHP's	Head of Patient Experience	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
1076	2: Improve the quality and safety of health care	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, increased mortality and morbidity and further treatment requirements. There are additional streams of mandatory work from SGHD and HPS being introduced over 2017/18. These include SSI surveillance programmes for Colorectal and Vascular Surgery, increased surveillance time frames and data requirements within existing programmes for CSection and Hip Arthroplasty. In addition following the introduction of ECB surveillance in 2016 this is now to be extended to all Gram Negative Bacteraemia. The MRSA screening programme continues with compliance measured against clinical risk assessment with 24hours of admission. Concerns have been raised re the quality of The electronic data collection for MRSA CRA and this has now commenced manual validation for 4 months until a review of electronic systems can be completed. This has a further impact on resource pressures. Clinical Risk assessment for CPE is being added to surveillance programme and will include areas not previously covered by MRSA protocols eg Maternity services and Paediatric services. CPE key performance indicators are anticipated to be similar to those of MRSA	Development of the NHSL Infection Service, encompassing all specialist clinical/medical, nursing and pharmaceutical aspects of infection continues. The aim is to offer a coherent, clinically excellent and efficient approach to improve the quality of NHSL care of patients with, or at risk of, infection whilst ensuring cost-effectiveness of service by 'delivering more for less'. The integration of services supports the Scottish Governments' 'Vision 2020' that aims to improve the nation's health whilst providing integrated health and social care. The integrated service project board consists of key professional team representatives and these are: Head of Infection Prevention and Control Service, Lead Infection Prevention and Control Nurse, Infection Control Doctor, Senior Consultant Microbiologist and Virologist, Chair Antimicrobial Management Team, Senior Consultant Infectious Diseases. The progress against the plans to expand of the IPCT Geographical Structure to include medical representatives has made limited progress due to lack of appropriately qualified medical personnel. Support is currently still sourced through the current ICD any local projects and developments are on hold until the teams are more reliably established. The single point of contact whilst it is to be tested at WGH the default will be to forward any calls for medical teams to the relevant services duty rooms NHS Lothian Infection Concerns have been escalated to the HAI Executive Lead regards the Local Committees implementation and reliability as a means to deliver the intended clinical ownership The Lothian Acute services and LICAC will be kept appraised of the situation but this also requires to be managed through the Acute Services management team. The NHS Lothian Infection Committee reports to the Board through Healthcare Governance Committee. Lothian Infection Control Advisory Committee receives the reports from the committee along with reports from the public health and environmental aspects. The review of It LICAC's role has been postponed to allow the work to be undertaken in the IJB s and HSCP. In addition to LICAC and local committees, Infection Prevention and Control routinely report at a senior management level to CMG and bi-monthly board papers. A review of CHP Committee has commenced with Edinburgh HSCP and Integrated Joint Board. The aim is to share the work developed there with the other Lothian IJBs and HSCB to develop structured governance and reporting mechanisms for IPC aspects across the Lothian services. A gaps analysis of support to HSCP is being undertaken with the HPT to develop a clearer understanding of current support and gaps in service support. The current 4 geographical regions (Edinburgh North, Edinburgh South, Mid & East and West Lothian) within the Infection Prevention & Control team have responsibility for both acute and NHS Lothian community hospital settings within their remits. Work has commenced to review the structure with the move of RHSC which is the major component of South Region to RIE site. A review of the current workload across the regions is ongoing as the service cannot sustain existing work streams and integrate the new work programmes into business as usual within the current workforce establishment. The HAI Strategy summarises the roles and responsibilities for the various levels across the organisation. This document was approved by the Board and disseminated to the Site Directors and Associate Nurse Directors to inform their Infection Control Committee's work plans. This strategy will be reviewed and updated in 2017/18 Education: • The HAI Education Strategy (Aug 2015) defines the training and education requirements for staff of all disciplines across the organisation. It will next be due for review in August 2017.	Risk Reviewed for period Apr-June 2017: (Normal Quarterly Update, Overall Risk still be reviewed) Risk register has been reviewed and updated. Additional actions have been added to support the introduction of the new work streams which are challenging within current resource availability and demands on service Risk Grade/Rating remains High 16 with the successful achievement of LDP for CDI and the level of current pressures form outbreaks and incidents. However it should be noted that the situation can change at any time	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 4	Medical Director	Head of Infection Control Service	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
			None of these additional work streams are resourced. There is a risk that there will be significant gaps in information and data collated within the SSI as there are challenges within clinical resources who are essential in contributing to the surveillance protocol and data collection. The increased ownership and clinical engagement that was anticipated with the introduction of Local ICC has not been delivered. Local Management teams have chosen to integrate the ICC into other managerial meetings. This has resulted in limited opportunity for management to review performance on HAI related matters or develop any meaningful dialogue for improvement and/or prevention. The implementation of the NHS Lothian Infection Services structure remains a work in progress. Currently medical resources have not permitted allocation of an appropriately experienced or qualified ICD per region. There are suggestions this role can be allocated to Registers rather than Consultants. This could potentially post a clinical risk and could impact on the pressures on the nursing team and the current ICD post holder. In addition it is proposed the single point of contact be implemented but at present there is no clear resource of how this will be manned by the other speciality fields of the service such as AMT, Microbiology and Virology. The plan is to establish the single point of contact and test at WGH. However this has its limitations and could cause confusion with clinical teams.	• HAI education is within Corporate Induction and mandatory update programme. Compliance with mandatory training is undertaken by line managers as part of staff appraisal and personal development plans. Compliance is reported through dashboards giving managers oversight of service and individual compliance. Information is also available to managers in Empower/PWA system. Other packages are available through LearnPro and can be identified as part of staff PDP based on area of work. . IPCT provide reactive education as and when required as an outcome from investigations of incidents. As part of commitment to staff education it is planned IPCT will schedule a minimum of 4 update sessions which will be available to book through Empower/PWA • Following NHS Lothian pilot of the new NES SICEP programme which replaces the Cleanliness Champion Programme NES will commence roll out over the summer of 2017. The update to the education strategy will incorporate the change to the national SIPCEP programme Incidents/Outbreaks: • IPCNs work collaboratively with clinical and non clinical services to communicate risk, support improvement and escalate concerns as appropriate. Risks are identified through a number of routes such as snapshot audits, clinical visits and reviews of patients and HAI SCRIBE for risks associated with building works. Feedback is a combination of immediate verbal feedback, written SBAR and reports. IPCNs are part of local QITs and information on audits and HAI rates are reported to the site infection committees. A Problem Assessment Group (PAG) or Incident Management Team (IMT) is convened to investigate and manage any significant event or outbreak. These teams are supported by the wider multi-disciplinary team and any external stakeholders as appropriate. The Communications Team provide support to manage public release of information as required. • With the exception of 2 Public Holidays (Christmas Day and New Years Day) the Infection Prevention and Control Service provides a single point of contact duty nurse 7 days per week between 0830-1600hrs facilitating access to Infection Prevention and Control advice for clinical teams. Support out with these hours and on the two noted Public Holidays support is available from the duty medical microbiologist/virologist Surveillance: • IT systems are in place to allow IPCNs to monitor incidence, trends and patterns of HAI within their clinical remits. Weekly and Monthly reports with progress made against HEAT Targets are shared with clinical teams and senior management and are widely available on the Intranet. • Enhanced investigation and surveillance is carried out of all SAB , CDI incidences and ECB. ICNet is software surveillance tools which imports positive results and also has an alert set to notify team of increased incidence. An SBAR Report is provided to clinical and senior management teams where 2 or more cases are identified within the same clinical area within a defined timescale. There is also mandatory surveillance undertaken for Surgical Site Infections within Obstetrics for C Sections and Orthopaedics for Hip Arthroplasty. High risk organisms are also monitored through electronic surveillance e.g. MDR and XDRs. In addition to local reporting for SAB/CDI to infection control committees, HCG Committee and Clinical Management Group, mandatory surveillance is also reported to HPS who provide quarterly reports collating information from across Scotland. Increased incidence would instigate a problem assessment group and incident investigation would commence of required						

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			Support to the clinical teams and service deliverables are currently being impacted due to staffing within the service. This is a combination of, the ratio of trainees to trained IPCNs, sickness and absence including 2 staff on Maternity leave. Due to the level of trainees within the service and a reduction in available IPCN numbers there is an increased frequency in weekend working for the remaining staff. This has an impact on their availability for other duties throughout the week. In addition there is an expectation from clinical teams that the IPCT will extend into the HSCP remit as these areas become established. This will further deplete availability of resources	Controls Continued: • A review of the process for case reviews following Incidences where patients have CDI and SAB noted on their death certificate has been completed. These are now part of the DATIX SAE process and are led by clinical and site management teams. • Voluntary surveillance for facture neck of femur surgical site infection was discontinued to release some resources for the new mandatory programmes. However the resource release has had minimal impact as this was light surveillance and the 2 new programmes of Colorectal and Vascular Surgery are full surveillance. Work to develop the data collection is ongoing but is challenging as MDT support is proving difficult to establish. The use of electronic surveillance will capture some aspects but not all the extended components required in the data collection. Following discussions with HPS there will be a year implementation phase where data validation will not mandate all fields. HPS reports will not be published in the first year but will be available to support Boards in sharing information on data collected • Work is ongoing with our external providers for the ICNet software to install an HL7 feed which will help improve real time data available to team Antimicrobial Stewardship: • The Antimicrobial Management Team is responsible for the review and development of the Antimicrobial Prescribing Guidelines. They also provide oversight of antimicrobial use and compliance with guidelines and report findings to clinical teams to help drive improvement. Summary Reports are also provided to Clinical Management Team. Funding for the AMT Audit Nurses is being sourced elsewhere to continue these posts. A work plan and reporting mechanisms for data is being developed Policies and Guideline: • NHS Lothian has adopted the National Infection Prevention and Control Manual and has an ongoing programme of 2 yearly policy and development review for Lothian specific Infection Control policies. • The audits were updated in 2015 to those within the National Manual. Audit results are reported through the patient safety programme QIDs system, allowing clinical areas to directly enter data onto database and obtain reports to monitor own trends and patterns. This is an area of continued focus and improvement to support the clinical teams more effectively in 2017. Decontamination: • There is a Decontamination Steering Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment. This is chaired by the Director of Public Health. An operational group is being established to support local delivery led by Aria Tyrothoulakis Procurement of Equipment: • NHS Lothian's Procurement Strategy in support of the Efficiency and Productivity Programme and the Medical Devices Committee oversee the purchase of procurement and the supply of equipment and medical devices with input from the IPCT. Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE): IPCT, facilities and clinical teams work collaboratively to implement current national standards and guidance in new builds, refurbishments and maintenance programmes. There is a dedicated resource of 1 WTE Band 7 IPCN to support major projects.						

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

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	There is a risk that the availability of medical staffing will not be adequate to provide a safe and sustainable service to all patients because of the inability to recruit and increase in activity resulting in the diverting of available staff to urgent and emergency care. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology	<u>Governance & Performing Monitoring</u> • A report is taken to the Staff Governance Committee when required, providing an update of the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. • A Lothian Workforce Planning & Development Board has been established to coordinate work within all professional groups including the medical workforce. <u>Core prevention and detection controls</u> • Medical workforce risk assessment tool is available and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. • For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group and feed into the national medical workforce planning processes co-ordinated by NES/SG. A recent update paper was taken to the Staff Governance Committee providing a detailed up date and the current risk rating was supported. There was moderate assurance that all reasonable steps are being taken to address the risks.	Risk Reviewed A recent review of trained doctor establishments show significant improvements in recruitment from 2 years ago with an overall establishment gap of 4.3% from 4.9% in March 2015 and is relatively stable. There remain challenges in particular at the St John's site within General Medicine(7.6wte), there also remain gaps. There has however been recruitment to 2wte Ophthalmology posts with successful candidates taking up posts in June/July. Recruitment to 8wte posts to provide additional capacity at both RHSC and St John's sites in line with the recommendations of RCPCH review has been partially successful with 6wte successfully appointed, there remains however 2wte vacancies. For those specialities at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. Vacancies in 'hard to recruit' specialties regularly reviewed and different ways explored of delivering services where there are persistent gaps e.g. psychiatry and paediatrics. Ongoing implementation of risk assessment tools used to inform local workforce plans and solutions which minimise risk and are monitored closely through existing management structures. Risk Grade/Rating remains High/16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Medical Director	Head of Workforce Planning	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3189	3. Secure Value of Financial Sustainability	Facilities Fit for Purpose	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 reported backlog maintenance as at 1st May 2015 and reported in the Property Asset Management Strategy (PAMS) 2015 is now £67.4m which includes a 13% uplift for inflation which has been applied nationally. The PAMS describes the action which will be taken to reduce the figure, which includes estate rationalisation, capital investment and Re-provision projects.. •The financial plan for 2015/16 has allowed for a further £3m BLM allocation for 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 2015/16 has a number of capital projects which will improve the physical condition of the estate and reduce backlog maintenance. •The programme of works will continue to address high and significant risks. The programme continues into the financial year 2015/116. The allocation for this financial £3m has been committed. •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. - Regular updates are provided to the Capital Steering Group and Capital Investment Group •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.	Risk Reviewed for period April-June 2017 (Quarterly Review). To be reviewed. The 2016/17 Programme of works has now been completed and a number of projects completed. The allocation for 2016/17 of £2.5m. The programme of works concentrated on high and significant risk areas including fire precaution works at all sites, mechanical and electrical plant replacement, legionella, HEI, building fabric. The Backlog Maintenance items is currently being reviewed in the Estates Asset Management System (EAMS) which will be used to establish a programme of works for 2017/18 and future years. A review of the current risks and re-categorisation of the risks dependent on use of property, life expectancy of the property is reviewed and updated as required. Scottish Government has now agreed that BLM should not be reported on vacant properties which have been declared surplus. As a result the BLM items highlighted in a number of vacant properties will now be archived. Further surveys have been undertaken at the Western General Hospital, St Michael's and Health Clinics. This information is currently being reviewed by Hard FM and will be uploaded on to EAMS. Further Surveys are currently being undertaken on Edinburgh Community Properties The disposal programme, capital investment projects will contribute in reducing the overall backlog maintenance liability for the Board. The disposal disposal of 15 Craiglea Place, 162 & 163 Craiglea Drive, 151 Morningside Drive and 63 Morningside Drive, were concluded at the end of March 2017 which reduced the BLM exposure. Risk Grade/Rating remains High 16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 4	Deputy Chief Executive	Director of Operations - Facilities	Finance & Resources Committee

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

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3828	3. Improve Quality, Safety and Experience Across the Organisation	Nurse Workforce – Safe Staffing Levels	There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and / or inability to recruit to specific posts, the subsequently high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience.	<u>Governance & Performance Monitoring</u>
				• Two Nursing and Midwifery Workforce meetings are being held (one for in patient areas and one for community nursing) alternate months. These provide a governance structure to monitor progress against agreed actions and through monthly review at the Nurse Directors Committee with Chief Nurses.
				• Safe Staffing Group which reports to Staff Governance Committee.
				
				<u>Core Prevention and Detection Controls</u>
				• Recruitment Group, Safe Staffing and Nursing Workforce Groups to plan requirements
				• The agency embargo remains with every use of agency subject to scrutiny by a senior nurse.
				• Recruitment meetings to oversee the implementation of the recruitment plan are being held monthly
				• Use of tools to ensure safe staffing levels:
				  • A calendar to ensure the annual use of the nationally accredited workload and workforce tools is in place to ascertain required establishment levels
				  • eRostering and SafeCare Live tools are being rolled out to all nursing and midwifery teams, community teams and departments to provide real time information for local decision making around the deployment of the available staffing.
				• Datix reports are escalated on a weekly basis for reports of staffing issues/shortages these are reviewed by the senior management team at the PSEAG. The supplementary staffing and rostering detail is annotated with this information to provide context and enable risk to be understood.
				• Tableau Dashboard in place provides data overview of staffing at all levels.
					Risk Reviewed. For consideration at September 2017 HCG Committee.
					
					<u>UPDATE</u>
					The controls have been updated and are producing sustained results.
					
					The risk, with the exception of District Nursing, is showing a sustained improvement in the establishment gap for 3 successive months. This supports the previous amendment of the likelihood reducing to possible from likely although the impact would remain moderate (until the improvements can be shown to be sustained in the longer term)
					
					<u>ACTIONS</u>
					A new agency supplier is being engaged to supply into the exempt areas of critical care / theatres and PICU where 3/12 block booking is in place pending the national arrangements for bank for critical care and theatres
					
					The infrastructure for the Theatres and Anaesthetics, Critical Care national bank is in place.
					
					Health visiting continues to show an improving picture with an additional 40 being trained in 17/18.
					
					Increased number of trainee District Nurses being engaged (up from 7 to 17) for the specialist practitioner qualification and an alternate modular approach being implemented with 22 candidates on the first cohort
					
					Work is underway to improve the efficiency of the community complex care service for adults, working with the home ventilation team to reduce use of agency nurses.
					
					Use of agency nursing in some areas i.e. critical care, SJH and WGH remain. Vacancies in some areas i.e. community and REAS remain challenging but focused recruitment days are planned.
					
					Draft risk assessment and guidelines for the use of 1:1 specialling are being tested in 4 pilot wards (evidence of reduced reliance on 1:1 in early phase of testing)
					
					iPad minis have been procured to enable RIE site to use full functionality of SafeCare live as a test of change
					
					The eRostering and SafeCare live tools roll out is 60% complete with 256 rosters (6638 nursing staff) actively using eRostering.
					
					Risk Grade/Rating remains: Medium/9
						Satisfactory; controls adequately designed to manage risk and working as intended	Medium 9	Low 2	Executive Director Nursing, Midwivery & AHP's	Assistant Director - Nursing Workforce & Business Support	Healthcare Governance Committee

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3328	2:Improving the Quality and Safety of Healthcare	Roadways / Traffic Management	There is a risk of injury to staff, patients and the public from ineffective traffic management 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.	Risk Reviewed for period April-June 2017. Overall risk still to be reviewed. The Pan Lothian TM Plan is being updated monthly and tabled quarterly at each Heads of Service Meeting. This details the risks, controls and further actions required at each site. Applications have been submitted to extend the TRO at the REH and introduce a TRO at the AAH. Works now completed on both sites. Awaiting confirmation of the date for the TRO to be introduced The resurfacing of car park P at St John's Hospital (main visitors car park) is now complete and operational and has assisted with the implementation of traffic management controls. Additional works being considered for 2017/18. Works completed at the WGH to address the high risk items identified by the Traffic Management Group. – that is the alterations of the road network at Turner House. Cycle paths now completed on site. Traffic Management works are underway at Whitburn Health Centre. Works also completed at Liberton Hospital, PAEP and Midlothian Community Hospital. Additional works at St John's and WGH are being considered for funding in 2017/18. It has been agreed that Consort will undertake a traffic management audit on the RIE site. 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	Deputy Chief Executive	Director of Operations - Facilities	Staff Governance Committee

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1.4

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9:30 on Wednesday 12 July 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr M. Hill, Non-Executive Board Member (Chair); Ms S. Goldsmith, Director of Finance; Ms L. Williams, Non-Executive Board Member; Mr P. Murray, Non-Executive Board Member; Miss T. Gillies, Medical Director.

In Attendance Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Chief Officer, Acute Services; Mr I. Graham, Director of Capital Planning and Projects; Mr M Egan, Director of eHealth; Dr M. Gillies, Associate Medical Director Intensive Care (for item 16.5); Mr A McCreadie, Head Of Management Accounts; Mr P. McLoughlin, Strategic Programme Manager (for item 16.4) Ms Katie McWilliam (for item 10) and Miss L Baird, Committee Administrator (Minutes).

Apologies for absence were received from Professor A McMahon; Professor A McCallum; Ms K Blair and Mr D Small.

Declaration of Financial and Non-Financial Interest

The Chair invited members to declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. No such declarations were made.

10. Extension to Ferryfield House Contract

10.1 The Chair welcomed Ms McWilliam to the meeting.

10.2 Ms McWilliam provided a detailed verbal update laying out the current position and the proposed next steps. At the last meeting of the Finance and Resources Committee, Members agreed in principal to extend the lease for Ferryfield House for a period of 10 years with the option to break the lease without penalty at 5 years however Ms McWilliams would continue to pursue the option to buy.

10.3 The results of the IJB bed capacity exercise had determined that 3 additional beds were required to meet the demand, bringing the total number of beds required to 3203 going forward. Aspirations would focus on moving the bed base from a majority in hospital settings to a majority within care homes. Ms McWilliam drew the Committee's attention to 5 care homes that require to be replaced in the immediate future, thereby increasing the number of additional beds required to meet capacity to 332 from the previous stated 3. She noted the capital implications associated in replacing these beds and would explore options that would best fit the needs and demands of the service.

10.4 At present the Council market share was between 15-18%; there was potential to alter the market rate and bring forward creative commissioning opportunities, however this would rely heavily on capital from both the Council and NHS Lothian. Going forward land opportunities in RVH, REH, Stenhouse Market Gardens and Teaching and Research and Council land opportunities remained on the table if an adjustment to the market rate was not viable.

10.5 Ms McWilliam advised that the risk to unscheduled and scheduled care would be significant if the 60 beds at Ferryfield House were removed from the system. At present the land had been valued at £2.5 Million and the budget required for the service was £14 Million over 10 years.

10.6 Members agreed that this matter should be looked at in a wider context by the IJB and the Strategic Planning Committee in the first instance to develop a strategy and options appraisal. Once complete the options appraisal should be brought to Finance and Resources Committee to consider the funding. Timescales proposed were August for Strategic Planning Committee and September for Finance & Resources Committee.

10.7 Mr Murray raised concerns surrounding the potential for profiteering by the owners of Ferryfield House, and how that compares to other providers in a bid to ensure that a precedent was not set and the Board was restricted moving forward. Ms McWilliams advised that there was a national contract for care homes provided through COSLA and the Council operates a rigorous policy to obtain best value balanced with quality. She noted however that there were negotiations to address issues surrounding the skill mix required to support the changing population and how this would be factored into the future contracts.

10.8 The Chair thanked Ms McWilliam for her verbal update and she left the meeting.

11. Minutes from Previous Meeting (10 May 2017)

11.1 The minutes from the meeting held on 10 May 2017 were approved as a correct record.

12. Running Action Note

12.1 Members agreed that all matters arising were on the agenda with the exception of the Musselburgh Health Centre. The Chair requested that this action be removed from the note as the original action was unclear.

13. Matters Arising

13.1 Members Annual Report – Mrs Goldsmith advised that the report had been brought back for noting following the incorporation of comments from Ms Blair. The report had gone to the Audit and Risk Committee and was reviewed as part of the summary of assurance.

13.1.1 Members noted the Members Annual Report.

13.2 Disposal of RHSC at Sciennes – Mr Graham gave a verbal update on the disposal of the RHSC at Sciennes. He advised that since the previous meeting the first community right to buy application had been rejected. Although progress had been made to finalise the sale with the preferred bidder, to the extent that 10 points had been raised of which 8 were met immediately and 2 would have been addressed within 2 days, the sale had once again been put on hold. On 28 June 2017 Scottish Government informed NHS Lothian that a second community right to buy had been lodged.

13.2.1 Members expressed frustration at the timing of the late application, resulting in a further delay to the disposal of the site and the potential costs incurred by retaining the site during this period. Mr Graham assured the Committee that the incurred cost and concerns had been relayed to Scottish Government; the preferred bidder was aware of the timescales and remained interested, as did a few other parties. It was anticipated that the response from Scottish Government would be between 30 and 52 days.

13.2.2 The Committee noted the position to date.

14. Action Plan from Members' Workshop (including IJB Governance and including Terms of Reference)

14.1 Mrs Goldsmith introduced the action plan on financial planning linked to the Board's Corporate Objectives and Risk Register and ran through the process of development following the Members' Workshop. Members agreed it was essential that the action plan be shared with the Chairs of the IJBs to ensure that they were informed before work commenced, specifically on how they inform the Board and how in turn the Board informs the IJBs. She anticipated that the financial plan would be brought forward for consideration in September.

14.2 Mr Murray welcomed the report however he raised concerns that action 4 did not accurately describe the function of the corporate risk register and underplays its role in the organisation. Mrs Goldsmith agreed to address the wording so that it was fit for purpose.

SG

14.3 The Chair took Members through each action and Committee agreed to:-

- Consider the first draft of the NHS Lothian financial plan for the following financial year at its September meeting.
- Prepare a forward work plan for the Finance & Resources Committee for the Committee to approve. Including a clear schedule of business to be considered at each meeting, taking into account the specific issues included within this action plan.
- Adopt the standard levels of assurance and ensure that all appropriate reports recommend a level of assurance to the committee.
- Review the 2017/18 Financial Plan to determine whether what was approved matched the Board's strategies and objectives at that time; allowance would need to be made for essential one off cases that may not align with Boards top objectives or

Scottish Government targets, but provided significant benefit to patients and the service. Feed the learning points from this into the 2018/19 financial planning cycle.

- Ask NHS Lothian Finance Directorate to ensure that appropriate guidance, including financial planning assumptions were shared with IJBs so that they could share their financial plans for each Integration Joint Board by September 2017.

- Convene 6-monthly meetings between the Chair of the NHS Lothian Finance & Resources Committee and the corresponding Lead Member from each of the four Integration Joint Boards with the first meeting being in advance of September Finance and Resources Committee, if possible.

- To consider further what the governance oversight of the system of performance management would involve.

- A range of deliverable options with regard to what NHS Lothian can do to help the Integration Joint Boards account for the use of their resources be identified and shared.

- Define a process by which the Integration Joint Boards are assured by the NHS Board on the use of their resources, as they relate to set-aside functions and hosted services.

14.4 The Committee noted the next steps and the need for assistance of the Integrated Joint Boards in the delivery of the plan.

14.5 Members agreed it was essential that the action plan be continuously reviewed to ensure that it remained fit for purpose at the beginning for 2018.

Mr Crombie entered the meeting.

15. Financial Performance

15.1 Finance Update as at Month 3 - Mrs Goldsmith advised that Month 1 had closed on Friday and apologised for tabling a report at such short notice. At close the financial plan 2017/18 had reported a £22 Million shortfall in achieving financial balance. Committee Members were advised that following a review of 16/17 year end and slippage on other commitments the forecast shortfall had been revised to £13 Million. At period 3 NHS Lothian had overspent £0.9 Million bringing the year-to date overspend to £5.7 Million.

15.1.1 It was noted that medical staffing and nursing remained key factors of pay overspend; Acute SMT continued to monitor the situation and discuss how to drive down expenditure and agency costs due to sickness absence. The key factors of non-pay related to medical supplies, GP prescribing, drugs and legacy LRP. This would be reviewed regularly and improvements made reflected in future reports.

15.1.2 This year the finance team would take a different approach to LRP, creating credit for which each service area which would have to close the gap within the year. At present

there was a 7 million gap in efficiencies within the system and progress to drive down the gap remained slow.

15.1.3 Arrangements were in place to cover GP prescribing budget for 2017/18 outcome, to date the budget was overspent £1.2 Million. An additional £2.6 Million against prescribing was noted.

15.1.4 Next steps would focus on Q1 review and monitoring the position thereafter. Mrs Goldsmith would meet with Key Service Leads in August 2017 to discuss forecast, reality in light of the Q1 review and if necessary discuss what actions were required to mitigate further overspend and achieve year-end financial balance. Members agreed that it was essential at these meetings that the finance team was explicit in their expectations of improvement and actions required to make change. It was anticipated that an update on the financial position would be brought forward for consideration in September.

SG

15.1.5 Mr Murray noted the Nurse Rota introduction and previous claims that it would reduce spend and questioned whether benefit had been seen from its implementation. Ms Campbell advised that she couldn't answer the question in detail without checking the data. She agreed to liaise with Fiona Ireland and bring an update to a future meeting. It was noted that a site recruitment event had taken place and all vacant posts had now been filled.

JC

15.1.6 Mr Murray questioned to what extent savings had been influenced by variance analysis. In response Mrs Goldsmith advised that variation was at the very early stages, in the long term there would be sight of the effect of variation playing into financial recovery. Similarly, in the case of the improvement projects ongoing in Lothian, it would take time to see the benefit in the recovery plans. Mrs Goldsmith proposed that the September update include an update on variation.

15.1.7 The Committee discussed the challenges related to the release of NRAC funding and how this would be used to address the gap in funding. Mr Crombie advised Members present that the Chief Executive would continue to vigorously pursue NRAC funding with the Scottish Government on behalf of the Board.

15.1.8 The Committee took only a limited level of assurance from the verbal and tabled update on the financial position as at Month 3 (subject to the correction)

15.2 Developing a Longer Term Financial Strategy – Update – Mrs Goldsmith introduced the report that updated the Committee on the analysis undertaken on the 5 year outlook. She highlighted that from the analysis undertaken if uplifts and pay policies were maintained the Board would require a 20% reduction in acute sector to achieve financial balance. Though Corporate Services spend would be explored, expenditure within these services was not sufficient. Work to look at reducing the footprint of the estate would also be explored. A full discussion on these matters would be taken to the Chairs' and Chief Executives' groups.

15.2.1 Members agreed that the paper should be further developed and taken to a joint Finance & Resources Committee and Strategic Planning Committee workshop for fuller

discussion. Members proposed that key members of the Integrated Joint Boards also be invited to participate as they would be essential in identifying and delivering solutions. It was proposed that the action plan and documents from Tayside also be adapted to support discussions at the Workshop. Mrs Goldsmith agreed to take this action forward with Professor McMahon. The Chair requested that the date for the workshop maximises attendance to get a full and broad collaboration from F&R, SPC and the IJBs.

SG/AMcM

15.2.2 Members debated the best structure for the discussions at the workshop and the way forward. Members agreed that the direction of travel should include both a detailed timeline of the journey and a strategic plan that has real world aspiration noting what was mandatory and areas where there may be discretion.

15.2.3 Miss Gillies drew the Committee's attention to increasing pressures from new medicines. At present there was a gap of £44 Million across Scotland and that would only increase. Colleagues in Lothian and across Scotland continue to monitor and forecast trends but Members should be mindful of the increasing pressure.

15.2.4 The Committee agreed to take limited assurance from the report. Members noted the revised financial analysis and endorsed a broader discussion at the Strategic Planning Committee about the Board's priorities in light of the analysis.

Mr Egan entered the meeting.

15.3 Finance Corporate Risk – Members noted the report that considered the financial risk on the risk register.

15.3.1 The Committee agreed to accept the revision to the Corporate Finance Risk, number 3600 and reached the conclusion on the level of assurance gained by the corporate finance risk statement. Further to the recommendations from the Audit and Risk Committee, the Corporate Finance Risk *'The scale or quality of the Board's services was reduced in the future due to failure to respond to the financial challenge'*, detailed in appendix 1 was reviewed.

15.3.2 The Committee accepted a limited level of assurance from the report.

15.4 Payment Verification Protocols in Primary Care – Members noted that the report provided sight of the revision to the Payments Verification Protocols issued by Scottish Government in May 2017.

15.4.1 The Committee agreed to:

- Accept the report as assurance that the Directors Letter DL (2017)11 had been distributed to the Audit and Risk Committee.
- Take assurance that a system of post Payment Verification had been undertaken by Practitioner Services Division (PSD) in line with the Partnership Agreement, PV protocols in Directors Letter DL (2017)11 and that PV Managers confirm payments made to family health services practitioners (General Medical Practitioners, General Dental Practitioners, Community Pharmacists and Optometrists) were in line with relevant regulations.

- Take assurance that payments were being made to family health services practitioners, as detailed contractors as agreed at the quarterly meetings.

Mr McLoughlin entered the meeting.

16. Property and Asset Management Investment Programme 2017/18

16.1 Property and Asset Management Strategy 2017 – Mr Graham gave a detailed presentation on the Property and Asset Strategy. The Chair thanked Mr Graham for his presentation noting that there was a clear handle on property and asset management.

16.1.1 Mr Graham summarised the points of interest drawing the committee's attention to:

- The requirement against the Board to make an annual submission to Scottish Government of its property and asset management strategy.
- The submission of the interim update in the previous year and forthcoming state of NHS Scotland Assets and Facilities report.
- The two part submission comprising statistics from the asset groups and facilities areas; to include assets such as Medical equipment, vehicles, and IT as well as property.
- The use of PAMS as a reference point and benchmark for future business plans, to ensure that they link with Local Delivery Plan through the capital plan and strategies.
- The executive summary detailed at Appendix 1.

16.1.2 In light of the two sites currently compromised by PPI involvement, it was clear to the Members present that future investment at the Western General Hospital and St. John's Hospital sites would require capital funding.

16.1.3 The Committee considered the presentation on the key items from the PAMS and agreed to approve the formal submission of the PAMS for 2017 to Scottish Government.

16.2 Property and Asset Management Investment Programme – Mrs Goldsmith introduced the paper highlighting that the purpose of the report was to update the Committee on the status of PAMS and seek approval for further supplemental agreements with Consort.

16.2.1 Mr Graham spoke to the previously circulated paper and highlighted the following points of interest:

- Royal Hospital for Sick Children and Department of Neurosciences – increased risk to the timely completion and mitigation timetables, potential disputes between the Board and IHSL, pressure for derogation schedules, change documentation and the request for approval of the draft minutes detailed at Appendix 2 including delegating authority to the Chief Executive and Director of Finance in signing off the necessary documentation.
- Bangour Village Hospital – 9 offers had been received, lower than previous rounds however no bid had been received from the previous bidder. Due diligence would be followed before bringing offers forward for consideration. Work to progress the sale

would continue in a bid to mitigate future security and estates costs and ultimately relieve some financial pressure with the disposal of the property.

- East Lothian Community Hospital - dialogue with council and health and social care partnership would continue on Herdmanflat and Hopetoun Unit relating to the planned transfer of land and housing development to meet local demand. Other options and interests had also been noted.
- Primary Care Estate – a funded national survey of GP premises had commenced enabling premises to bring forward issues. Mr Murray requested that this be a key issue and proposed that there should be a long term sustainability strategy for primary care. He felt that this should be a matter for public consultation as maintenance needs to be linked to population and need.

16.2.2 Mr Murray requested that where NHS Lothian had not entered into a contractual arrangement, it be explicitly recorded within the detail of the paper. Mrs Goldsmith and Mr Graham agreed to bring forward a frame of assurance in future reports.

SG/IG

16.2.3 The Committee noted the progress to date against the agreed 2017/18 investment programme and the current progress of the disposal programme.

16.2.4 The Committee agreed to incorporated schemes approved but not yet funded or contractually committed into the priorisation process.

16.2.5 Members agreed to approve the minute for the completion of the supplemental agreement amendment associated with RHSC/ DCN and Consort. They delegated completion of this and related documentation to the Chief Executive and the Director of Finance.

16.3 Property and Asset Management Investment Programme 2017/18 Business Case Monitor – The Committee noted the progress and performance to date of each of the projects and associated key risks and issues.

16.4 Cancer Centre Update and Initial Agreement Haematology – Mr McLoughlin spoke to the report. He noted three key Areas of improvement required were upgrades to the radiotherapy bunkers, essential upgrades to pharmacy and to develop a fit for purpose Oncology Assessment Area. £10 Million capital contribution for enabling projects had been designated for NHS Lothian by Scottish Government; formal confirmation of the funding was anticipated in the near future.

16.4.1 Members anticipated that a full business case would be brought forward for consideration in September but remained mindful that the proposed level of funding, £10 Million would not be sufficient to address all areas prioritised. It was anticipated, however, that with the approval of the Haematology Initial Agreement and proposed joint procurement processes with the NHS Greater Glasgow and Clyde, some of the financial pressure would be mitigated.

16.4.2 Mr Mcloughlin noted that the attached initial agreement for Haematology would increase capacity and significantly change following a charitable donation of £11 Million to the service that will cover the capital costs for the project.

16.4.3 The Committee were assured from the information provided that the Haematology Initial agreement was a good opportunity that should be seized and would provide benefit not only to the haematology service but to neighbouring services and future projects within the Edinburgh Cancer Centre.

16.4.4 The Committee agreed to:

- Note the progress with the scoping of the Cancer Centre re-provision project team and support the development of the project team to engage with stakeholders and potential charities as part of the development of the business case.
- Note progress with the Linear Accelerator Business Case.
- Approve the Haematology Initial Agreement and delegate to the Director of Finance the completion of the deed of Grant and investment in design development in line with outline Initial agreement.

16.5 Clinical Information System Critical Care NHS Lothian Initial Agreement – Dr Gillies advised the Committee that The Royal Infirmary provided one of the largest Critical care Departments in Scotland and with the addition of DCN increasing capacity by 50%, it was imperative to have a clinical information system to improve the efficiency and effective management of the flow and storage of patient data; precedent for such a system had already been provided within Neonate and Paeds and other NHS Boards in Scotland.

16.5.1 Members discussed the importance of the system being able to communicate with the current systems in place; a stand-alone or medical device based system would not be acceptable.

16.5.2 Costings had been explored and were detailed in the paper for both the interim system at the RIE and then a full roll out to other sites.

16.5.3 Mr Egan was confident that eHealth would be able to support a clinical information system if it was similar to those already within NHS Lothian, and the framework to deliver and implement the system was robust. He was explicit in the inability to support this if it was considered to be a medical device.

16.5.4 Further work was required to identify and implement appropriate governance arrangements for the system. The unit should draw attention to the benefits of such as system and how it will improve efficiency and patient safety within the unit. **JCam**

16.5.5 The Committee noted the clinical argument for the providing the CIS in Critical Care and its inclusion in the eHealth Strategy 2015-17.

16.5.6 The Committee noted that the Lothian Capital Investment Group had supported an initial agreement in June 2017 with the expectation that further recommendations as described in the paper were addressed in an outline Business Case.

16.5.7 The Committee agreed to support the procurement and installation of An ICU Clinical Information System on the RIE Site, thereafter rolling out to other sites in Lothian, as and when finances and infrastructure allow.

16.5.8 The Committee supported the development of a business case and full options appraisal.

17. Any Other Competent Business

17.1 There were no other items of competent business for consideration.

18. Date of Next Meeting

18.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 20 September 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

18.2 Further meetings would take place on the following dates in 2017:

- Wednesday 15 November 2017

DRAFT

NHS LOTHIAN

1.5

STAFF GOVERNANCE COMMITTEE

Minutes of a Meeting of the Staff Governance Committee held at 9:30am on Wednesday 26 July 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs A Mitchell (Chair); Mr B Houston; Mr A Joyce; Mr J Oates; Ms H Fitzgerald; Mr S McLaughlin; Mrs J Butler and Professor A McMahon.

In Attendance:
Dr J Corcoran Chief Nurse, Clinical Education & Training (Item 16.1); Mr J Smith, Senior Project Manager (Item 16.2); Mr G Curley, Director of Operations – Facilities (Item 17.2); Mr S Haddow (iMatter Operational Lead) (Item 18.1); Ms A Langsley (Interim Head of Corporate Education & Employee Development, Item 18.4); Mr D Richardson (Lead Health & Safety Adviser); Ms J Campbell (Chief Operating Officer) and Mr C Graham (Board Secretariat).

Apologies for Absence were received from Mr T Davison; Mr J Crombie; Mrs R Kelly; Miss T Gillies and Dr A Leckie.

Declaration of Financial and Non-Financial Interest

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

14. Minutes of the Previous Meeting

14.1 The Minutes and Action Note of the Staff Governance Committee Meeting held on 31 May 2017 were approved as a correct record.

15. Matters Arising

15.1 Staff Governance Arrangements for the IJB's – West Lothian Response – It was noted that the action to write to the IJB had been undertaken. A response was still awaited and Mrs Butler would follow this up if not received shortly.

JB

16. Presentations

16.1 Career Framework for Nurses - Dr Corcoran spoke to the handout detailing the NHS Lothian Education/Career development pathway for Nursing and Midwifery, Bands 2 to 7. The pathway gave a clear idea of what was available within nursing and midwifery and showed different ways and access points for joining nursing; with career progression and covered mandatory training requirements. There was discussion on band 2 healthcare support workers' learning needs; clinical skills for all bands; the pathway to advance practitioner level and internal training programmes.

16.1.1 The Chair asked how it could be ensured that staff were aware of the full range of opportunities available. Dr Corcoran stated that the information was available on HR Online and within job descriptions. Mrs Butler asked if there was a link to the personal development planning process. Dr Corcoran replied that this could be done and the access points included.

16.1.2 Mr Joyce stated that this was a good document outlining the journey but wondered how seamless the journey was, particularly around band 4 nurse training. Dr Corcoran assured the Committee that the process should be seamless and the training was running with both full time and part time nurses with a low dropout rate.

16.1.3 Ms Campbell asked if the framework was used in recruitment campaigns. Dr Corcoran confirmed that a recruitment leaflet had been produced and more work around encouraging people into the organisation would take place.

16.1.4 There was discussion on options for reaching out other than relying on traditional recruitment methods; this included the option of having personal stories online. Mrs Butler added that this had been done for modern apprentices but could be built on. Professor McMahon advised that having previous students telling their personal stories at recruitment days had proved to be inspirational.

AMcM/JCam

16.1.5 The Chair thanked Dr Corcoran for reporting to the Committee. The Committee felt that this was a very powerful piece of work and an excellent document to build from.

16.2 Workforce Redesign – Mr Smith gave a presentation covering workforce redesign. The presentation looked at Outpatients Nursing and the WGH Main Theatre Nursing:

16.2.1 Outpatients Nursing - Mr Smith reported that the project had looked at 14 different teams, previously developed in isolation. The teams had been brought together and there were issues around widespread variation in ways of working and differences in staff competencies of those on the same grade; this had led to a lack of flexibility and resentment amongst colleagues. Other challenges included sickness absence, waiting lists and a lack of money. The redesign also considered the band 5's role and looked at Process Mapping service; clinic type and pathway function. The project had also used Time to Care to consider how capacity could be freed up and how roles could be expanded and advanced. The aim was to build a capable and sustainable workforce within a healthy organisational culture.

16.2.2 WGH Main Theatre Nursing – The challenges involved with the theatres project had included cultures and behaviours; staff moral; high staff turn-over causing an inability to build up skill mix; high absence rates and agency usage. In relation to staff experience a questionnaire had been undertaken and this had showed that only 4% of staff had a current personal development plan. This made staff experience a key area for improvement; this was achieved by inviting feedback through a monthly newsletter, regular team meetings and everyone having a current personal development plan. One of the early benefits of the project was a significant reduction in agency usage.

16.2.3 There was discussion on tests of change to look at freeing up band 5 capacity to address waiting lists; opportunities to address service demands and service flexibility. Mr Smith also highlighted issues around staff engagement and sensitivities as the project had progressed. Mr Joyce stated that staff side were fully supportive of this work whilst recognising that some areas required to be handled sensitively. The Committee agreed that this work complemented the ongoing work which Dr Corcoran was undertaking.

16.2.4 Mr Houston asked how the areas selected for the project had been chosen. Mr Smith stated that there had been several meetings to select the areas and the areas had been selected as they were in the right place to engage; for other areas this had not been the right time. Ms Campbell added that this was a pan outpatient project which was starting out in a small scale. The modern outpatient programme would be coming in and would change the demand profile.

16.2.5 The Chair thanked Mr Smith for his presentation.

17. Assurance and Scrutiny

17.1 3828 – Nurse Workforce – Safe Staffing Levels Risk Transfer - The Committee agreed that this risk was more appropriate sitting with Staff Governance and agreed to transferring over this risk from the Healthcare Governance Committee.

17.2 3328 – Roadways/Traffic Management - Mr Curley introduced the paper outlining the progress on managing the risks associated with roadways and traffic management. There was discussion on the ongoing significant planning; capital allocation; engineered road solutions; maintaining of safety and assurance levels and the investment programme. Mr Curley pointed out that the moderate assurance level would be unlikely to change this year unless there was significant investment to resolve issues. It was recognised that there was always competition for funding with clinical priorities and other service enhancements.

17.2.1 Mr Curley reported that there had been two issues on the RIE site in the last 12 months and two issues at WGH and St John's. There was further discussion on risk assessments; traffic management plans for each site; investment plans and rolling programmes; driver training and the reporting and review of RIDDORS. The Committee noted that RIDDORS were reported to the Health and Safety Committee on a quarterly basis. There was full visibility of any significant change or alteration to policy/procedure due to a RIDDOR.

17.2.2 Ms Fitzgerald asked about compliance legislation management and ignorance of guidance. Mr Curley explained that an NHS Lothian level 1 policy would apply to every stakeholder and was not just a NHS Lothian control measure. Where the policy was not sufficient to ensure control a suite of documents had been developed to support managers and help demonstrate assurance. This cannot be applied to patients or visitors but can be applied to the NHS Lothian supply chain.

17.2.3 Mr Curley stated that risks on the RIE site had been acknowledged and that the new dynamics of the site had increased activity. Consequently a traffic management consultant had been engaged to conduct a fitness for purpose audit which would report in October.

17.2.4 The Chair thanked Mr Curley for his update and the Committee accepted the recommended Moderate Assurance level.

Mr Curley left the meeting.

17.3 3455 – Management of Violence and Aggression - The Chair stated that the paper did not give the information that had been required. Speaking on behalf of Miss Gillies, Mrs Butler explained that the risk around management of violence and aggression had been on the risk register for a few years now and remained a high risk. The Medical Director had commissioned a review of the management of violence and aggression and this was being undertaken by Dr Alastair Leckie (Director LOHS). Issues around violence and aggression included high reporting of incidents; poor specification of level of harm; a lack of apparent organisational learning and a low uptake of training sessions.

17.3.1 The Committee noted that Dr Leckie had produced an initial report, however the wider governance piece on the end to end management of violence and aggression needs to be better reflected and more focus on approaching the investigation of incidents was necessary; the organisation learning was also fundamental. Mrs Butler confirmed that the Medical Director would bring a report to the October Staff Governance Committee meeting which would include recommendations on how best to move forward with improving the management of violence and aggression.

TG

17.4 3527 – Medical Workforce Sustainability - Speaking on behalf of Miss Gillies, Mrs Butler reported that following on from the paper at the March meeting, it was important for the Staff Governance Committee to understand that workforce planning of medical staff does not change quickly at national level. The Committee noted that training grade medical staff recruitment is at a UK or Scottish level for substantive posts and locums for service are recruited to by individual boards for any gaps unfilled after two rounds of recruitment. Currently there were 16 such vacancies from a total of 1034 training posts, with no one speciality in particular being adversely affected.

17.4.1 Other changes noted since March were:

- Successful recruitment to 34 Clinical Development Fellow posts
- 8 posts identified at consultant level for paediatrics in West Lothian, 6 of these had been recruited to, 2 being actively recruited to.

17.4.2 The Committee noted that the level of risk had not changed since the March update and agreed to maintain the Moderate Level of Assurance proposed.

17.5 Staff Governance Workplan – 2017/18 - The Committee approved the updated Staff Governance Workplan for 2017/18.

17.6 Staff Governance Assurance Statement - The Committee confirmed the Statement of Assurance which had been updated following the meeting on 31 May 2017. It was noted that future statements would be populated by mapping across the workplan timelines and highlighting issues discussed at each meeting. The Chair thanked those involved for their work to get the workplan and statement to the current stage.

18. Healthy Organisational Culture

18.1 iMatter Update - Mr Haddow reported the good news story that as of 24 July the final team confirmations had been added to the iMatter system meaning that all staff (24,000) were registered. There was also discussion on the promising Health and Social Care Partnerships response rates. This meant that the Stage 1 Implementation Plan was now complete with everyone checked in. Work had now moved on to developing review cycle times as the system would not be able to handle everyone undertaking iMatter surveys at the same time. Mr Haddow stated that there was likely

to be three runs of the system, meaning by the end of summer all staff would have answered a questionnaire with a full report available by the end of the calendar year.

18.1.1 The Committee discussed the key performance indicators; team and directorate EEI scores; team sizes and structures; conversion rates from reports to action plans and any proposed changes to the design of the iMatter process. Mr Haddow stated that the process itself had not changed as this was nationally driven.

18.1.2 The Committee noted that the Staff Engagement Experience Programme Board would allow the sharing of iMatter experiences as an opportunity for teams to learn from each other.

18.1.3 There was also discussion around scrutiny and the signing off of achievements. Mr Haddow clarified that teams scrutinized themselves and this would most likely be reflected in next year's EEI scores. After 5 years' worth of data the system would be able to give EEI score trend information which would help future learning.

18.1.4 Finally the Committee recognised the great achievements being made within Estates and Facilities to raise the response rate to 54% from the previous national staff survey response rate of 18%. Whilst this was a huge improvement it remained short of the 60% mark which would produce a directorate report.

18.1.5 The Committee agreed to the Significant Assurance recommended.

Mr Haddow left the meeting.

18.2 Whistleblowing Monitoring Report - The Chair reported that she had agreed with Mr Oates that he would introduce this paper in future recognising the Chair's role as Whistleblowing Champion.

18.2.1 Mrs Butler stated that since the last Staff Governance Committee meeting training sessions had been held and there were training dates now available through to March 2018. After March there would be evaluation to determine if ongoing training was required.

18.2.2 The monitoring data for the period October 2016 to 14 July 2017 was noted and there was discussion on the Whistleblowing v Grievance Checklist which was currently with Human Resources for discussion but should be in place by the end of August 2017.

18.2.3 The Committee also considered the format of the proposed Whistleblowing update paper for the October NHS Lothian Board meeting. The Committee approved the format of the proposed report and agreed to the Moderate Assurance proposed in the paper.

18.3 Health and Safety Update - The Committee welcomed the paper providing an update on work ongoing to reform the Health and Safety Committee. Mr Richardson reported that three sub-committees were being considered to look at different risk aspects – Patient Safety; Staff Safety and Workplace, Transport & Contractors Safety.

18.3.1 Mr Richardson added that in relation to RIDDOR statistics, reporting timescales had increased dramatically however investigations into adverse events remained a challenge. Mr Richardson hoped to provide further assurance on this at the next Staff Governance Committee meeting. The Committee noted that the Medical Director's intention was for the Health and Safety Committee to mirror Staff Governance and to challenge the integrated agenda.

TG

18.3.2 The Chair thanked Mr Richardson for a very comprehensive paper which helped the Committee satisfy its assurance requirements. It was hoped to see assurance from the health and safety workplan coming through from October. The Committee noted that no minutes from the previous Health and Safety Committee had been provided and no visibility was an issue as the minutes contributed towards the assurance structure. Miss Gillies to take steps to resolve.

TG

Mr Richardson left the meeting.

18.4 Fire Safety – Mandatory Training Compliance - Ms Langsley reported that the mandatory compliance level at the end of May 2017 had been 77.1% and at the end of June this had risen to 78.6%, this was an encouraging shift. It was noted that there had been a 6.5% compliance increase within Facilities and this had been attributed to the DVD roll out.

18.4.1 Ms Langsley also reported on the recent staff consultation around fire safety training. There had been 600 responses and the themes had been consistent for example – the availability of practical training; location of training and duplication of training. The management actions around fire safety training had been based on the feedback received. It was planned to begin implementation of the management actions from August 2017 to January 2018.

18.4.2 There would be more work required on certain sites and locations along with continued work with the Fire Safety Team to look at compliance outliers

18.4.3 The Committee agreed to accept the Moderate Assurance recommended and noted that the management actions continued to improve and sustain compliance.

Ms Langsley left the meeting.

19. Sustainable Workforce

19.1 Workforce Report - Mrs Butler introduced the standard report which had now been altered as requested at the last meeting. Mrs Butler reported that the next two areas of mandatory training in which performance would be reviewed would be Health Associated Infection and Public Protection.

19.1.1 The Committee noted that overall KSF performance remained poor at 44.6%; however the Committee commended the work of the West Lothian Health and Social Care Partnership in achieving 91% against KSF performance and the work of facilities to reach 63%.

19.1.2 Mrs Butler stated that the national eKSF system licence would run out in March 2018 and as yet there was no HR System to replace it, the NES Turas cloud- based system was being suggested and considered. Further information would come to the October Committee meeting.

JB

19.2 Safe Staffing Levels - Professor McMahon stated that this report carried over the themes from the previous presentations from Dr Corcoran and Mr Smith. The report gave an update on the national policy direction for safe staffing legislation to be enacted by April 2019 and the local actions that are in place to ensure safe staffing levels. There were a number of workstreams set out in the paper which were to make sure that staffing levels were safe and staff being utilised appropriately. The Committee noted that safe staffing was a SNP manifesto commitment.

19.2.1 Professor McMahon reported that a national group had now been established and he, Mrs Butler and Ms Jane Anderson (Unison) were all members. A Lothian group had also been set up to meet after the national group. Professor McMahon was representing Nurse Directors nationally and Mrs Butler representing HR Directors nationally.

19.2.2 There was discussion on site-specific recruitment; training and skill mix. Professor McMahon pointed out that it was anticipated that Boards would be left to individually work out safe staffing numbers but that the workforce tools could be used to give a baseline to work with.

19.2.3 The Chair stated that there appeared to be a huge raft of initiatives and asked about the timeframe and how the Committee could be assured regarding what progress these initiatives had achieved and how they were being rolled out.

19.2.4 Professor McMahon replied that eRostering was 60% complete and that the learning being gained as this progressed was being used together with tableau workforce dashboards to allow users to see overall establishment, vacancies and annual leave and could be used for planning and managing teams effectively.

19.2.5 Mrs Butler added that from the national context the first national workforce plan demonstrates that nursing demand would exceed supply until 2021 and the challenges associated with this and the urgent need to develop new roles and workforce models must not be underestimated.

19.2.6 There was further discussion on the registered workforce working to the top of their licence; optimal skill mix; entry points for training; Scottish Government training places and IJB engagement.

19.2.7 The Chair reminded the Committee that the paper related to safe staffing and asked what had changed in terms of risk since the last review in October 2016. Professor McMahon confirmed that all initiatives were new since last June and that these were being looked at forensically with service colleagues and married up with other intelligence such as Datix data. Moving forward the data would develop in terms of acuity and could start to be measured.

19.2.8 The Committee agreed to significant assurance that NHS Lothian is well placed to influence the legislation as it is developed and has an infrastructure in place to support the implementation of the safe staffing legislation. The Committee also agreed to take moderate assurance that the current actions within Lothian are providing areas with a range of data to inform decision making around safe and effective staffing and enable the optimum deployment of the staffing resource. It was noted that data and metrics would be required the next time the update came to the Committee for discussion.

Dr Corcoran and Mr Smith left the meeting.

20. Capable Workforce

20.1 Medical Education and GMC Visit – On behalf of Miss Gillies, Mrs Butler reported that this would be the first of regular reports on the quality and provision of medical education for undergraduates and postgraduates in NHS Lothian, with a particular emphasis on the attainment or otherwise of the standards set by the GMC before their visit in October 2017.

20.1.1 Mrs Butler informed the Committee that the recent Board Development Session had been led by the Medical Director and medical education team and had focussed on the GMC visit and the areas to be visited - Paediatrics, General Medicine and Medicine of Old Age.

20.1.2 In preparation for the visit each of these specialties had provided a self assessment and GAP analysis as detailed within the received papers. The Committee noted that this was the first time this was being presented formally for governance discussion.

20.1.3 It was agreed that regular reports should come to the Committee moving forward and that the flow diagram needed to include the Staff Governance Committee. Mrs Butler would feed this back to the Medical Director.

JB/TG

20.2 NMC Visit to Edinburgh Napier University – Professor McMahon reported that the NMC would be undertaking its first formal visit to Edinburgh Napier University in November. A report on the output from the visit would come to the January 2018 Staff Governance Committee meeting.

AMcM

21. Effective Leadership and Management

21.1 Executive Management Leadership and Talent Management in NHS Scotland - Mrs Butler reported on the current ongoing national level discussions in relation to Executive Level Leadership and Talent Management in NHS Scotland. Mrs Butler also outlined local developments in relation to the progress with a Leadership and Management Framework.

21.2 Mrs Butler reassured colleagues that the Board's Remuneration Committee were sighted on this work and the revised arrangements which would come into effect for the 2018/19 Performance round following testing in other NHS Board. The Remuneration Committee had also noted that any wider issues as a consequence of these new arrangements had been remitted to the Staff Governance Committee to decide what if any information would be required to be transmitted to the wider Board.

21.3 There was discussion on the tight timescales around this work and the very high level plan for delivery. Mr Houston stated that there appeared to be high risk around this. Mrs Butler advised that Scottish Government colleagues were committed to the actions and timelines as outlined. However NHS Lothian's actions against the Everyone Matters 2017/18 Action Plan would be dictated by the rate of progress nationally.

21.4 Mrs Butler confirmed that the Leadership and Management Framework would come to the October meeting.

JB

22. For Information and Noting

22.1 The Committee noted the following items:

- Minutes of the Lothian Partnership Forum held on 29 May 2017
- Minutes of the Staff Engagement and Experience Project Board held on 7 June 2017
- Minutes of the Workforce Planning and Development Programme Board held on 29 May 2017
- National Workforce Plan (Executive Summary) Full Report Here

23. Any Other Business

23.1 EU Citizens Working in NHS Scotland – Scottish Government Guidance – The Committee discussed the correspondence received from the Scottish Government. It was acknowledged that the University of Edinburgh had invested a large amount of funding into managing the response to Europe and Brexit. Also many consultants within NHS Lothian work alongside academic colleagues.

23.1.1 Mrs Butler reported that the HR team was in the process of developing its own web pages relating to EU Citizens' information; this would include signposting to legal advice. Mrs Butler added that NHS Lothian planned to undertake an internal communications piece to encourage EU citizens employed by NHS Lothian to register using a central email address in order that any policy or other advice issued by the Scottish or UK Governments could be communicated directly. Mr Joyce suggested that the website information should also signpost to Trade Union contact as well.

24. Date of Next Meeting

24.1 It was noted that the next meeting of the committee would be held on Wednesday 25 October 2017 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

NHS LOTHIAN

1.6

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 9.00 am on Monday, 28 August 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr M Ash (**MA**) (Chair), Non-Executive Board Member; Ms C. Hirst (**CH**), Non-Executive Board Member; Mr P. Murray (**PM**), Non-Executive Board Member; and Ms Kay Blair (**KB**), Non-Executive Member.

In Attendance: Ms J. Bennett (**JBenn**), Associate Director for Quality Improvement and Safety; Ms J Brown (**JBr**), Chief Internal Auditor; Mr C Bruce (**CB**), Lead on Equalities and Human Rights; Mr D Eardley (**DE**), Scott Moncrieff; Ms S. Goldsmith (**SG**), Director of Finance; Professor A McCallum (**AKM**), Director of Public Health and Health Policy; Mr C. Marriott (**CM**), Deputy Director of Finance; Mr J. Old (**JO**), Financial Controller; Mr A. Payne (**AP**), Corporate Governance Manager; Ms L. Baird (**LB**), Committee Administrator;

The Chair reminded Members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Nobody declared an interest.

19. Minutes of the Previous Meeting held on 19 June 2017

19.1 The minutes of the meeting held on 19 June 2017 were accepted as an accurate record of the meeting.

20. Running Action Note

20.1 NHS Lothian Corporate Risk Register– Members noted that the matter remained ongoing therefore the due date would be amended accordingly. A review of the risk register was underway and Ms Bennett anticipated that this would be complete by October and an update brought forward to the December meeting.

20.2 Acute Hospitals Committee Annual Report 2016/17 - Ms Blair proposed opening the discussion to the whole group, recognising the role that IJBs has on the functions and services which the Acute Hospitals Committee oversees, and the need for the IJBs and the Acute Hospitals Committee to have effective working relationships at the Acute Hospitals Committee on 29 August 2017. Once views were collated a response would be brought to the Audit and Risk Committee in December.

20.3 Lessons Learnt - Members agreed to pick this matter up under item 6.1 on the agenda, Update on Ensuring the Right Thing Happens in Practice.

20.4 Write-off of Research and Development 2016/17 & Schedule of Losses – SFR 18.0 – For those actions due but remain ongoing the Chair requested that future updates should clearly state when an update will be given.. He requested that Ms Goldsmith provide a report on these matters for the December meeting. **SG**

20.5 The Committee accepted the update on the actions detailed within the Running Action Note.

21. Risk Management (Assurance)

21.1 NHS Lothian Corporate Risk Register

21.1.1 Ms Bennett highlighted that the review and the workshop would focus on ensuring that there was a consistent mechanism in place across the Governance Committees to provide assurance that the risks within their remit were in line and supported the delivery of the Corporate Objectives. She commented that to date risks have not been explicitly identified from consideration of the Board's corporate objectives. The session may lead to identifying risks associated with the health of the population and quality which have not previously been so prominent. After some discussion Members agreed that to maximise resources it would be sensible to draw all strains of risk together and consider extending the remit of the workshop to include other Governance Committees.

21.1.2 Mr Murray drew the Committees attention to risk 3829 related to GP workforce sustainability and the forthcoming internal audit on workforce sustainability and questioned whether the scope would cover general practice.

21.1.3 Ms Brown commented that internal audit were planning to look at workforce, however they would like to narrow down the scope of the exercise rather than do some high level report.

21.1.4 Mr Murray referred to the risk on GP workforce sustainability, and highlighted that he had concerns that the Board has a strategic workforce challenge which presents itself in a variety of areas. He would like the issue to have more prominence than it has to date, and have the same level of understanding and assurance as is the case for the strategic financial risk. Mrs Goldsmith advised that a workforce strategy is being developed.

21.1.5 Members agreed that given the recent and continued publication of staffing issues within the NHS it would be prudent to get assurance that the Staff Governance Committee were sighted on the matter.

21.1.6 The Committee agreed to refer the matter to the Staff Governance Committee. Mr Payne would liaise with Ms Butler, Director of Human Resources and Organisational Development and Mr Ash would liaise with his counterpart on the Staff Governance Committee to ensure that she was sighted on the Committee's concerns. **AP/MA**

21.1.7 Mr Murray acknowledged the progress made against the harm free care risk and achieving 99.9%. Members agreed that more positive work should be brought forward instead of merely highlighting the negatives.

21.1.8 Mr Murray referred to the risk on unscheduled care (4-hour performance) (Risk 3203), and commented that the description of the controls in place does not change. Ms Bennett explained that this risk is under review, and acknowledge that it is not clear at the moment what is a control and what is an update. She highlighted that it is important that this risk links into the work which the integration joint boards are taking forward. Ms Bennett explained that a mapping exercise has been done across IJBs on the work to tackle the GP sustainability risk, however a similar exercise has not yet been done on the 4-hour target.

21.1.9 Members agreed that there was a needed to formally define the lines of communication between the integration joint boards and the Audit and Risk Committee, specifically who was providing assurance, to whom and when. It was agreed that Ms Bennett would seek the views of the Chief Officers and the Chairs to inform discussions and consider a way forward on 2nd October. **JBenn**

Mr Bruce Entered the meeting.

21.1.10 Ms Hirst noted the positive changes within the documentation in respect of language reflecting the focus of the actual risk however she still had reservations surrounding the title of the management of deteriorating patient's risk. Ms Bennett advised that there had been extensive discussion at Healthcare Governance Committee and agreed to pick this matter up at their next meeting. **JBenn**

Mr Old entered the meeting.

21.1.11 The Committee agreed that it would be good if the Board had a development session on risk in early 2018, and the Chair asked Mrs Goldsmith to confirm that a date has been set. **SG**

21.1.12 The Chair advised the Committee shall have new members soon. A half day session is being organised for the Committee to have a preliminary discussion on risk, however the chairs of other committees and officers will be invited to attend.

21.1.13 The Chair commented that for the risks that are consistently red, we should be examining options as to how they are presented on the risk register and monitored.

21.1.14 The Audit & Risk Committee agreed to:

- Acknowledge the corporate risks are undergoing review to improve the expression of risk, controls and actions.

- Accept significant assurance that the Corporate Risk Register contains all appropriate risks.

- Accept that as a system of control, the Governance committees of the Board have confirmed they are assessing the levels of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

22. Counter Fraud (Assurance)

22.1 Counter Fraud Activity – Mr Old presented the report which highlighted that there were 3 open referrals and 3 open operations as at 4 August 2017.

22.1.2 The Committee accepted the report.

Mr Old left the meeting.

23. Internal Audit (Assurance)

23.1 Internal audit Progress Report (August 2017) – Ms Brown gave an overview of the report. She highlighted plans to make use of graduates to fill the gap created by sickness absence in the short term and future plans to utilise the graduate programme and apprenticeships to address staffing issues. Mrs Goldsmith advised that the Chief Executive had set a challenge to consider how a regional finance function could operate. Mr Marriot and Ms Brown would continue to explore all options and provide assurance to the Audit and Risk Committee that the resources available to the Internal Audit Team were sufficient to discharge their duties and fulfil the internal audit plan.

23.1.1 Ms Brown gave a brief overview of performance in respect of the KPIs, highlighting that:

- Draft terms of reference – 2 out of 6 were agreed at 3 weeks however this had not impacted the delivery of the review.
- The target for close out meetings had been met on 2 out of 4 occasions due to annual leave and the team remained focused on improving this.
- 3 out of 4 draft reports were issued within 15 working days after completing the fieldwork, and the team would continue to focus on this.

Ms Hirst requested that the notes column remain as it supported the understanding of the percentages detailed within the report.

23.1.2 Ms Brown drew attention to a proposed revised reporting format for internal audit, which aims to align internal audit reports with the assurance levels being used in the Board's system of governance. Following a query from the Chair, Ms Brown agreed to ensure that it was clear that each finding had a corresponding management action. **JBr**

23.1.3 Mr Murray questioned the circumstances in which some audits had been re-scoped. Mr Brown advised that some audits are cyclical and others prioritised by risk. For each year the internal auditors consider the risk register and discuss the areas with the relevant director, to ensure that the audit is focused on the right priorities rather than doing an audit which nominally falls in that director's area of responsibility. Ms Brown confirmed that she presents the proposed audit plan to the Corporate Management Team to ensure that all audits remain in line with the Boards interests and were the best use of Internal Audit resource . Mr Murray commented that he was very interested in the scoping of the audit of the quality programme, in light of the level of resource being deployed in that area.

23.1.5 Ms Hirst proposed that there should be some consideration of the quality of communications across the primary and secondary sectors, and in between departments, highlighting that it was a common theme within complaints. There was agreement that communication was key and needs to be looked at by the subject was vast and scope would need to be narrowed. Mrs Goldsmith agreed to consider communication in the development of the 2018/19 audit plan. **SG**

23.1.6 The Committee agreed to accept the report.

23.2 Reports with Green Ratings (August 2017) – Ms Brown went through each of the audit with green ratings highlighting the key issues and provided assurance that she was content with the management response provided.

23.2.1 Members noted the positive audit of the Hospital Laundry and agreed that the positive outcome should be feedback to the service. The Committee agreed that good work should be recognised when it was seen. Mrs Goldsmith agreed to refer this to the Deputy Chief Executive. **SG**

23.2.2 Members questioned the green rating against the Property Transaction Monitoring audit given the inconsistent application of process across all areas of the organisation. Internal Audit was assured by the processes that were in place and the management response therefore the finding was categorised as minor.

23.2.3 Members agreed that it was essential that all reports related to the integration joint boards should be shared with their own audit committees.

23.2.4 With regard to the audit on Performance Targets and Reporting (IJBs) the Committee agreed that this was an area which required further work. Most of the measures are determined by the Scottish Government, rather than being locally developed. The Chair reminded the members that the integration scheme set out responsibilities for both the Board and the Councils to provide the integration joint boards with performance information . Members noted that this matter would be picked up under the work which the Deputy Chief Executive is leading.

23.2.5 The Committee accepted the Internal Audit Report on Reports with Green Ratings (August 2017).

23.3 Equality and Diversity (August 2017) – Ms Brown gave a brief overview of the report noting the key findings.

23.3.1 Mr Bruce advised the Committee that the agreed actions will be completed on time. He added that focussing on legal compliance is not a particularly effective way to go forward. The focus should be on outcomes, and trying to help people to do what they want to do better.

23.3.2 Members noted that it was disappointing that the completion of integrated impact assessments had decreased year on year. The committee supported the identification of a new process and training that did not add further burden to the organisation. It was agreed that the approach to training should mirror the development of policies and recognise how training would be implemented and applied in all areas of the organisation.

23.3.3 Members attention was drawn to the impact assessment previously circulated by Margaret Douglas as a useful background on Equality and Diversity matters. Mr Bruce agreed to circulate it to the group for their information if required.

23.3.4 Ms Brown advised that the report and management response was encouraging and reflected the work being done. She was reassured by the management actions.

23.3.5 Members agreed to accept the report on Equality and Diversity (August 2017).

Mr Bruce left the meeting.

23.4 Internal Audit Follow-up (August 2017) - since the previous report of June 2017 24 actions had been closed off. Ms Brown was mindful that there were a few long terms actions outstanding however she noted that with process of review new actions would be produced and added regularly therefore there would always be outstanding actions. She was comfortable with progress made and would continue to pursue the closure of long term actions.

23.4.1 The Committee agreed to accept the report.

24. General Corporate Governance (Assurance)

24.1 Update on Ensuring the Right Thing Happens in Practice – Mr Payne gave a brief overview of the scheduled update summarising the progress to date. He noted that this was a long term process, encouraging the development of policies and procedures with proper consideration as to how they will be implemented in practice. .

24.1.1. Professor McCallum commented that there are opportunities to use implementation science, and not continuing with methods which we know do not work. The challenge is how we get assurance that new working practices are indeed working.

24.1.2 Ms Bennett added that “the what” and “the why” is covered in policy. It is essential to test in practice the procedures, which cover “the how”. All policies need to be implemented flexibly with due regard to the operational circumstances.

24.1.3 Mr Murray commented that the Board needs to get a proper understanding as to what it involves to put in place a robust infrastructure that would support the effective implementation of policies and procedures.

24.1.4 Ms Hirst commented that there is limited accountability for policies not being implemented. She added that managers have a crucial role to play to ensure that employees are effectively aware of the material that is pertinent to their roles. There should not be a simple expectation that all employees should have the knowledge, and it does require deliberate measures to make this so. Ms Hirst stated that “top-down” techniques do not work, it has to be done from the bottom up..

24.1.5 Ms Bennett advised that the point about testing things in practice is in the new Procedure for Developing Policies & Procedures. However there needs to be an infrastructure to support that testing.

24.1.6 The Committee noted that the Healthcare Governance Committee will be considering a report on the subject. The Chair requested that an update be brought back to the Audit and Risk Committee in the spring of 2018. **AP**

24.1.7 The Committee accepted the report.

25. Date of Next Meeting

25.1 The next meeting of the Audit and Risk Committee would take place at **9.00** on **Monday 4 December 2017** in **Meeting Room 7, Second Floor, Waverley Gate**.

DRAFT

1.7

STRATEGIC PLANNING COMMITTEE

Minutes of the meeting of the Strategic Planning Committee held at 9.30 on Thursday 10 August 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr B. Houston, Board Chairman (chair); Mr M. Ash, Non-Executive Board Member; Mr T. Davison, Chief Executive; Ms T. Gillies, Medical Director; Ms S. Goldsmith, Director of Finance; Ms F. Ireland, Non-Executive Board Member; Mr A. Joyce, Employee Director, Non-Executive Board Member; Professor A. McCallum, Director of Public Health; Professor Alex McMahon, Nurse Director; Mr P. Murray, Non-Executive Board Member; Professor M. Whyte, Non-Executive Board Member.

In Attendance: Ms J. Anderson, Partnership Representative; Mr C. Briggs, Director, Strategic Planning; Ms J. Butler, Director of Human Resources; Dr A. Kirolos, Specialty Registrar in Public Health Medicine; Mr R. McCulloch-Graham, Chief Officer, Edinburgh Health and Social Care Partnership; Ms E. McHugh, Chief Officer, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes).

Apologies: Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr M. Hill, Non-Executive Board Member.

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

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

1. Minutes and Actions from Previous Meeting (8 June 2017)

1.1 The minutes from the meeting held on 8 June 2017 were approved as a correct record.

2. The People's Health

2.1 Harm Reduction

2.1.1 A paper had been previously circulated and Dr Kirolos gave a presentation. The Committee welcomed the focus on this vulnerable group. Ms McHugh suggested that looking at the whole system including community services would be the best way to maximise resources, and that there was a role for public health to help Integration Joint Boards to understand this population cohort to inform policy and strategy in all the Lothian areas, not just Edinburgh. Dr Kirolos noted that although the report was focussed on Edinburgh, the results were likely to apply to all Lothian areas.

2.1.2 There was discussion of what NHS Lothian could do to influence a preventative approach focussing on root causes of harm from drug use. Part of this was related to

the Child Commissioner's work on reducing adverse childhood experiences such as trauma, poverty and neglect. Prevention for adults included support with social relationships and employment. Professor McCallum agreed to come back to the Committee with more information on these preventative approaches at the next meeting. **AMcC**

2.1.3 It was noted that the collection of data on patients at risk of harm was not yet robust enough for alerts on TRAK to be added so that professionals could ask the right questions and arrange for HIV testing, but the team was working towards this.

2.1.4 It was suggested that each Integration Joint Board should receive a similar paper and have a focussed discussion in this area. The Councils also had the ability to input preventative work as they were involved at points of crisis: admission to hospital, prison, social services, housing, education, homecare and criminal justice. If systems of support were built up then clinicians would be more able to engage and aske the appropriate questions or make the appropriate referrals. The results of the IJB discussions would be brought back to the Committee in 6 months' time. **IJB reps**

2.1.5 The impact of reduced funding in this area would be increased length of stay and increased number of admissions. Ways to reverse this and implement the reduced funding model were being considered.

2.1.6 It was noted that Hepatitis C prevalence and drug related deaths had increased in recent years and that there had been a HIV outbreak in Glasgow. Many factors affected this increase in addition to NHS services for instance a change in government benefits making the population more volatile, and a rise in homelessness.

2.1.7 Members accepted the recommendations laid out in the paper.

2.2 Edinburgh Children's Services Plan

2.2.1 Professor McMahon gave a verbal update. The Edinburgh Children's Services Plan had not yet been signed off by the City of Edinburgh Council. Once approved, the plan would be submitted to the Scottish Government and this Committee would then receive it for information in October 2017. **AMcM**

3. Integration

3.1 Integration Joint Board Directions

3.1.1 Mr Briggs advised that the Integration Joint Boards had done a lot of work and there had been good examples of them making instructions specific to their own needs. The Edinburgh IJB directions were not yet completed but a lot of work had been done; they had been approved by the Edinburgh Integration Joint Board Strategic Planning Group and would be submitted to the Edinburgh IJB on 11 August 2017.

3.1.2 An update on implementation of directions would be given at the next Midlothian IJB and this could also be submitted to this Committee. IJBs would also be publishing annual reports soon.

3.1.3 There was discussion about ensuring that strategic plans of the IJBs and the Health Boards were compatible with one another. For example NHS Lothian's strategic plan was to have handed over Liberton by March 2018 but Edinburgh IJB's plan was now for September 2018 which would cause greater expense to NHS Lothian as it would continue providing the service for Edinburgh after the other IJBs had moved out. Decisions must be pragmatic and negotiated between all parties.

3.1.4 Mr Davison noted that NHS Lothian had delegated commissioning of services to IJBs but had retained the responsibility and the risk. Midlothian and East Lothian IJBs had made plans to move out of Liberton based on their community hospitals, the existing Midlothian Community Hospital and the East Lothian Community Hospital which was in progress, but Edinburgh had not yet commissioned its community hospital although NHS Lothian has made land available for this. Mr Davison made it clear that the Edinburgh Integration Joint Board needed to finalise its commissioning plan as a matter of urgency.

3.1.5 Mr McCulloch-Graham agreed that the new hospital needed to be commissioned, but added that there must be an interim solution for Edinburgh as any new hospital would take years to build.

3.1.6 A more formal comparison between the different strategic plans was suggested but it was noted that there was a link between IJB members who were also non executive members of the Board. It was noted that all IJB plans were built on the NHS plan but that there needed to be constant discussion. There were many areas where the IJBs and NHS Lothian worked well together but some areas for improvement. There were processes in place but an underlying shared vision was needed. There was frequent discussion between IJB chief officers and the NHS Lothian executive team at monthly Corporate Management Team meetings.

4. Lothian Hospitals Plan

4.1 <u>Fragile Services</u>

4.1.1 Mr Briggs gave a presentation on services which were fragile due to small numbers of patients and staff with suggested process for assessing such services and solving any problems. It was suggested that an annual paper on fragile services be submitted to the Committee including a list of services considered fragile and actions on resolving any problems.

4.1.2 The Committee welcomed the approach laid out and suggested that similar criteria be applied when starting new services which may be fragile. It was noted that clinical education should be considered as one of the criteria when deciding whether to continue or start a new service, to prevent trainees needing to leave Scotland to complete certain training.

4.1.3 It was noted that there were currently a number of ways to make decisions about services and in individual cases this could include discussion with the Scottish Government and with the National Services Division, but all Boards were looking to establish a more formal process.

4.1.4 There also needed to be discussion of this process nationally so that the full national picture for services was understood. The National Planning Forum was previously a forum for such discussions but this part of its remit had been changed; there needed to be a push for a return of this level of planning.

4.1.5 Members approved the recommendations laid out with the addition that new services would also be considered, and that educational aspects would be included in the criteria. The paper would be submitted to the Corporate Management Team before being brought back to the Strategic Planning Committee in its final form.

5. Pan Lothian Business

5.1 NHS Lothian Strategic Financial Plan

5.1.1 Mr Briggs gave a presentation. A paper had been presented at the Finance and Resources Committee which showed that the financial trend for the next five years would require removing resource from Acute services as GP and primary care resources were protected by the Scottish Government for the Integration Joint Boards. Due to the financial gap, the current system was unsustainable and a decision on priorities needed to be made. There needed to be a wider strategy on how to make decisions before a financial plan could be made.

5.1.2 Mr Houston suggested that in order to make real changes there needed to be a forum for discussion at a highly abstract level for overall vision; either the Strategic Planning Committee or a different forum. The challenges experienced should shape the overall vision, but the focus should not be on solving individual problems but for envisaging an overall solution. There needed to be a change from considering how much services cost to provide to considering what services can be provided with the resources available. There needed to be a way to resolve short term insolvency in order to have time to make transformational change.

5.1.3 Ms Goldsmith added that there needed to be a practical understanding of some changes that have been agreed; it had been agreed that the balance of care should be shifted to primary care but it was not clear what sustainable primary care looked like, what different workforce would be required, and what the costs would be. A direction was needed to enable this change.

5.1.4 Changes could be made incrementally starting with the easy and obvious. Suggested changes could be categorised by degree of risk and degree of positive impact, allowing the risk appetite to be determined.

5.1.4 The group planning and overseeing these changes needed external input from operational staff, council staff, and NHS staff. There could also be input from those who had been involved in transformational change in other organisations. Partner agencies also needed to be engaged for a whole system approach; NHS services could not be separated from social care, housing, employment, etc. Partnership representatives and patient representatives would also be required to ensure a clear and transparent process and prevent political barriers to change.

5.1.5 Mr Davison noted that the policy environment was incoherent. Over half of NHS Lothian's budget was protected for Integration Joint Boards and further funds were protected for specific areas of acute care. Costs were increasing about 7-8% annually due to inflationary pressures on payroll, new drugs prescribing, and increasing population. Annual uplift was 1%. Savings had to be made from non ring-fenced funding. Funding allocations needed to be made more coherently, for instance not spending money on meeting waiting times targets when whole system changes were required to improve the situation, and not spending £8 million on new drugs unless there was further funding. Spend needed to be based on overall priorities.

5.1.6 Mr Briggs would draft a design of the 'futures group' following individual discussions with members of the Committee. **CB**

6. Regional Planning

6.1 A number of specialities had been identified where regional diagnostic and treatment services could resolve workforce issues and improve resilience. These regional services were expected to use resources in a different way which would be more efficient, but would not make savings.

6.2 This would mean that services would be delegated both down to Integration Joint Boards and up to regional specialties so that keeping local agendas and coherent whole system agenda would become more challenging.

6.3 Finance, Human Resources and Communications were 'in scope' for considerations of how these services could be provided regionally. These could release 20-20% of staff to save £3 million, but impact on the fiscal situation would be marginal. There had also been tentative agreement between all Health Boards, Integration Joint Boards and Councils to look at regional planning for diabetes prevention and treatment. Regional leads would be appointed for Finance, Human Resources and Communications but single regional finance directors had not been recommended because this would be incompatible with the unchanged governance structures.

7. Date of Next Meeting

7.1 The next meeting of this group would take place at **9.30** on **Thursday 12 October 2017** in **Meeting Room 7**, second floor, Waverley Gate.

7.2 A further meetings in 2017 would take place on the following date:
- Thursday 14 December 2017.

NHS LOTHIAN

1.8

ACUTE HOSPITALS COMMITTEE

Minutes of the meeting of the Acute Hospitals Committee held at 14:00 on Tuesday 29 August 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms K. Blair, Non Executive Board Member (chair); Ms T. Gillies, Medical Director; Ms F. Ireland, Non Executive Board Member; Mr A. Joyce, Employee Director, Non Executive Board Member; Ms A. Mitchell, Non Executive Board Member; Ms J. Oates, Non Executive Board Member.

In Attendance: Ms S. Ballard-Smith, Nurse Director, Acute Services; Ms J. Campbell, Chief Officer, Acute Services; Ms M. Carr, Director of Diagnostics, Anaesthetics and Critical Care; Mr B. Currie, Project Director, Royal Hospital for Sick Children / Department of Clinical Neurosciences Re-provision (item 4.3); Dr E. Doyle, Associate Divisional Medical Director (items 4.2 and 5.1); Mr A. Jackson, Associate Director, Strategic Planning; Ms R. Kelly, Associate Director of Human Resources; Mr R. Mackie, Senior Information Analyst; Mr C. Marriott, Deputy Director of Finance; Ms F. Mitchell, Site Director, Royal Hospital for Sick Children (items 4.2 and 5.1); Dr N. Maran, SPSP Clinical Lead (item 3.2); Ms B. Pillath, Committee Administrator (minutes); Mr A. Tyrothoulakis, Site Director, St John's Hospital.

Apologies: Professor A. McMahon, Nurse Director; Ms M. Whyte, Non Executive Board Member; Mr B. Cook, Medical Director, Acute Services.

Chair's Welcome and Introductions

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

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

1. Minutes from Previous Meeting (29 August 2017)

1.1 The minutes from the previous meeting were approved as a correct record subject to one amendment to paragraph 2.1.10.

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

2. Fiscal Governance

2.1 Quarter 1 Financial Performance

2.1.1 Mr Marriott gave a presentation which would be circulated around Members. Ms Gillies noted that due to a policy shift by the Scottish Government expensive medicines not approved by the Scottish Medicines Consortium, including ultra-

orphans would be expected to be made available to patients. Exceptionality could not be used including in cases where the medicine had not been approved by the Scottish Medicines Consortium due to lack of cost effectiveness. The cost of ultra-orphans was high with some at approximately £800,000 per course.

2.1.2 Mr Marriott noted that Boards not accepting non recurrent funding for specific areas unless there would be a benefit, and advising the Scottish Government that Boards could not afford to follow Scottish Government guidance unless corresponding funding was given as the uplift of 1% per year did not cover the annual real increase in spend to keep services running. All Boards were in a similar position.

2.1.3 Ms Ireland noted that freezing vacancies made a short term saving but was not beneficial in the long term as it would take years to recover and would increase agency spend. When staff numbers had previously been reduced they had later had to be replaced. It would be better to reduce agency spend, and targets were in place for this.

2.1.4 Ms Campbell noted that £12 million of NHS Lothian's budget was spent per year on reducing waiting times with no extra funds provided by the Scottish Government to meet the targets it had set. If this resource was not put into reducing waiting times there would be 40,000 patients breaching the treatment time guarantee.

3. Performance Assurance

3.1 Diagnostics

3.1.1 A paper had been previously circulated and Mr Tyrothoulakis gave a presentation. The extension of use of the Faecal Calprotectin (FCP) test by GPs to patients already on the waiting list as well as new patients was working well and allowed some patients to be taken off the waiting list resulting in a 300 per month reduction in GI outpatient appointments.

3.1.2 There was a regional endoscopy unit which was not being used to its full capacity; there was a need to expand the criteria for patients treated there. This would be discussed at the regional planning chief executives group at the end of September 2017.

3.1.3 There had been some improvements in other areas and Mr Tyrothoulakis was optimistic about further improvement.

3.1.4 Ms Campbell noted that the level of external provider capacity required had not been found this year as fluctuating use of the service had meant the companies had reduced staff levels. National capacity would be procured instead. The companies in question provided staff that used NHS Lothian facilities at weekends to carry out procedures. A longer term strategy for use of external providers would make more sense but this was dependent on government announcements of non-recurrent spending which were not given in advance.

3.1.5 Members accepted the recommendations laid out in the paper and accepted limited assurance as systems of control and improvement programmes were in place.

3.2 Deteriorating Patients including Cardiac Arrest

3.2.1 The Chair welcomed Dr Maran to the meeting and she spoke to the previously circulated paper. The review was carried out at the request of the Healthcare Governance Committee to ensure that as much as possible was being done to reduce the small number of cardiac arrests in hospital. There would be a focus on the biggest group of patients experiencing cardiac arrests, who were those were intervention may not be appropriate. The previous focus had been on the smaller numbers of deteriorating patients where the risk of cardiac could have been recognised sooner.

3.2.2 In response to a question about the reliability of the data used for the evaluation, Ms Gillies advised that this was data for improvement and not data for performance. Clinicians were asked to record information at a local level on all cardiac arrests. The data needed to be used locally but also be aggregated to system level so that learning could be shared. Dr Maran added that in areas with only small numbers of cardiac arrests it could be difficult to recognise themes locally, so aggregated data was required.

3.2.3 In response to a question about driving actions for improvement, Ms Gillies advised that currently the anticipatory care plan could not be separated from clinical governance and care of patients. More work was needed to ensure actions were being taken and the groups of patients identified were separated out in terms of the response required: one group needed escalation to a higher level of care; the second group needed a decision made as to when not to escalate if intervention was no longer appropriate.

3.2.4 In response to a question about the phrase ‘deteriorating patients’ and whether it was appropriate to use this, Dr Maran advised that this represented deterioration of physiological condition and was a phrase understood by clinicians nationally.

3.2.5 Members accepted the recommendations laid out in the paper with limited assurance. A further update on progress would be submitted to a future meeting. **TG**

3.3 Quality and Performance Report

3.3.1 Mr Jackson spoke to the previously circulated paper. Members felt that where ‘proforma is not met’ was noted in the paper there should be a note stating at which Committee the detail was being considered. It was noted that as Committees received assurance from detailed papers rather than the quality and performance report proforma the paper had been reformatted to reflect this.

3.3.2 Due to the time lag of Committees getting through all the areas in their remit, Ms A. Mitchell asked how the Committee could be assured that trends were not deteriorating in the meantime. Executive directors should be aware of deteriorating trends and these would be brought to the relevant Committee and discussed with Committee chairs at agenda setting meetings.

3.3.3 It was noted that as an update was to be brought back to the Committee on every area where only limited assurance was achieved, this could make agendas very full; the Committee may not have time to cover its full remit. Ms Campbell advised that the Committee could agree when a short update needed to be given and when detailed discussions needed to take place on a particular area so that the Committee could keep track.

3.3.4 Members accepted the recommendations laid out in the paper and noted their disappointment at the deteriorating trend in seven areas.

4. Corporate Governance

4.1 Waiting Times Update

4.1.1 Ms Campbell spoke to the previously circulated paper. The numbers of patients waiting longer than the treatment time guarantee were still high but improving. Additional funding had been agreed specifically for reducing outpatient waiting times and external providers were being found. There had been improvement in vascular outpatient waiting times which would clear the backlog of patients waiting and due to recent recruitment to vacancies would be able to sustain this.

4.1.2 Services were looking for further waiting list initiatives as this had been requested by the Scottish Government. There would be more consideration of demand reduction tests in other areas following the success of the PCP testing. A pilot would take place with NHS 24 for keeping in touch with patients waiting for long periods of time; this would use an algorithm to that patients could be moved to self care if appropriate or moved forward on the waiting list if urgent.

4.1.3 Members accepted the recommendations laid out in the paper.

4.2 Maternity Programme Board Review

4.2.1 The Chair welcomed Dr Doyle to the meeting and he spoke to the previously circulated paper. Most of the actions delegated to the Maternity Programme Board had now been completed and the group had decided to change its terms of reference to concentrate on implementation of the Scottish Government 'Best Start' review. The new group would be called the Maternity and Neonatal Strategy Group. As this group would be community focussed it would no longer report to the Acute Hospitals Committee.

4.2.2 Ms F. Mitchell noted that there had been extremely good engagement among all staff involved in the Maternity Programme Board. Mr Oates asked whether there were plans for evaluation of the success of the Board so that the methods of managing recommendations and actions could be used in other areas. The high level of engagement was due to the obvious need to carry out the recommendations; there had also been good support from the executive team and good project support. It was agreed that Mr Campbell would do a formal evaluation. **OC**

4.2.3 Members accepted the recommendations laid out in the paper.

4.3 Royal Hospital for Sick Children Re-provision

4.3.1 The Chair welcomed Mr Currie to the meeting and he spoke to the previously circulated paper. Mr Currie explained that due to delays in 2016 and the progress of work the Programme Board did not believe the new hospital would be ready to hand over to NHS Lothian by the original date of 12 October 2017. Following the handover there would be a 14 week commissioning period prior to the move into the hospital for commissioning of medical equipment and transfer of equipment. This work would require the full 14 weeks. The Programme Board therefore made the decision to delay the moving date. This decision was made 48 hours prior to the Board meeting on 2 August 2017 and an update was given at that Board meeting. It was acknowledged that the short notice before going to the Board was not ideal.

4.3.2 A further issue was a dispute between NHS Lothian and IHSL on the contractual requirements relating to high voltage units, negative pressure ventilation to rooms, and imaging room design. A dispute resolution process had been started but negotiations were also underway in the hope of resolving the issue satisfactorily without going through the formal process. Further announcements to staff and the public were on hold until an outcome to this was known. If NHS Lothian's position was upheld then revision works would have to be done to the new building.

4.3.3 It was noted that the delay would not affect the cost of the building as there were no unitary charges to NHS Lothian until both parties had agreed the hospital was complete and the handover had taken place. Recruitment costs and the costs of the project team would increase due to the delay as well as additional costs for using the existing RHSC for longer. Mr Marriott noted that modelling was being done for mitigation of extra costs and protect NHS Lothian's position, and solicitors were involved.

4.3.4 Mr Currie clarified that the high voltage unit and ventilation to rooms were required and the hospital could not be opened until these had been added. The sooner the fixes were incorporated into the building the more cost effective to all parties as it would become more difficult to make changes as the building neared completion.

4.3.5 It was noted that the period for the formal dispute process was 22 to 26 weeks, which would take the opening date even further into the future. Mr Currie clarified that it was hoped that the ongoing information negotiations would resolve the dispute sooner than this, and as soon as possible.

4.3.6 Mr Currie advised that the project team had been well supported in their by NHS, legal and technical colleagues.

4.3.7 Members accepted the recommendations laid out in the paper and asked to be kept informed of progress.

5. Clinical Governance

5.1 Paediatrics Services Update

5.1.1 The Chair welcomed Ms F. Mitchell and Dr Doyle to the meeting and Ms F. Mitchell spoke to the previously circulated update.

5.1.2 Ms Gillies noted that she and Mr Crombie had attended a West Lothian council meeting and that there needed to be further communication with councillors as there was a lack of understanding of the issues involved and a feeling that the St John's Hospital Paediatrics Service was a political issue.

5.1.3 Ms F. Mitchell noted that the Royal College of Paediatrics and Child Health had tried to engage the public at the time of the Review by carrying out a highly publicised public survey and holding public sessions but the survey had been completed mainly by the politically motivated and public sessions were poorly attended especially by the parents of young children. There were also joint public engagement sessions between the RCPCH and NHS Lothian. More public sessions were currently being advertised to give members of the public an opportunity to understand the issues and to have their say.

5.1.4 All three of the inpatient children's units in Scotland were struggling and NHS Grampian was closing its Elgin children's unit to inpatients.

5.1.5 The Scottish Government was supportive of the process of the review and a situation report was sent to them weekly giving numbers of patient transfers to the Royal Hospital for Sick Children.

5.1.6 The number of patient transfers to the RHSC was likely to increase during the winter and planning needed to start. The public position was that work was ongoing to allow the ward to reopen to inpatients.

5.1.7 Members accepted the recommendations laid out in the paper, were supportive of the approach taken wanted their thanks to be conveyed to the teams involved for their hard work in keeping the service running and working to resolve problems.

6. Minutes for Information

The previously circulated minutes from the following meeting were noted:

6.1 Healthcare Governance Committee, 11 July 2017;
6.2 Staff Governance Committee, 26 July 2017.

7. Date of Next Meeting

7.1 The next meeting of the Acute Hospitals Committee would take place at **14.00** on **Tuesday 7 November 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

Item 4.1 Minutes

Edinburgh Integration Joint Board

1.9

12:00 pm, Friday 11 August 2017
City Chambers, Edinburgh
Present:

Board Members:

Councillor Ricky Henderson (in the Chair), Carolyn Hirst (Vice Chair), Michael Ash, Colin Beck, Carl Bickler, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Kirsten Hey, Councillor Derek Howie, Alex Joyce, Angus McCann, Rob McCulloch-Graham, Councillor Claire Miller, Ella Simpson, Pat Wynne.

Officers: Colin Briggs, Gail Cochrane, Wendy Dale, Ann Duff, Michelle Hughes, Jamie Macrae, Allan McCartney, Maria McIlgorm, Julie Tickle, Cathy Wilson

Apologies: Shulah Allan, Michelle Miller, Richard Williams.

1. Directions 2017/18

The draft directions for 2017/18, to be issued to the Chief Executives of the City of Edinburgh Council and NHS Lothian, were outlined.

During discussion, the following points were raised:

- Self-Directed Support would be referenced specifically in the narrative around Direction 3 (Key Processes).
- It was noted that the date for the exit of Liberton Hospital in Direction 5 (September 2018) was at odds with NHS Lothian's plan to be out by March 2018. Members were assured that the move would take place as early as possible and that the September date was to allow for potential delays.
- A short and long-term capacity plan in respect of bed-based support for older people was being worked on and would be presented to the September meeting of the Joint Board.
- The Transformation Board of the Edinburgh Health and Social Care Partnership would be responsible for the coordination of the delivery plans for the Directions.
- The "pull model" for orthopaedics, referenced in Direction 6, should be applied to all services.

- Delivery plans would be presented to the Joint Board following approval of the Directions.

Decision

1) To agree that performance indicators would be developed along with the delivery plans and reported through the Performance and Quality Sub-Group.

2) To otherwise approve the set of directions for 2017/18 to be issued to the Chief Executives of the City of Edinburgh Council and NHS Lothian.

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

1.10

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 15 June 2017	2pm	Committee Room, Midlothian House, Buccleuch Street, Dalkeith EH22 1DN.

Present (voting members):

Cllr Catherine Johnstone	Tracey Gillies
Cllr Jim Muirhead	Alex Joyce
Cllr Pauline Winchester	Alison McCallum
	John Oates

Present (non voting members):

Eibhlin McHugh (Chief Officer)	Alison White (Chief Social Work Officer)
David King (Chief Finance Officer)	Hamish Reid (GP/Clinical Director)
Dave Caesar (Medical Practitioner)	Caroline Myles (Chief Nurse)
Patsy Eccles (Staff side representative)	Aileen Currie (Staff side representative)
Keith Chapman (User/Carer)	Rosie McLoughlin (User/Carer)
Ewan Aitken (Third Sector)	

In attendance:

Fiona Huffer (NHS Lothian)	John Boyd (EY, External Auditors)
Mike Porteous	Jamie Megaw (Strategic Programme Manager)
Mike Broadway (Clerk)	

Apologies:

Cllr Derek Milligan	

Midlothian Integration Joint Board

Thursday 15 June 2017

1. Welcome and introductions

The Chief Officer, Eibhlin McHugh, in welcoming everyone to this Meeting of the Midlothian Integration Joint Board, suggested that in light of the number of membership changes, the Board take Agenda Item 5.1 first, which was agreed.

Report No.	Report Title	Presented by:
5.1	Membership of Integration Joint Board	Eibhlin McHugh

Executive Summary of Report

This report provides information about the proposed Council nominations for membership of the Midlothian IJB following the Local Government Elections in May 2017, and proposed changes within the NHS membership of the Midlothian IJB. Further the report also sought nominations from the Board in relation to the vacant positions within the Audit and Risk Committee.

Summary of discussion

Having heard from the Chief Officer, who advised that in addition, Margaret Kane had stepping down as one of the two user/carer representatives, and that Rosie McLoughlin would be taking over until such time as a permanent replacement could be found, the Board welcomed everyone to the MIJB, particularly those newly appointed members.

Decision

The Board:

- **Endorsed the Council nominations for voting members of the Midlothian Integration Joint Board including the nomination of Derek Milligan to the position of Chair until August 2017;**
- **Endorsed the proposed changes within the NHS voting membership of the Midlothian Integration Joint Board including the nomination of John Oates to the position of Vice-Chair until August 2017;**
- **Noted and endorsed that in August 2017, the Chair of the Midlothian Integration Joint Board confirmed at today's meeting would become the Vice Chair of the Midlothian Integration Joint Board and the Vice-Chair of the Midlothian Integration Joint Board confirmed at today's meeting would become the Chair of the Midlothian Integration Joint Board;**
- **Note that under paragraph 3.2 of the Midlothian Integration Scheme the above appointments of Chair and Vice-Chair would be for two years from August 2017;**

- **Expressed their thanks to Margaret Kane for her contributions to the work of the MIJB and endorse the appointment of Rosie McLoughlin until such time as a permanent replacement could be found; and**

- **Agreed to continue consideration of the nomination of members to fill the three vacant positions within the Audit and Risk Committee including the appointment of the Chair of the Committee to the August Board meeting.**

Action
Chief Officer/Chief Finance Officer/Clerk

Thereafter, in the absence of the Chair, Derek Milligan, the Vice-Chair, John Oates assumed the Chair for the remainder of the meeting, following which there was a round of introductions.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been circulated with the following amendments:

(a) an updated 'final' copy of the Draft Annual Accounts 2016/17, which replaces the version previously circulated as Appendix 3 to the 'Draft Annual Accounts - 2016/17' report – Item No 5.8 refers - had been circulated electronically under separate cover;

(b) an additional item of business had also been circulated electronically under separate cover (copies were also tabled), namely a report by the Chief Officer, entitled 'Midlothian IJB Complaints Handling Procedure' which would be considered as Agenda Item 5.9; and

(c) Agenda Item 5.6 - Measuring Performance Under Integration would be taken as the second item of business immediately after the Directions Paper – Item 5.2.

3. Declarations of interest

No declarations of interest were received.

4. Minutes of Previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on Thursday 20 April 2017 were submitted and approved as a correct record.

4.2 Matters Arising from previous Minutes:

With reference to paragraph 4.2, the Chief Officer confirmed that an update on any issues arising from the 2017/18 Directions that had been issued to both Midlothian Council and NHS Lothian would be fed back into the August Board meeting.

Action: Chief Officer

With reference to paragraph 5.6, the Strategic Programme Manager provided the Board with an update on the work being undertaken in developing primary care services in Midlothian. He highlighted the current position with regards GP provision and made reference to the need to better manage people's expectations and communicate changes in the ways in which services were provided.

In response to concerns regarding provisions for more vulnerable clients/groups and also provision of clear signposting as to how to access services, the Strategic Programme Manager advised that they were aware of both issues and were actively working to address them. The Chief Officer also offered reassurance on these points and advised there would be an opportunity to discuss matters in greater detail at the Development Session in November, which would focus on Primary Care.

Action: Chief Officer/Strategic Programme Manager

5. Public Reports

Report No.	Report Title	Presented by:
5.2	Directions - Summary of progress to implement 2016-17 Directions	Jamie Megaw

Executive Summary of Report
With reference to paragraph 5.6 of the Meeting of 27 October 2016, there was submitted an update summarising the progress made by Midlothian Council and NHS Lothian in delivering the Directions set by the MIJB for 2016-17. The Directions were intended to provide further clarity about the key changes which need to be made in the delivery of health and care services in Midlothian as laid out in the Strategic Plan.

Summary of discussion
Having heard from the Strategic Programme Manager, the Board discussed ways in which the impact of public education programmes could best be assessed; the involvement of the voluntary sector, other agencies and joint working in general; and the impact, and awareness, of new services such as MERRIT.

Decision
After further discussion, the Board: • **Noted the progress made in achieving the Directions as outlined in the report.**

Action
Strategic Programme Manager

Midlothian Integration Joint Board

Thursday 15 June 2017

Report No.	Report Title	Presented by:
5.6	Measuring Performance Under Integration	Jamie Megaw

Executive Summary of Report

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

Decision

Having heard from the Strategic Programme Manager, the Board:

- **Noted the baselines that would be used to measure performance against the Local Improvement Goals.**
- **Noted that at this time it was not possible to draw meaningful conclusions on progress towards the goals.**
- **Noted that the IJB would receive an update on progress every three months. The next update would be in September 2017**

Action

Strategic Programme Manager

Report No.	Report Title	Presented by:
5.3	Sustainable and Affordable Social Care Services	Eibhlin McHugh

Executive Summary of Report

This report summarised the work being undertaken to reshape services in social care in response to the growing budget pressures on Midlothian Council. In particular the report drew attention to two specific policies intended to ensure a more robust approach to the equitable provision of social care.

Summary of discussion

The Chief Officer reminded the Board of the demographic pressures not simply just in terms of population growth, but also the increasing number of people with long term health conditions and complex care needs who were living longer, which when considered against a backdrop of Adult Social Care being required to make a significant contribution to the Council's savings programme and a growing problem of recruitment and retention, particularly in the field of care at home, made reducing expenditure in care services a major challenge. It also highlighted the vital importance of the drive towards creating sustainable and affordable social care services.

Having heard from the Chief Officer, the Board, in considering the Report, discussed in particular the management of expectations and also the increasing use of new technology. Consideration was also given to the 'Fair Allocation of Care' and 'Transport' policies, copies of which were appended to the report.

Decision

The Board:

- **Noted the continuing severe pressures on Midlothian Council which required a significant programme of savings within Adult Social Care; and**
- **Noted the proposed new policy intended to ensure a more equitable and affordable allocation of resources in relation to:-**
  - **(a) people with complex needs;**
  - **(b) transport for social care users.**

Action

Chief Officer

Report No.	Report Title	Presented by:
5.4	National Mental Health Strategy 2017-27	Alison White

Executive Summary of Report

This report provided a summary of the objectives and key actions outlined in the new national 10 year mental health strategy published by the Scottish Government on 30 March 2017. The strategy highlighted how common it was for people to experience mental health problems during their lifetime. Considerable emphasis was placed on both prevention and recovery from periods of mental ill-health. The report also provided some commentary on the current situation in Midlothian in relation to the key recommendations of the Strategy, highlighting some of the actions already being undertaken.

Summary of discussion

Having heard from the Chief Social Work Officer who emphasised that the Strategy had implications for a range of agencies beyond health and social care, the Board discussed the implications of the growing incidence of mental health issues and the potential impacts on both quality of life and demands for services.

Decision

The Board:

- **Noted the new national strategy on Mental Health; and**
- **Agreed that the implementation of the strategy in Midlothian would be through the local Strategic Planning Group for Mental Health reporting to the IJB Strategic Planning Group.**

Midlothian Integration Joint Board

Thursday 15 June 2017

Action
Chief Officer

Report No.	Report Title	Presented by:
5.5	Carers (Scotland) Act 2016	Alison White

Executive Summary of Report

The purpose of this report was to provide the IJB with information about the Carers (Scotland) Act (2016) and new duties under the legislation.

The report explained that the Carers (Scotland) Act 2016 was a key piece of new legislation that promised to 'promote, defend and extend the rights' (Scot Gov.) of adult and young (unpaid) carers across Scotland. The Act aimed to "ensure better and more consistent support for carers and young carers so that they can continue to care, if they so wish, in better health and to have a life alongside caring" (Scot Gov.). The legislation had implications for Adult Health and Social Care Services and both Education and Children's Services.

Summary of discussion

The Chief Social Work Officer in presenting the report highlighted that the Scottish Government had invited Midlothian Health and Social Care Partnership to be one of eight integrated authorities to participate in pilot work based on tests of change in relation to different provisions in the Carers Act. The focus of the pilot work in Midlothian had yet to be finalised but was likely to focus upon the preparation of Adult Carer Support Plans; the pilot work would take place between April and October 2017 and financial support would be receive of £10,000 (allocated to the relevant NHS Board in the first instance for onward transmission to the Integration Authority).

The Board, in discussing the implications of the new legislation, considered how these challenges could be managed whilst supporting the delivery of better support to carers and how partners in the voluntary and other sectors could contribute to that process.

Decision

The Board:

- **Noted the implications of the new legislation; and**
- **Agreed to request a full report on the planned implementation of the Act in Midlothian**

Action
Chief Officer

Midlothian Integration Joint Board

Thursday 15 June 2017

Report No.	Report Title	Presented by:
5.7	Financial Update – 2016-17 and 2017-18	David King

Executive Summary of Report

The purpose of this report was to lay out the IJB's final out-turn position for 2016/17, considers what lessons could be learnt from that position and continue to reflect and refine the financial planning and management for 2017/18. The report advised that it should be noted that the IJB required to break-even in 2017/18

Summary of discussion

Having heard from the Chief Finance Officer, the Board discussed the considerable financial challenges in meeting the requirement to break even, and the ongoing work that was being undertaken in conjunction with the Council and NHS Lothian to address matters in the 2017/18 financial planning process in that the Partnership was considering a fundamental redesign of the delivery of social care services for adults and the budget for GP prescribing had been reset at the closing position for 2016/17 with a more prudent financial model for 2017/18. However, there remained a significant pressure from efficiency and recovery plans and these would be a key issue that the IJB would have to take assurance on during the financial year.

Decision

The Board:

- **Noted the IJB's financial position at the end of 2016/17;**
- **Accepted the final financial budget proposition from NHS Lothian for 2017/18;**
- **Noted the funds carried forward on behalf of the IJB by Midlothian Council from 2016/17 to 2017/18; and**
- **Noted the further financial update on the financial planning and management process for 2017/18 and the expectation that the IJB would break-even.**

Action

Chief Finance Officer

Report No.	Report Title	Presented by:
5.8	Draft Annual Accounts 2016-17	David King

Executive Summary of Report

The purpose of this report was to highlight the requirement for the IJB to prepare a set of annual accounts for the financial year 2016/17. A draft of these accounts must be agreed by the IJB before 30th June whereupon the draft must be published on the IJB's website and presented to the IJB's auditors for review.

Midlothian Integration Joint Board

Thursday 15 June 2017

The report brought together the elements required for the IJB to approve the draft annual accounts for the year ending 31st March 2017. This included the presentation of the Chief Internal Auditors opinion on the governance of the IJB and the Annual Governance statement for the IJB which itself formed part of the IJB's annual accounts.

Decision

The Board, having heard from the Chief Finance Officer:

- **Noted the contents of the Internal Audit Annual Assurance Report;**
- **Noted that the weaknesses identified with internal controls in 2016/17 would be followed up in 2017/18 and updates would be provided to the MIJB Audit and Risk Committee;**
- **Approved the Annual Governance Statement; and**
- **Approved the outline draft Annual Accounts for 2016/17.**

Action

Chief Finance Officer

Report No.	Report Title	Presented by:
5.9	Midlothian IJB Complaints Handling Procedure	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to highlight the requirement for Midlothian IJB to comply with new model Complaints Handling Procedure (CHP) as per the Scottish Public Services Ombudsman (SPSO) instruction.

The report explained that Integration Joint Boards (IJBs) were listed under the SPSO Act 2002, and as such were expected to have a complaints handling procedure, which complied with the principles approved by the Scottish Parliament in January 2011. To this end, the Scottish Public Services Ombudsman had developed a template for IJBs (based on the Model Complaints Handling Procedure (CHP) for Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland). A Midlothian version of this CHP was appended to the report along with a self-assessment compliance form, which the Chief Officer required to complete and sign confirming compliance with the new CHP.

Summary of discussion

Having heard from the Chief Officer, the Board welcomed the opportunity to comment on the CHP, which it was noted required to be submitted to the SPSO by Monday 3rd July 2017.

Decision
The Board: • **Noted the requirement for IJBs to conform to a new Complaints Handling Procedure;** • **Noted the requirement for the Chief Officer to complete and submit the CHP and the self-assessment compliance form to SPSO by Monday 3rd July 2017;** • **Agreed that any comments on the CHP be fed back to the Chief Officer by no later than Wednesday 28th June 2017** • **Agreed, subject to the above, the adoption and implementation of the Complaints Handling Procedure; and** • **Agreed that the Chief Officer arrange appropriate communication of the Complaints Handling Procedure internally and to the wider public.**

Action
Chief Officer

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

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

8. Date of next meeting

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

- Thursday 24th August 2017 2pm **Midlothian Integration Joint Board**
- Thursday 14th September 2017 2pm Development Session

The meeting terminated at 4.15 pm.

East Lothian Integration Joint Board

1.11

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 29 JUNE 2017
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:
Mr P Murray (Chair)
Councillor S Akhtar
Councillor S Currie
Councillor S Kempson
Councillor F O'Donnell
Ms F Ireland

Non-voting Members Present:
Dr R Fairclough
Dr A Flapan
Mr D King
Mrs M McKay
Mr T Miller
Mr D Small
Mr D Harvie
Mr A Wilson
Mr E Stark
Ms M McNeill

ELC/NHS Officers Present:
Mr B Davies
Ms M Garden
Mr S Allan
Ms M Anderson (Items 11-13)

Clerk:
Mrs F Stewart

Apologies:
Ms F Duncan
Ms A MacDonald
Dr J Turvill
Ms S Saunders
Mr A Joyce
Ms M Whyte

Declarations of Interest:
Councillor O'Donnell advised that she was employed by a charity and this contract would end on 30 June 2017.

1. CHANGES TO THE VOTING MEMBERSHIP OF EAST LOTHAN INTEGRATION JOINT BOARD AND THE TERMS OF REFERENCE FOR IJB AUDIT & RISK COMMITTEE

David Small advised that, following the local government elections on 4 May 2017, East Lothian Council had met on 23 May 2017 and approved its voting members for the East Lothian Integration Joint Board for the period 2017-2022.

The Chair invited nominations for Depute Chair of the IJB and Councillor O'Donnell was elected.

Decision

The IJB agreed to:

i. note that the East Lothian Council voting members will be: Councillor Shamin Akhtar, Councillor Stuart Currie, Councillor Sue Kempson and Councillor Fiona O'Donnell.

ii. the appointment of Councillor O'Donnell as Depute Chair of the IJB for the period 2017-2019.

iii. to note that a review of the terms of reference of the Audit & Risk Committee would be undertaken to ensure that they reflect the audit and risk arrangements of NHS Lothian and the Council's Audit & Governance Committee. The new terms of reference would be presented to the IJB's August meeting and nominations for membership will also be sought at that time.

2. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 30 MARCH 2017

Elliot Stark advised that he was not recorded as having attended the meeting. Otherwise, the minutes of the East Lothian Integration Joint Board meeting of 30 March 2017 were approved.

3. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 30 MARCH 2017

Ministerial Steering Group – Councillor Akhtar enquired if there was an update and David Small replied that a communication had just been issued on planning (strategic) groups. It had been agreed at the Carers Strategy Breakfast on 26 June 2017 that this would include a Carers Strategic Group and eligibility criteria for the group was expected to be finalised by September 2017. Councillor O'Donnell enquired if Carers of East Lothian would be part of this group and Mr Small advised that carers would be represented on all of the groups.
Delayed Discharges – David Small advised that the last time performance figures on delayed discharges had been reported to the Committee was in March 2017. The April

census showed that there had been 26 delayed discharges (target 14) although the figure of 14 had been achieved 2 days later. The May census showed there had been 9 delayed discharges (target 14) and the census yesterday (28 June) showed there had been 12 delayed discharges (target 14). Mr Small stated that the IJB aimed to sustain the improving trend and highlighted the need to focus on the most complex of cases. Councillor O'Donnell asked if a 72 hour target had yet been introduced (an indicator included in the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014. Mr Small replied that a 72 hour target was an aspirational figure and not an official target.

Set Aside Investment Proposals for 2017/18 – David King referred to proposals for Acute Medical Units (AMUs) and advised that NHS Lothian had agreed to create and fund a new unit to provide emergency care. The IJB would not invest money in this unit in 2017/18 but NHS Lothian would provide funding for the expansion of bed numbers in AMUs for this financial year.

Drug and Alcohol Funding in East Lothian 2016/17 and 2017/18 - Councillor O'Donnell stated that Dr Turvill had already seen the effect of a reduction in funding for drug and alcohol abuse. David King advised that talks had taken place on the share of Government funding to 4 groups responsible for addressing drug and alcohol abuse; East Lothian Council, Scottish Government, MELDAP (Midlothian and East Lothian Drugs and Alcohol Partnership) and the IJB. This followed a redesign of the drug and alcohol services driven by a reduction of 23% in Government funding for the financial year 2016/17. Mr King stated that the IJB would now receive 11% of funding rising to 12% next year. There would also be a small amount of additional resources to develop new projects.

4. CHAIR'S REPORT (VERBAL)

Peter Murray, Chair, stated that it was a privilege to be invited to chair the IJB and he looked forward to working with Councillor O'Donnell (newly appointed Depute Chair) and David Small, Director of Health and Social Care Partnership. He also paid tribute to the valuable contributions made by the previous Chair, Councillor Donald Grant and Depute Chair, Mike Ash.

Mr Murray stated that he had enjoyed meeting members of the Committee and was grateful for everyone's time. He looked forward to the work ahead and encouraged everyone to be active participants.

Mr Murray advised there had been a suggestion that roles of members of the IJB could have more clarity. He invited everyone to consider the definition of their roles and this would be discussed at the next meeting.

5. NHS HEALTHCARE GOVERNANCE COMMITTEE

Fiona Ireland provided feedback which would impact on the IJB directions on alcohol, drugs and mental health services and advised that there had been agreement in Quarter 1 to continue funding RIDU (Regional Infectious Diseases Unit), GUM (Genito-urinary Medicine), and toxicology.

She also advised that a redesign of the Ritson Clinic and detox services was ongoing and that there was to be an allocation of Scottish Government funding for pharmacy care.

6. EAST LOTHIAN COUNCIL POLICY & PERFORMANCE REVIEW COMMITTEE AND AUDIT AND GOVERNANCE COMMITTEE

This item would be brought back on a future date when it had been established how structured feedback would be received from these committees.

7. FINANCIAL UPDATE – 2016/17 OUT-TURN AND 2017/18 UPDATE

A report had been submitted by the Chief Finance Officer laying out the financial out-turn for 2016/17 for the IJB and updating the financial projections and planning for 2017/18.

David King summarised the report, clarifying a number of points. On the 2016/17 out-turn, he advised that there had been an agreement that any health overspends against the IJB budget would be covered by NHS Lothian and East Lothian Council. Mr King reported that there had been an overspend in Adult Wellbeing and £1m additional funding had been received from East Lothian Council. Mr King also pointed out that Social Care and Adult Wellbeing were not the same thing and those two areas would need to be reconciled at some point.

Mr King advised that the final net charge made by East Lothian Council to the IJB for delivering services in 2016/17 was £44.3m and this included a charge of £0.7m for the Housing Revenue Account (HRA). This sum was ring-fenced as funds could not be moved out of the HRA and therefore any HRA underspend was not available to the IJB. Mr King also referred to the significant overspend against the GP prescribing budget which had proved challenging.

Mr King advised that a letter had been received from NHS Lothian on 2 May 2017 on the Budget Agreement for 2017/18 which included targets to be met by the IJB. A draft letter in response was attached to the report and Mr King stated that it was important for partners to engage with the IJB on pressures outwith its control. It was also important that there was a clear understanding on roles of responsibility as the draft letter would be sent to NHS Lothian on behalf of IJB members.

Councillor Currie stated that it might not be correct that funds cannot be moved out of the HRA and provided some context on the use of HRA funds. David King undertook to seek clarification on that point from Council Officers.

Fiona Ireland enquired if the underspend in 2016/17 would impact on the 2017/18 budget and David King replied that he did not recall any material change.

Margaret McKay noted from the report that work was underway to transform Lothian Learning Disability services, an issue which had not yet been fully explored by the IJB. She proposed that a focussed discussion on learning disability could be scheduled for a future IJB meeting and David Small agreed this would be of value. He stated that, while much work was going on behind the scenes, a strategic paper on learning disability would be brought to a future meeting.

Mr Small referred to recommendation 2.4 of the report, stating that the IJB financial monitoring would need to focus on partnerships breaking even as additional resources were not available in 2017/18.

Fiona Ireland stated that details of the £3.3m of efficiencies needed to be made available, as the IJB could not sign up to this without such information.

Decision

The IJB agreed to:

i. note the financial out-turn for 2016/17;

ii. accept the formal budget proposition from NHS Lothian for 2017/18;

iii. note the drug and alcohol funds carried forward on behalf of the IJB by East Lothian Council from 2016/17 to 2017/18; and

iv. note the financial update for 2017/18 and the expectation that the IJB will break-even.

8. INTERNAL AUDIT OPINION AND ANNUAL REPORT 2016/17

The Chief Internal Auditor had submitted a report to advise that the Public Sector Internal Audit Standards (PSIAS) required the Chief Internal Auditor to prepare an annual internal audit opinion and report that can be used by the Integration Joint Board (IJB) to inform its governance statement.

Mala Garden, Chief Internal Auditor, presented the report, stating that the IJB's senior management had responsibility for establishing a sound system of internal control and for monitoring the continuing effectiveness of these controls. She outlined the main objectives of internal control and stated that her evaluation of the IJB's control environment was informed by a number of sources including statutory and other compliance. During 2016/17, a number of areas had been identified with scope for improvement. They included: the lack of a clear audit trail to monitor expenditure incurred for certain categories of the social care fund; the need to ensure that the performance management framework sets out how the IJB would measure performance against the Strategic Plan; and a review of the risk register to ensure that it included all ongoing and emerging risks facing the IJB.

Margaret McKay observed that some areas of weakness had been identified the previous year and the Chief Internal Auditor replied that an action plan was included in the next report to address weaknesses identified over the past year.

Councillor O'Donnell highlighted another area of weakness identified for scope with improvement; the progress requiring to be made on Participation and Engagement and the Workforce Development and Support Plan, to ensure compliance with the Integration Scheme.

Councillor Currie stated that engagement was a key issue and suggested there should be a paragraph specifically on this matter. He acknowledged that some good work was being carried out but stated that there were concerns around the extent of engagement with external members. David Small agreed with both Councillors that further work was required.

Decision

The IJB agreed to note that the Internal Audit Opinion and Annual Report 2016/17 was a formal confirmation of Internal Audit's opinion on the overall adequacy and effectiveness of the IJB's framework of governance, risk management and control for the period ended 31 March 2017 with agreement that further work is required on engagement.

9. DRAFT ANNUAL ACCOUNTS 2016/17

The Chief Finance Officer had submitted a report bringing together the elements required to present for approval the draft annual accounts for the IJB for the year ending 31 March 2017. This included the Annual Governance statement for the IJB which itself formed part of the IJB's annual accounts.

David King, Chief Finance Office, presented the report. He advised that a set of annual accounts had to be presented in draft for approval to either the IJB or a committee of governance of the IJB by 30 June 2017 whereupon the accounts would be presented for audit by the IJB's auditors. Mr King explained that the accounts contained a range of sections but broke down into three main parts; the Management commentary which considered the pressures and issues facing the IJB in the next financial year, the Annual Governance Statement and the financial statements which showed that the IJB had broken even in 2016/17.

Mr King asked the Committee to approve the accounts thereby allowing him to forward them to the auditors.

David Small advised that in 2016/17, the first year of operation for the IJB, two performance reports had been brought to Committee. In 2017/18, four performance reports would be brought forward.

Margaret McKay enquired about the budget for Social Care Fund Appeals and Mr King replied that this was included in this year's budget.

Councillor Akhtar stated that the IJB needed to know what difference it was making to people's lives. The Chair replied that work still needed to be done on performance management. Bryan Davies, in his new role of Planning and Performance, stated that he would prepare a quarterly and annual performance report for the IJB. He also intended to develop a management team report on service delivery. A decision had also to be made on how the IJB would measure performance. The Chair stated that it was important to ensure that there was clarity on how the IJB was achieving its goals, to look at balances and adjust if necessary.

Decision

The IJB agreed to:

i. approve the Annual Governance Statement; and

ii. approve the draft Annual Accounts for 2016/17

10. INTEGRATION JOINT BOARD PERFORMANCE REPORT

The Chief Officer had submitted a report to inform the Integration Joint Board (IJB) of its duty to publish an annual performance report for 2016-17 as its first year of operation and the progress so far producing this report.

Bryan Davies, Group Service Manager for Planning and Performance, presented the report. He advised that the Scottish Government guidance required the report to describe, as a minimum, performance against specific elements, including National Health and Wellbeing Outcomes, Core Integration Indicators and Financial Performance. However, there was an expectation that the annual performance reports would include information beyond the minimum list to allow IJBs to highlight particular achievements. The East Lothian report under development was currently seeking input from colleagues across the Health and Social Care Partnership (Appendix 1) to gather accounts of good practice and achievements against the national performance indicators.

Councillor Currie stated that it was important the report captured where the IJB had made a difference and added value. It was equally important to identify areas where more work needed to be done. He added that performance always looked backwards and it was good to look forwards. The Chair stated that there were ambitious expectations for the IJB and he wanted people to share that vision. He hoped that, when the report was published, the IJB could be proud of what it had achieved and plan more ambitious changes for the future.

Councillor O'Donnell stated that it was important to recognise how decisions made by the IJB impact on people's lives and made a difference.

Margaret McKay, Carers in East Lothian, advised that Carers Groups in East Lothian could be asked for feedback on how carers' needs are being met. Bryan Davies replied that, following a procurement exercise, there was now a new framework for care at home services. A programme of change was planned for this year, bringing many positive benefits.

The Chair stated that, at NHS meetings, he had gained a sense that there was a growing understanding of the role of the Partnership and consequently, people were becoming more supportive of the work carried out by their IJBs.

Councillor Currie stated that there was a huge amount of information on performance available to view on the Scottish Government website but it was important to make the information clear for members of the public. A benchmarking framework was useful to indicate performance against the Scottish average and other Local Authorities.

David Small stated that it as helpful to hear the emphasis which partners wanted to see in the performance report due out in August 2017.

Decision

The IJB agreed to:

i. acknowledge the legislative requirement for it to publish an annual performance report for its first year of operation, 2016-17, and that such a report will need to be produced in subsequent years;

ii. note there is an expectation in legislation that the 2016-17 performance report will be published by 31 July 2017; and

iii. note that because of timings of IJB meetings over the summer, publication will be delayed to allow the report to be formally considered at the 24 August IJB meeting before being released. It is known that some other IJBs across the country are planning a similar delay in publication.

11. CARE INSPECTORATE GRADES: EAST LOTHIAN

Information contained in the IJB Performance report from February 2017 advised that grades of inspected services across East Lothian were at "amber". The IJB expressed concern at this and asked for a follow up report. This paper analysed the trends of the grades from the last two inspections to identify if this information holds merit. The report looked at the progress of services including Care Home services, Care At Home services, Day Centres and Resource Centres.

Bryan Davies, Service Manager for Planning and Performance, presented the report, advising that grades across all the services in East Lothian generally showed trends of either maintaining or improving following recent inspections, with the exception of a small number of providers who had had their grades reduced. One Care Home provider continued to be under close monitoring and it was expected that this would improve at the next follow up inspection. A second Care Home was undergoing close monitoring following a recent inspection although final grades had yet to be awarded. One Care at Home provider had not met the required grades and had consequently not been awarded a care contract in order to maintain quality in service provision.

Mr Davies advised that Care at Home services in East Lothian had recently undergone a tendering exercise and a new framework was put in place from 1 April 2017 that included 15 providers. A minimum of Care Inspectorate Grade 3 overall was required to qualify on to the framework and there were incentives for providers to improve their grade to 4. Older People's Day Centres across East Lothian had been graded for the first time over 2016/17 as these services were newly registered with the Care Inspectorate.

Mr Davies summarised the grades across Care Home Services advising that, since the last inspection, 41% of homes had increased their grades from their previous inspection. Of the Care at Home service providers, 46% had increased their grades since their last inspection.

Dr Marilyn McNeil enquired how Care Inspectorate ratings were communicated to the public and David Small replied that all Care Inspectorate reports were in the public domain. The reports were intended to be open and transparent, and were accessible to families researching available services.

Councillor Currie observed that a small number of the care services showed below average ratings and stated it was important to acknowledge when things were not going well. Mr Small replied that there were dedicated resources for monitoring such providers, including a Strategy Officer specifically for Care Homes, and all agencies were committed to working together. The Chair added that the aim was to have the highest level of care at all times.

Danny Harvie, ELCAP, hoped that the report would give confidence to the general public. They also had the opportunity to compare East Lothian's performance with

other Local Authorities and see how East Lothian compared positively with other Authorities.

Fiona Ireland, NHS, enquired if there was a forum which would provide assurances on any care services which were rated at Grade 3 or below and David Small replied that a Clinical and Care Governance Group would bring all quality and assurance into a single forum. Work had already begun on this and an update would be brought to the IJB. Ultimately, there was the Public Protection Committee and any significant incidents were reported there.

Dr Richard Fairclough stated that some of the care home gradings were not as good as others and enquired if there were any upgrades to care homes planned. David Small replied that it was anticipated there would be a paper in the autumn on the direction of travel for a reprovision of two council care homes and NHS hospitals. Margaret McKay noted that only a small percentage of care establishments had had their grades reduced, but when homes could care for 20 to 60 people, such figures could not express the impact that such a change could have on the lives of those being cared for. Mrs McKay also noted that one Care Home had achieved the highest grades available and suggested that this home could be engaged to share good practice.

Councillor O'Donnell advised that she and Bryan Davies were meeting the local representative of the Care Inspectorate on 14 July. She understood that there was going to be a review of inspection criteria and she invited any other items for the agenda.

Decision

The IJB agreed to note the information in relation to current Care Inspectorate grades for services across East Lothian.

12. PRIMARY CARE PREMISES IN HADDINGTON

The Chief Officer had submitted a report to inform the Integration Joint Board (IJB) that proposals for a project were being developed to replace or extend the current GP Practice premises in Haddington and to seek IJB support.

Miriam Anderson presented the report. She advised that all capital projects which seek funding from NHS Lothian had to follow the path described in the Scottish Capital Investment Manual and the Strategic Assessment represented the first stage of this process. Appendix 1 to the report showed the Strategic Assessment for primary care premises in Haddington which had been scored locally from an NHS perspective. The Assessment showed the business needs for change, the benefits which would result from resolving those business needs and prioritisation scores. Based on the scores, a range of options would be explored and a business case for change would be developed.

Councillor Currie stated that a patient centred solution was important and adequate public transport services had to be available for people living outside Haddington to allow people to access services. Ms Anderson replied that a more serviceable site could be considered or the current site extended. She would be engaging with a wide number of people and consultations were expected to last for at least 10 months. She gave an assurance that all options would be explored and both financial and non-financial matters considered.

Councillor Akhtar welcomed this report and enquired if the engagement would be with Haddington GPs alone or if wider groups would be consulted, included young people. Ms Anderson replied that the parameters of the consultation process had not yet been finalised.

The Chair agreed that broader aspects of the process needed to be considered, but the first step was to submit the strategic assessment.

Decision

The IJB agreed to support the strategic assessment for this project and agreed that it should be presented to the NHS Lothian Capital Investment Group before proceeding to Initial Agreement stage.

13. IJB MEETING DATES FOR 2017/18

The Chief Officer had submitted a report to set the dates for meetings of the East Lothian Integration Joint Board for 2017/18.

Decision

The IJB agreed to approve the dates for meetings of the East Lothian Integration Joint Board for 2017/18, including development sessions, as set out in Sections 3.2 and 3.3 of the report.

Signed .....
Peter Murray
Chair of the East Lothian Integration Joint Board

NHS LOTHIAN

1.12

Board
4 October 2017

Chairman

APPOINTMENT OF MEMBERS TO COMMITTEES

1 Purpose of the Report

1.1 Over the last few months the Board's membership has been refreshed as a consequence of some members leaving and new members joining. This has had an impact on committee membership which needs to be addressed to ensure the system of governance operates effectively.

1.2 Lothian NHS Board's Standing Orders state that "The Board shall appoint all Committee members". This report has been presented to the Board so that it may consider the recommendations from the Chairman on committee appointments.

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

2 Recommendations

The Board is recommended to:

2.1 Nominate Angus McCann to replace Shulah Allan as a voting member of the City of Edinburgh Integration Joint Board, with the appointment to take effect from 1 January 2018.

2.2 Appoint Professor Tracy Humphrey to replace Shulah Allan on the Healthcare Governance Committee with effect from 1 January 2018.

2.3 Appoint Councillors Fiona O'Donnell and Ricky Henderson to the Acute Hospitals Committee with immediate effect.

2.4 Remove Fiona Ireland from the Acute Hospitals Committee with immediate effect.

2.5 Appoint Professor Tracy Humphrey, Councillor Derek Milligan and Councillor John McGinty to the Staff Governance Committee with immediate effect.

2.6 Remove John Oates from the Staff Governance Committee with immediate effect.

2.7 Appoint Councillor Ricky Henderson and Angus McCann to the Finance & Resources Committee with immediate effect.

2.8 Appoint Martin Connor and John Oates to the Audit & Risk Committee with immediate effect.

2.9 Appoint Carolyn Hirst, Professor Tracy Humphrey and Angus McCann to the Strategic Planning Committee with immediate effect.

2.10 Appoint Martin Connor as the Chair of the Reference Committee with immediate effect.

3 Discussion of Key Issues

Shulah Allan

3.1 Shulah Allan's term of office ends on 31 December 2017 and her current appointments include being a member of the Healthcare Governance Committee and the City of Edinburgh Integration Joint Board. When the NHS Board wishes to remove one of its voting members on an integration joint board, it is required to provide one month's notice in writing to the member and the integration joint board.

Strengthening the Relationship between the Integration Joint Boards and the Acute Hospitals Committee

3.2 Given that integration joint boards have a key role with regard to unscheduled care, it is appropriate that the Acute Hospitals Committee membership includes members of integration joint boards. To address this point and increase the presence of local authority members on this committee, it is recommended that Councillors Fiona O'Donnell and Ricky Henderson be appointed to it. John Oates (Midlothian) and Alex Joyce (all 4 IJBs) will remain on the committee, meaning that all four IJBs are represented.

3.3 The above will increase the number of non-executive members on the Acute Hospitals Committee to 8, whereas the terms of reference states there will be 4. In the interests of reducing the population, it is recommended that Fiona Ireland be taken off the Acute Hospitals Committee.

Filling Vacancies on Several Committees

3.4 There are two non-executive vacancies on the Staff Governance Committee. It is recommended that Professor Tracy Humphrey, Councillor Derek Milligan and Councillor John McGinty be appointed to this committee. Additionally it is recommended that John Oates be removed from this committee.

3.5 There are two non-executive vacancies on the Finance and Resources Committee. It is recommended that Councillor Ricky Henderson and Angus McCann be appointed to this committee.

3.6 The terms of reference of the Audit and Risk Committee provides for there to be up to six members. There are currently only three members which is just sufficient for quorum. It is recommended that Martin Connor and John Oates be appointed to this committee.

3.7 There are two non-executive vacancies on the Strategic Planning Committee. It is recommended that Carolyn Hirst, Professor Tracy Humphrey and Angus McCann be appointed to this committee.

3.8 The Board agreed on 2 August 2017 to delegate to the Chairman the ability to appoint a Chair of the Reference Committee, in the event that the Reference Committee needed to meet before the appointment of new non-executives had been completed. Peter Johnson was previously the chair of the Reference Committee however his term of office had ended. It is recommended that Martin Connor be appointed as the chair of the Reference Committee.

4 Key Risks

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

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

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

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

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

8 Resource Implications

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

Alan Payne
Head of Corporate Governance
27 September 2017
alan.payne@luht.scot.nhs.uk

NHS LOTHIAN

Board Meeting
4 October 2017

1.13

Chairman

SCHEDULE OF BOARD AND COMMITTEE MEETINGS FOR 2018

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the dates for Board and Committee meetings in 2018.

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

2 Recommendations

2.1 To **agree** the dates for Board and Committee meetings in 2018.

3 Discussion of Key Issues

3.1 The list below shows proposed Board and Committee dates for 2018. Relevant Committee Chairs have been consulted on the proposed Committee dates which have been developed with regard to previous meeting cycles and the effective conduct of business.

3.2 The meeting dates for the NHS Lothian Information Governance Assurance Board are currently being scheduled and shall be confirmed at a later date. All of the Board's Governance Committee dates can now be accessed on the Board Website along the new Board Members' Handbook.

LOTHIAN NHS BOARD

Board Meetings	Development Days
7 February 2018	10 January 2018
4 April 2018	7 March 2018
27 June 2018	16 May 2018
1 August 2018	18 July 2018
3 October 2018	12 September 2018
5 December 2018	7 November 2018

FINANCE & RESOURCES COMMITTEE

23 January 2018
21 March 2018
23 May 2018
25 July 2018
19 September 2018
21 November 2018

STAFF GOVERNANCE COMMITTEE

31 January 2018
28 March 2018
30 May 2018
24 July 2018
24 October 2018

LOTHIAN PARTNERSHIP FORUM

27 February 2018
24 April 2018
26 June 2018
28 August 2018
30 October 2018
18 December 2018

HEALTHCARE GOVERNANCE COMMITTEE

16 January 2018
13 March 2018
8 May 2018
10 July 2018
11 September 2018
13 November 2017

AUDIT & RISK COMMITTEE

26 February 2018
23 April 2018
18 June 2018
27 August 2018
3 December 2018

REMUNERATION COMMITTEE

20 February 2018
10 April 2018
17 July 2018
16 October 2018
17 December 2018

STRATEGIC PLANNING COMMITTEE

8 February 2018
12 April 2018
7 June 2018
9 August 2018
11 October 2018
13 December 2018

ACUTE HOSPITALS COMMITTEE

20 February 2018
17 April 2018
19 June 2018
21 August 2018
16 October 2018
11 December 2018

4 Key Risks

4.1 Meetings are scheduled at a dates which are not suitable for the appropriate conduct of business or when a sufficient number of members can attend, leading to the Board and its committees not being able to efficiently and effectively carry out their roles.

5 Risk Register

5.1 There are no implications for NHS Lothian's Risk Register in this report and its recommendations.

6 Impact on Inequality, Including Health Inequalities

6.1 This is an administrative matter and the paper has no direct impact on inequalities

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

7.1 This is an administrative matter and has no impact on strategies, policies, service change or patient care. The relevant committee chairs have been consulted.

8 Resource Implications

8.1 There are no resource implications arising from the recommendations in the report.

Chris Graham
Secretariat Manager
28 September 2017
chris.graham@nhslothian.scot.nhs.uk

NHS LOTHIAN

2.1

Board Meeting
4th October 2016

Chief Quality Officer

NHS LOTHIAN QUALITY 5 YEAR PLAN

1 Purpose of the Report

1.1 This report presents the five fundamental elements of a change programme to transform NHS Lothian into a High Performing Organisation, defined by the pursuit of excellence and value through continuous improvement and disruptive innovation. The means to achieve this will be an organisational Quality Management System (QMS).

2 Recommendations

The Board is asked to:-

2.1 Note the five recommendations described in Appendix 1:-

- To become a High Performing Organisation (HPO) through transformational change across nine system-wide domains
- To demonstrate 'on the ground' evidence of a HPO that creates optimal conditions for continuous quality improvement and disruptive innovation at microsystem level
- To invest in effective 'catalytic' infrastructure to accelerate change
- To align and deploy change management infrastructure and approaches in the pursuit of aspirational strategic objectives
- To engage with patients, workforce and key partners and create a detailed roadmap for the next 18 months and broader vision for the coming five years

2.2 Support the further development of these recommendations into a comprehensive and costed five-year change programme

2.3 Invite a future paper describing additional investment to support this five year programme, including a proposal for endowment funding

2.4 Invite a future paper describing a detailed implementation plan breaking down the key recommendations into a series of SMART actions

3 Discussion of Key Issues

3.1 In late 2015, the Board agreed to support the early development and implementation of a prototype Quality Management System. In addition to realignment of existing improvement support resources, funding for the initial development was secured through a business case to the Board and Edinburgh and Lothian's Health Foundation.

3.2 The subsequent 18 months has seen significant achievement and learning through the prototyping of 'wrap-around' quality management infrastructure support for front line teams. Much has been learned about how to develop, deploy and sustain this infrastructure and engage it productively with operational services.

3.3 Further crucial insights have been gained concerning the impact of the organisational culture into which support has been deployed, and how this influences activity and outcomes. Our local learning is strongly reflected in the experience of other organisations pursuing similar ambitions.

3.4 The focus of the next five years development of our Quality Management System should be firstly on creating the most fertile and facilitative organisational culture and secondly the creation, development and deployment of supporting infrastructures.

3.5 At a fundamental level, the three key activities we must see across our organisation are:-

- To understand and respond to the experiences of the people using and providing our services
- To continuously improve in the pursuit of excellence
- To always approach innovation in the mind-set of disruption

3.6 The experiences and outputs of all these activities should be captured, reflected upon and learned through a Learning Healthcare System

3.7 Our ultimate goal is to be a High Performing Organisation achieving best in class quality, cost and performance outcomes.

3.8 The Chief Quality Officer would be delighted to respond to any Board member seeking further information.

4 Key Risks

4.1 The transformation we propose will take no less than five years to be realised.

4.2 The development of internal capability and capacity could be compromised by competing national and local pressures upon NHS Lothian.

4.3 Not using 'exnovation', as well as 'innovation', to free time and other resources in pursuit of our goals.

5 Risk Register

5.1 There are no new implications for NHS Lothian's Risk Register. The Quality approach outlined in the paper attached should contribute to a reduction in the number and severity of registered corporate risks, especially in relation to patient experience, outcomes and financial sustainability.

6 Impact on Inequality, Including Health Inequalities

6.1 The Quality Five Year Plan and Quality Management System is founded on the six dimensions of quality, including equity. Equality impact assessments will be undertaken as part of considering any major changes to processes and protocols**.**

7 Involving People

7.1 Patient experience is vital for high quality care and we have therefore made it central to our quality programmes and training. All of the clinical quality programmes are using significant patient feedback to inform work, mainly in the form of patient follows, and we train all staff attending the Quality Academy in methods of gathering feedback. Our Quality Directorate website shares all our information with the wider public through the internet and social media; we have no closed intranet presence. Perhaps most importantly, despite these efforts we remain dissatisfied with our present level of patient, family and workforce engagement and are fully committed to doing much more as we develop.

8 Resource Implications

8.1 Presently, no specific resource is sought but a further paper describing additional resource requirements will follow, as per point 2.3

Simon Watson
Chief Quality Officer
25/09/2017

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List of Appendices

Appendix 1: ‘Core elements within a Five Year transformational plan for Quality Management in NHS Lothian’

LothianQuality

BETTER HEALTH, BETTER CARE, BETTER VALUE

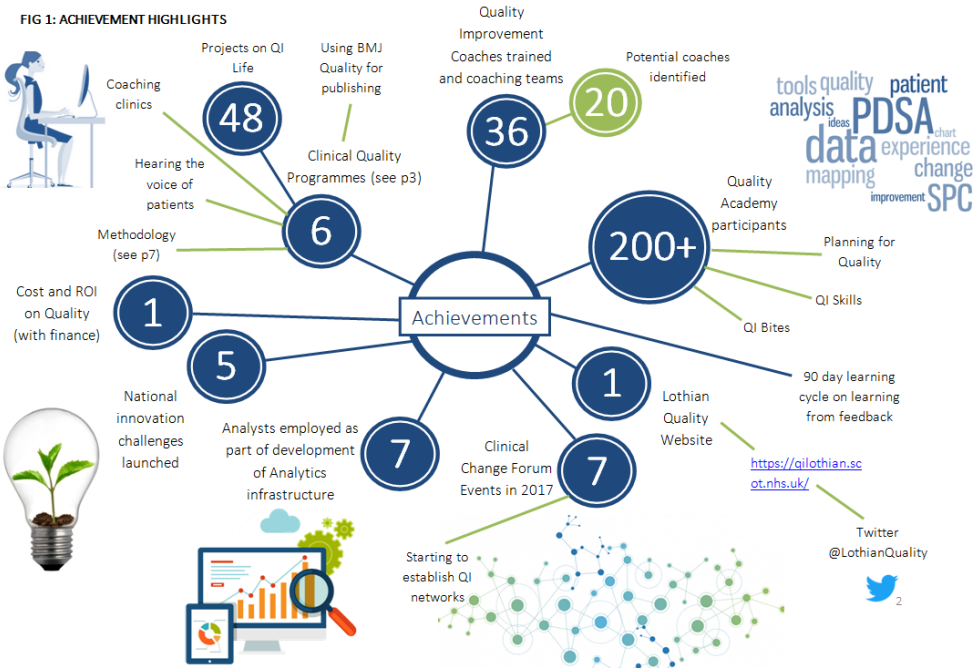
NHS Lothian

Core elements within a Five Year transformational plan for Quality Management in NHS Lothian

5 Year Plan

This document outlines key elements within a proposed five-year development plan for NHS Lothian's Quality Management System. It builds upon the prototyping work undertaken in 2016-17 to create a transformational, fully-embedded and integrated approach putting quality at the heart of NHS Lothian. Whilst there is much to say about progress to date, this document intentionally focuses on the future.

A high-level info graphic of some key achievements is shown below:



More detailed information on the progress of current Clinical Quality Programmes and related activities can be found though the Quality Directorate website. The CQO will provide more detail on past achievements in a short presentation at the October 2017 Board meeting. All those working in the Quality Directorate will be delighted to provide additional briefings as requested.

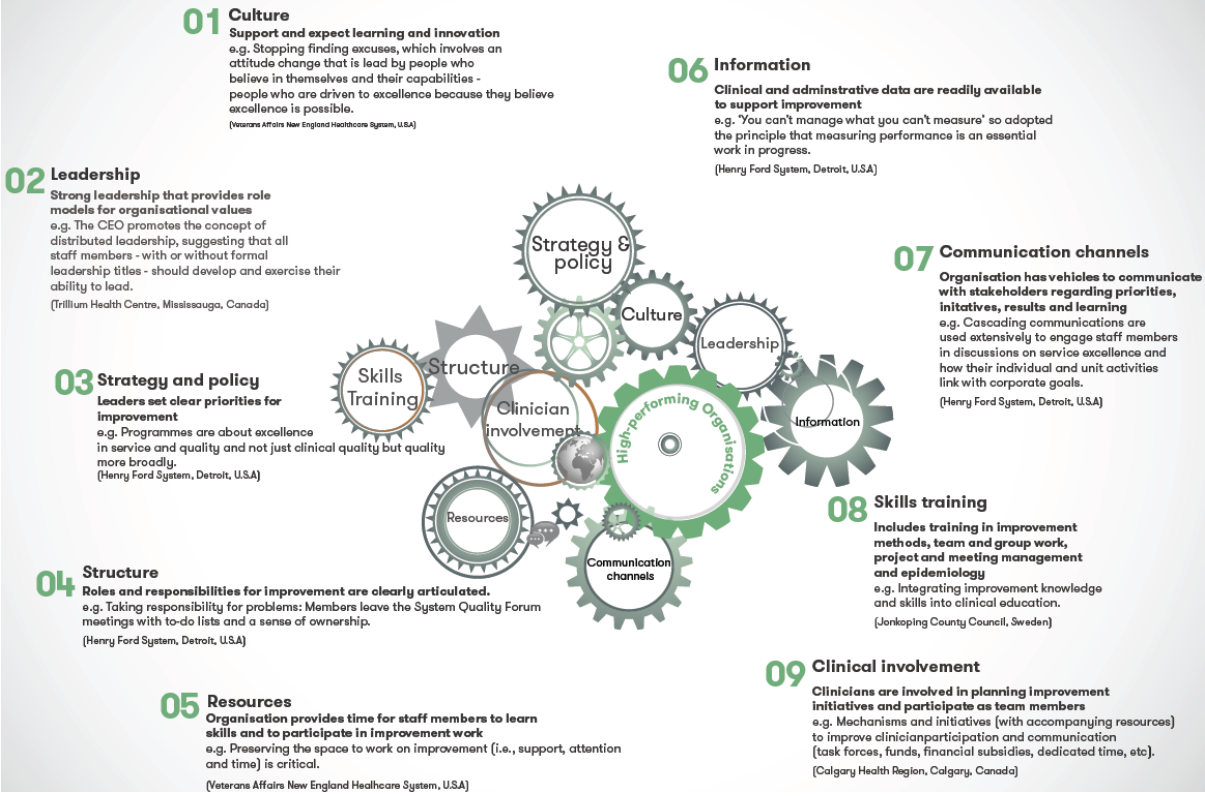
The remainder of this document focusses on the coming five years with respect to five key recommended actions for NHS Lothian :-

1. To become a High Performing Organisation (HPO) through transformational change across nine system-wide domains
2. To demonstrate 'on the ground' evidence of a HPO that creates optimal conditions for continuous quality improvement and disruptive innovation at microsystem level
3. To invest in effective 'catalytic' infrastructure to accelerate change
4. To align and deploy change management infrastructure and approaches in pursuit of aspirational strategic objectives
5. To engage with patients, workforce and key partners and create a detailed roadmap for the next 18 months and broader vision for the coming five years

Recommendation 1: To become a High Performing Organisation (HPO) through transformational change across nine key system-wide domains

Much has been achieved and learned during eighteen months of prototyping our Quality Management System. However, reaching our goals requires whole system change to support continuous quality improvement, disruptive innovation in the pursuit of excellence. A seminal study of high-performing healthcare systems identified nine key organisational attributes necessary to create these conditions.

Fig. 2 Nine key attributes of high-performing healthcare organisations



The first and most important recommendation is to purposefully transform our organisation so that, in five years' time, these attributes are clearly our new way of working. As evidence for this, a visitor in 2023 should experience the following: -

Culture

- Our highest priority is striving to put the voice of those we serve at the heart of all we do
- Best in class cultural survey scores for valuing experimentation, disruptive innovation and pursuit of excellence at all levels
- Rewards and incentives directly aligned to the improving quality, disruptive innovation and creating a Learning Healthcare System.

Leadership

- The Executive Team and Board role model the behaviours, values and attitudes that create a quality and innovation-focused organisation
- All leaders in NHS Lothian actively distribute authority to experiment and innovate in the pursuit of excellence
- Leadership decision making is clearly informed by data and information within a learning healthcare system

Strategy & policy

- The process of prioritising and establishing major quality management programmes is collaborative, rational and clear, reflecting key organisational values, vision, mission and strategic objectives.
- All elements of Realistic Medicine will be strongly embedded across clinical operations, with 'Being Open' as our standard communication approach
- An effective, symbiotic organisational relationship between cost, quality and performance management supporting financially-viable, sustainable and high-quality services

Structure

- The Quality Directorate supports the operational implementation of the Quality Management System based upon Juran's 'Trilogy' model
- Wider corporate change management services have clear and complementary roles and are deployed strategically
- All corporate services have clearly defined, inter-dependent roles as 'shareholders' in the wider Quality Management System

Resources

- Major quality management programmes are initiated by agreeing formal compacts between NHS Lothian/HSCPs and individual delivery services
- Programmes that drive out waste and unwarranted variation will share financial and other benefits amongst the wider organisation and locally participating services
- Significant resource is dedicated to an information-driven learning healthcare system focussed on identifying and delivering greater value for those we serve

Information

- All those working in NHS Lothian are enabled, informed and discerning users of information and high-quality analysis
- Lothian has best-in-class care and cost information provision and analytical services supporting a Learning Healthcare System
- Lothian demonstrates excellence in data quality and governance, whilst avoiding unbalanced risk appetites that impede progress

Innovation

- The mechanisms by which the organisation supports disruptive innovation are clear, effective and sustainable
- All proposals for significant managed change go through robust, credible and effective 'reframing' as a standard part of their development; change through disruption, rather than 'upgrading' is our default position
- NHS Lothian routinely runs open innovation programmes to facilitate external agencies supporting our search for productive and disruptive innovation
- Ideas for new 'products' (in the broadest sense) are routinely supported from conception, through development to successful commercialisation with tangible benefits for the individual 'inventors' as well as the wider organisation

Communication

- Lothian provides high quality daily information exchanges describing our progress and achievements to the wider public
- All staff are empowered, equipped and enabled to capture experiences, ideas and achievements in the service of our patients
- All our routine communication updates on the quality improvement, disruptive innovation and the pursuit of excellence are through the most open, widely-accessible media available

Skills training

- All staff receive regular training to at least practitioner-level and routinely access expert coaching in quality management
- Bespoke training is provided to those in extended or specific roles critical to developing the quality management system
- Quality management training is provided through all corporate staff development and education functions

Involving people [workforce and public]

- All staff members routinely contribute to continuous quality Improvement and innovation
- The majority of successfully tested change ideas come from patients, families and front-line staff
- Regular and meaningful engagement between staff and patients on approaches to service delivery drive a more person-centred system of care

Recommendation 2 : To demonstrate 'on the ground' evidence of a HPO that creates optimal conditions for continuous quality improvement and disruptive innovation at microsystem level

Over the past eighteen months, the Quality Directorate has developed, tested and refined a process to establish major Clinical Quality Programmes within NHS Lothian. Six prototype programmes have received additional 'wrap around' support during 2016-17, deployed to address defined quality, cost and performance challenges.

The basic framework for establishing prototype Clinical Quality Programmes is described in the Quality Directorate website, key elements being:-

- Funding to protect time for programme leadership
- Dedicated Improvement advisor/programme management support
- Dedicated health and financial analytical support
- Bulk places on Quality Academy courses for leadership and wider workforce
- Enhanced access to coaching support
- Enhanced access to disruptive innovation support
- Mentorship from senior team member within the Quality Directorate
- Executive sponsorship

Elements of all these proved beneficial to varying degrees. Some of this variation has related to the support provided but much reflects other factors. A critical learning point has been the vital importance of deploying support within 'fertile' organisational environments. Lessons from local experience and wider learning identify eight key factors necessary for this 'fertility': -

- Leadership behaviours and culture that empower broad-based 'front line' experimentation and innovation
- Working across organisational boundaries, especially into community care
- Being genuinely person-centred, ever aware of the danger of 'tokenism'
- Quality management capability and experience
- Meaningful and effective systems to collect data for the analysis and production of useful information
- Robust and effective learning systems
- Genuine willingness to embrace and encourage disruptive innovation
- Co-creation of an empowering, strategically-aligned suite of change programmes and projects to maximise value

We must recognise the vital importance of these factors, as evidenced by their presence in our 'exemplar' local services. A key quality and innovation programme for NHS Lothian should be to purposefully benchmark, measure and improve the expression of these factors across all our key delivery services. In addition to generating more improvement and innovation, this will also allow additional 'wrap around support' to accelerate progress. Such a programme should be a top priority for our Quality Management System and wider supporting infrastructure.

Recommendation 3: To invest in effective 'catalytic' infrastructure to accelerate change

In addition to transformational change to our existing macro- and micro-systems, a number of further specific infrastructure enablers will act as 'catalysers' for change in NHS Lothian. These can be deployed at all levels; over long periods in major clinical quality programmes, to accelerate short-term changes at microsystem level or as part of our system-wide capability building.

1. **Bespoke training services through the Quality Academy, coaching networks and corporate Quality Improvement Support**

These services will support quality management at all levels. The training and coaching support will be built upon the current two in-house programmes (Planning for Quality and Quality Improvement Skills) and the QI bites programme. The sustainability model will depend upon a strong collaborative partnership with wider organisational training and development services. Wherever possible, key staff in all these services will be invited to join the Quality Academy and Coaching Network Faculty. Presently no other Board in Scotland has comparable training and coaching programmes. So far as Quality Management is concerned, we provide 'exceptional' rather than 'normal' NHS education and development activities.

2. **Enhanced services to capture feedback from, and proactively engage, service users in quality management and innovation**

In recent years Lothian has seen significant progress in developing services to capture, respond to and learn from feedback from those we serve. The Patient Experience Team has a corporate role and its strong links to the Quality Directorate are highly valued. However, evidence from prototype Clinical Quality Programmes demonstrates a real need to rebalance broader information capture towards patient reported outcomes and experiences. In addition, further development of enablers to encourage public engagement with quality improvement and innovation should be developed. These would include a focus on health literacy, community networking and other engagement opportunities.

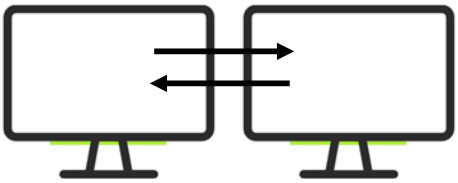
3. **Healthcare & Financial Information provision and analytical services**

High quality data, information and analytical capabilities are crucial elements of quality management. Converting our abundant data into valuable information is a constant and growing challenge but also a major opportunity. The prototype Clinical Quality Programmes frequently highlighted the value of information to understand variation and challenge assumptions. For engaged and motivated teams within quality programmes, the supply of information is often the rate limiting variable.

It is vital to link healthcare and financial information, intelligence and skilled practitioners in a joint effort to truly define value, waste and the nature of variation. Much can be done though technology but perhaps more through the confidence of healthcare analysts and financial management professionals in engaging with wider teams undertaking quality management and innovation activities. The implementation of the 2016 Information Strategy in is well underway and synergies with broader financial strategies are increasingly recognised and being developed. There are considerable opportunities for further cross fertilisation.

4. eHealth innovation and development to support business intelligence systems

The importance of data extraction, processing and analysis has already been stated. As important is infrastructure to capture, organise and present data for analysis. Whilst there are many calls upon our corporate eHealth services, investment in analytical capability must be supported by investment in eHealth systems, technologies and professionals.



5. Support for disruptive innovation

A potential pitfall for any organisational change is to 'tune the engine' when what is required is entirely different form of propulsion. The NHS has struggled to move innovation from 'sustaining' mode to novel, 'disruptive' innovation. Overcoming this struggle is vital if we are to maintain the core, essential values of our universal NHS.

Developing a workforce with the confidence and capability to disruptively innovate is an exciting opportunity and will require open-mindedness to novel ideas and partners. This endeavour will challenge us in many ways, in particular our approach to problem solving and the creative process.

An organisational plan to enhance local disruptive innovation is in the final stages of development, building upon learning from the NHS-Scottish Enterprise Innovation Programme hosted in Lothian. The three key elements in this plan will be:-

- Establishing meaningful 'reframing' of change ideas through the lens of disruptive innovation as routine practice
- Identifying and initiating open innovation challenges to share our wicked problems with external partners
- Enhancing our ability to take ideas for innovative new products from conception to production, sale and income generation

The final Innovation Plan will be shared in Q4 of 2017.

Recommendation 4 : To align and deploy change management infrastructure and approaches in the pursuit of aspirational strategic objectives

Whilst our organisation should focus on improving the systemic culture, capability and capacity for Quality Management, purposeful deployment of high-impact Clinical Quality Programmes should be continued. These programmes should not stick dogmatically to a single philosophy of change but instead use a range of tried-and-tested approaches within Lothian, principally:-

- Breakthrough series collaborative programmes
- Microsystems and pathway focussed approaches
- Lean production system-based methodology

Potentially programmes should also be identified through a triangulation of information sources:-

- Macro-system data pertaining to cost, volume and apparent unwarranted process and outcome variation
- Microsystem evaluation of readiness for change (with reference to key factors described in Recommendation 2)
- Wider analysis of change needed to achieve strategic objectives

These elements together with the proposed approach to change, an evaluation framework and anticipated benefits should be clearly described in a formal compact between programme and NHS Lothian senior leadership. Upon agreement of the compact, additional catalytic change infrastructure can be deployed.

An initial examination of various business intelligence data suggests that up to 25 major programmes could impact on most recorded clinical activity in NHS Lothian. However, a degree of sophistication in identifying and constructing programmes will be needed for maximum return on investment. A key issue will be sequencing, balancing and 'dosing' of organisational support. The process of becoming a major programme may be gradual, rather than abrupt.

There are risks in deploying resource exclusively through current management lines, not least the potential for future restructuring. Deployment across networks with long-term, patient-

centred characteristics could be more sustainable and also would demonstrate distributed leadership.

A key success factor will be the creation of clear, aspirational and inspirational strategic goals for major quality programmes. A local exemplar of this approach is the Lothian Newborn Care Collaborative Quality Programme (2016-18), whose goals are:-

- Building strong and effective teams
- Well babies being with their mothers
- The best family experiences
- Reducing harms associated with infections

An immediate action in developing the next phase of our Quality Management System is to review and refresh our current top-line goals and communication strategy. The emphasis on engagement, aspiration and inspiration should not be underplayed.

Whilst the opportunity to create and refresh a series of current and relevant priorities is empowering, great attention should also be paid to ongoing and vital objectives. The Quality Management System will align to and support all our strategic objectives. Particularly close alignment will be to financial sustainability, Realistic Medicine and the evolution of our Regional Plan.

a) *Financial sustainability*

Key dimensions of NHS Lothian's 2017 outline Financial Strategy include:-

- Information-driven analysis of demand, need and capacity
- Stakeholder engagement
- A focus on understanding and augmenting the value we provide
- A clear framework for setting priorities and measuring deliverables

This approach has been outlined in response to, perhaps, the greatest financial pressure the NHS has seen since its inception. Importantly the strategy envisages that the development of quality management will, as a minimum, make an essential contribution to ongoing financial sustainability as part of NHS Lothian's ongoing "business as usual" savings. Some aspects of quality management such as disruptive innovation might, over time, deliver more of the transformative change required to deliver sustainability but at this stage this has not been assumed.

Financial and quality management are closely connected, especially when care provision is characterised by the highest possible quotient of value and least waste. There are a number of high profile, estimates of the potential for waste reduction in the NHS ranging between 1-30%. All are based on assumptions, and our biggest challenge is identifying solid opportunities to improve quality, reduce waste and avoid unnecessary costs. Tools such as the ISD Discovery system and the evolving NHS Lothian PLICs identify apparent unexplained variation in practice, process and outcome. However, all rely upon data sets about which there are real data quality concerns so 'noises' within them should be investigated but not assumed to be meaningful 'signals'.

Unfortunately, there is no accepted tool to confidently, reliably and pro-actively identify specific opportunities for improved quality with reduced cost. All reports of significant cost avoidances through quality management programmes have relied upon retrospective analyses in which often the greatest yields were often in unexpected places.

Indeed, our analysis of cost reduction opportunities in three of our programmes has been based on estimates of the cost of current waste such as missed appointments, inappropriate referrals, and the potential for harm from longer length of stays which will only be validated once the change have been embedded. A further challenge for our current way of working is that savings are often delivered in other parts of the organisation from where the improvement is being tested/implemented.

Nevertheless, within the UK and elsewhere, organisations that have intentionally made 'quality' their guiding star for all activities are often faring best in these financially constrained times. Whilst investing in methods to retrospectively measure cost savings linked to quality programmes, they compensate for the absence of predictive tools by adopting a 'total quality' approach to raising the level of quality management across their whole organisations through: -

1. A focus on value – i.e. pre-emptively stating 'what good looks like' and relentlessly pursuing excellence
2. Co-creating shared aspirational goals with their workforce and those they serve
3. A 'total quality' approach, whereby the conditions required for a whole organisation are understood and purposefully created
4. Measuring and analysing variations in healthcare and cost outcomes from macro- to micro- level
5. Quality aspirations reaching beyond narrowly-defined clinical or service goals to encompass a broad range of high value activities

Over the previous 18 months, tools to retrospectively identify improvements linked to financial benefit have been identified and the beginnings of a value-mapping framework developed. It is also evident that as our quality management system develops so will the quality of our data. This in turn will improve the outputs of PLICs giving clinicians access to a much-improved source of intelligence on the resource impact of their practice and that of their peer groups. When this is combined with outcome data we, as an organisation, will have a much-improved understanding of value than we do currently

b) Realistic Medicine

Realistic medicine poses six key challenges to the medical profession and wider health and social care systems. Three (reduction in harm and waste, unnecessary variation in practice and outcomes and becoming improvers and innovators) are primary objectives of the Quality Management System. The remainder are very closely aligned and the Quality Management System will provide an evidential framework to support challenging conversations and new ways of working. This already aligns with the metrics we are developing for current programmes and the initial work we have undertaken on cost measures.

c) East of Scotland Regional Health and Social Care delivery plan

Although the regional delivery plan is a work in progress, key themes and priorities are emerging including:-

- Four key workstreams (Acute, Primary and Social Care, Prevention and upstream population health and corporate business support functions)

- Five functional groupings (finance, workforce, communications & engagement, digital health and quality improvement)

- Key lessons learned from the creation of similar STPs in England, including the importance of engagement and planning 'in the clear' and the challenges of change that 'downgraded' local services

- The importance of being strategic in approach, focussing on 'how' more than 'what' and not assuming that if throw 'the kitchen sink' at a problem some will stick

Whilst quality management activity works best at the front line, creation of the conditions for success is scalable and testable. Furthermore, the Breakthrough Series Collaborative model – one of the key quality improvement approaches – is proven to work at regional or national level. Before deploying elements of Lothian's Quality Management System locally, the opportunity for regional deployment, testing and shared learning should be explored including referencing work also underway on quality management in both NHS Fife and NHS Borders Opportunities for collaboration and sharing corporate quality management functions – for example, the Quality Academy – should also be sought.

Recommendation 5: To engage with patients, workforce and key partners and create a detailed roadmap for the next 18 months and broader vision for the coming five years

With support from the Board, the outline plan will be expanded into detailed transformational change programme plan through wider engagement with key stakeholders across the region and beyond.

The fruits of this engagement will lead be described in two further papers that the Board will be invited to receive. These will describe: -

- A proposition for additional investment to support the five-year plan, including a proposal for endowment funding
- An implementation plan breaking down the key recommendations outlined above into a series of SMART actions

Simon Watson, Chief Quality Officer

27th September 2017

Oct - Dec 17

Engagement through networks and hierarchies across Board to refine the outline programme.

Early development evaluating and benchmarking tools for recommendationsn1&2

Refine medium- and long-term strategic goals

Jan - Mar 18

Create long list of potential major programmes

Finalise 'readiness for change' tools

Begin to develop macro-level HPO evaluation tools

Complete and present five year plan at level of detail to CMT and Board

Apr - Jun 18

Begin development work on compact for two or more major clinical quality programmes

Begin to develop plan to enhance eight key features of sucessful microsystems

Jul - Sept 18

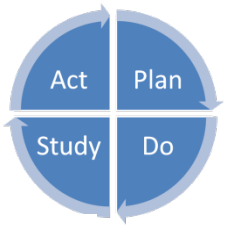
Agree compact and commence two new major clinical quality programmes

Finalise and begin implementation of the pan lothian programme to improve microsystem capability across Lothian

Oct - Dec 18

Begin scoping for the next major clincial quality programmes, drawing upon our previous long list

Commence evaluation of work undertaken to previous 18 months work



Jan - Mar 19

Finailise slection and prepare to launch next major quality management programmes

Complete evaluation and reflect upon lessons learned

Commence planning for the next 18 months

All stages of development will involve a Learning System overseen by a strategic advisory group of experts and opinion leaders

NHS LOTHIAN

2.2

Board Meeting
4th October 2017

Chief Quality Officer

QUALITY AND PERFORMANCE IMPROVEMENT

1 Purpose of the Report

1.1 This report provides an update on the most recently available information on NHS Lothian's position against a range of quality and performance improvement measures.

1.2 Any member wishing additional information on a particular measure should contact the specific lead director identified, having accessed to self-service pack initially. Matters relating to the monitoring and assurance process should be directed towards the Chief Quality Officer.

2 Recommendations

2.1 The Committee is invited to:

2.1.1 Accept that performance on 14 measures considered across the Board, including those relating to the Hospital Scorecard, are currently met with 19 not met. It is not possible to assess performance on dementia post-diagnostic support or complaints stage 1 or 2; and

2.1.2 Accept Board Committees are continuing with the enhanced programme of assurance agreed, with a provisional timetable for remaining measures outlined in this paper To date, 19 measures have been considered with significant, moderate and limited assurance reached on 1, 8 and 10 instances respectively. On no occasion was 'no assurance' concluded.

3 Trial of Lighter Documentation Approach

3.1 This is the second month trialling the lighter documentation approach. A summary of the approach is incorporated into the following table.

3.2 An excel file has been circulated with the papers with work underway currently to migrate that into a dashboard.

Table A – Summary of Lighter Approach Trial

Committee	Previous Approach	Lighter Approach
Board	• Overview for all measures • Assurance Summary • Proformas where not met	• Overview for all measures • Assurance Summary • ~~Proformas where not met~~ • Self-Service Pack
Governance Committee	• Overview for all measures • Assurance Summary • Detailed Measure Paper • Proformas where not met	• Overview for all measures • Assurance Summary • Detailed Measure Paper • ~~Proformas where not met~~ • Self-Service Pack

4 Recent Performance

4.1 Against the measures considered, most recent information demonstrates that NHS Lothian met 14 of the 36 measures considered, whilst 19 were not met. As detailed above, it is not possible to make an assessment on Dementia Post-Diagnostic Support or Complaints Stage 1 or 2.

4.2 Board committees have been delegated the responsibility for seeking assurance for the measures contained in this report, seeking to conclude levels of assurance for those areas that they have examine, considering "*What assurance do you take that the actions described will deliver the outcomes you require within an acceptable timescale?*"

4.3 The assessments made to date are set out both in Table 1 19 have been considered with significant, moderate and limited assurance being reached on 1, 8 and 10 instances respectively. On no occasion was 'no assurance' concluded;

4.4 The delegation of measures to governance committee and detail behind assurance gradings are available in the appendix.

Table B – Assessed Levels of Assurance

			Assurance Level				
			Not yet assessed	**None**	**Limited**	**Moderate**	**Significant**
Board	Met	15	-	-	-	-	-
	Not Met	18	-	-	-	-	-
Acute Hospitals Committee	Met	9	8	0	0	1	0
	Not Met	9*	2	0	5	4	0
Healthcare Governance Committee	Met	5	4	0	0	1	0
	Not Met	9	2	0	5	1	1
Staff Governance Committee	Met	0	-	-	-	-	-
	Not Met	1	-	-	-	1	-

*The Diagnostic measure has been separated out in terms of assurance so although there are 8 measures not met the diagnostics has been split into 3.

Table 1: Summary of Latest Reported Position

Measure[1]	Healthcare Quality Domain [2]	Type [3]	Assurance Committee	Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard[4]	Trend[5]	Published NHS Lothian vs. Scotland[6]	Date of Published NHS Lothian vs. Scotland[7]	Target/Standard	Latest Performance	Reporting Date	Lead Director
Cardiac Arrest (per 1,000 discharges)		Quality	Acute Hospitals (AHC)	Limited	Aug 17	Not Met	No Change	Not Applicable	Not Applicable	0.95 per 1,000 discharges (median)	1.76 (median)	Aug 17 (Mthly)	TG
Falls With Harm (per 1,000 occupied bed days)		Quality	Healthcare Governance (HGC)	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Not Applicable	Not Applicable	0.31 per 1,000 occupied bed days (median)	0.26 (median)	Aug 17 (Mthly)	TG
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)	Safe	LDP	HGC	Moderate	Jul 17	Met		Worse	Mar 17 (Quarterly)	0.32 (max) (<=262)	0.20 (rate) 67 (incidences)	Aug 17 (Mthly)	TG
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)		LDP	HGC	Moderate	Jul 17	Not Met	No Change	Better	Mar 17 (Quarterly)	0.24 (max) (<=184)	0.26 (rate) 83 (incidences)	Aug 17 (Mthly)	TG
Hospital Standardised Mortality Ratios (HSMR) (within limits)		Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	1 All sites within HS Limits	NHS L 0.85 / RIE 0.84 / SJH 0.84 / WGH 0.77	Mar 17 (Qtrly)	TG
48 Hour GP Access – access to healthcare prof		LDP	HGC	TBC	TBC	Met		Worse	2015/16	90% (min)	91.5%	2015/16	DS
48 Hour GP Access – GP appt		LDP	HGC	TBC	TBC	Not Met	Deteriorating	Worse	2015/16	90% (min)	74.8%	2015/16	DS
Four hour Unscheduled Care (% <=4 hrs)		LDP	AHC	Moderate	Feb 17	Met		Better	Jul 17 (Monthly)	95.0% stretch to 98.0%	95.1%	Aug 17 (Mthly)	JC
Alcohol Brief Interventions (ABIs) (Number)		LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Better	2016/17	9,757 (Annual) 2,440 (per Quarter)	3,932	Jun 17 (Qtrly)	AMcM
CAMHs[8] (<=18 wks)		LDP	HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Jun 17 (Quarterly)	90.0% (min)	51.7%	Aug 17 (Mthly)	AMcM
Cancer (<=31-day) (% treated)		LDP	AHC	Limited	Jul 17	Not Met	Deteriorating	Worse	Jun 17 (Quarterly)	95.0% (min)	87.8%	Aug 17 (Mthly)	JC
Cancer (<=62-day) (% treated)		LDP	AHC	Limited	Jul 17	Not Met	Deteriorating	Better	Jun 17 (Quarterly)	95.0% (min)	85.3%	Aug 17 (Mthly)	JC
Diagnostics (<=6 wks) - Gastroenterology/ Urology Diagnostics			AHC	Limited	Aug 17	Not Met	Deteriorating	Worse	Jun 17 (At month end)	0 (max)	3,553	Aug 17 (Mthly)	JC
Diagnostics (<=6 wks) - Radiology/Imaging			AHC	Moderate	May 17								
Diagnostics (<=6 wks) – Vascular Labs	Timely		AHC	To be reviewed	To be reviewed								
Drug & Alcohol Waiting Times (% <=3 wks) - Edinburgh IJB		LDP	HGC	Limited	Sep 17	Not Met	Improving	Worse	Jun 17 (Quarterly)	90.0% (min)	85.0%	Jun 17 (Qtrly)	MM
Drug & Alcohol Waiting Times (% <=3 wks) - Midlothian & East Lothian IJB (MELDAP)		LDP	HGC										EWDS
Drug & Alcohol Waiting Times (% <=3 wks) - West Lothian IJB		LDP	HGC										JF
IPDC Treatment Time Guarantee (<=12 wks)		LDP	AHC	Moderate	May 17	Not Met	Improving	Better	Jun 17 (Quarterly)	0 (max)	83.9% 1,198	Aug 17 (Mthly)	JC
IVF (% <=12 months)		LDP	AHC	TBC	TBC	Met		Worse	Jun 17 (Quarterly)	90.0% (min)	100.0%	Aug 17 (Mthly)	JC
Outpatients (<=12 weeks)		LDP	AHC	Moderate	May 17	Not Met	Deteriorating	Worse	Jun 17 (at month end)	95.0% (min)	64.5% 23,195	Aug 17 (Mthly)	JC
Psychological Therapies (% <=18 wks)		LDP	HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Jun 17 (Quarterly)	90.0% (min)	60.9%	Aug 17 (Mthly)	JF
Referral to Treatment (% <=18 wks)		LDP	AHC	Limited	Feb 17	Not Met	Deteriorating	Worse	Jun 17 (Monthly)	90.0% (min)	79.4%	Aug 17 (Mthly)	JC
Stroke Bundle (% receiving)		Quality	AHC	Moderate	Nov 16	Not Met	Improving	Not Applicable	Not Applicable	80.0% (min)	74.4%	Jun 17 (Mthly)	JC
Planned Repeat Surveillance Endoscopy (past due date)[9]			AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0 (max)	4,543	Aug 17 (Mthly)	JC
Delayed Discharges (>3 days) – East Lothian IJB			HGC										DS
Delayed Discharges (>3 days) – Edinburgh IJB	Effective		HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Jul 17 (Monthly)	0 (max)	218	Aug 17 (Mthly)	MM
Delayed Discharges (>3 days) – Midlothian IJB			HGC										EM
Delayed Discharges (>3 days) – West Lothian IJB			HGC										JF
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days		Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	All NHS L Sites (RIE, SJH & WGH), Within Hospital Scorecard Limits	NHS L 25.17 / RIE 30.89 / SJH 21.91 / WGH 23.96	Jan - Mar 17 (Qtrly)	TG
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met					NHS L 47.22 / RIE 59.25 / SJH 35.17 / WGH 50.57		TG
Hospital Scorecard – Standardised Medical Readmission rate within 7 days		Quality	AHC	TBC	TBC	Met					NHS L 57.50 / RIE 57.66 / SJH 66.49 / WGH 62.18		TG
Hospital Scorecard – Standardised Medical Readmission rate within 28 days	Efficient	Quality	AHC	TBC	TBC	Met					NHS L 126.35 / RIE 131.27 / SJH 143.59 / WGH 123.53		TG
Hospital Scorecard – Average Surgical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met					NHS L 0.97 / RIE 0.92 / SJH 0.89 / WGH 1.11		TG
Hospital Scorecard – Average Medical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met					NHS L 1.19 / RIE 0.86 / SJH 1.37 / WGH 1.45		TG
Staff Sickness Absence Levels (<=4%)		LDP	Staff Governance	Moderate	Mar 17	Not Met	Improving	Better	2016/17	4.0% (max)	4.71%	Jul 17 (Mthly)	JB
Early Access to Antenatal Care (% <=12 wks)	Equitable	LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Better	2015/16	80.0% min for each SIMD[9] quintile	91.6%	Jul 17 (Mthly)	AMcM
Smoking Cessation (quits)		LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Not Met	Deteriorating	Better	2015/16	404 (min for this quarter)	303	Mar 17 (Qtrly)	AKM
Complaints - Stage 1 (%<=5-day)		Quality	HGC	TBC	TBC	TBC[10]	TBC	TBC	TBC	TBC[10]	61.9%	Jun 17 (Mthly)	AMcM
Complaints - Stage 2 (%<=20-day)		Quality	HGC	TBC	TBC	TBC[10]	TBC	TBC	TBC	TBC[10]	69.4%	Jun 17 (Mthly)	AMcM
Detect Cancer Early (% diagnosed)		LDP	HGC	Significant	Nov 16	Not Met	Improving	Better	2014 & 2015 (Combined Calendar Years)	29.0% (min)	26.9%	2015 & 2016 (Combined Calendar Years)	AKM
Dementia – East Lothian IJB	Person-Centred	LDP	HGC	To be reviewed	To be reviewed	TBC[11]	Not Applicable	Part 1: Worse / Part 2: Worse	2014/15	TBC[11] (exptd diag rate + 1 Year (min) PDS)	Part 1: 25.5% / Part 2: 64.3%	2014/15 (TBC)	DS
Dementia – Edinburgh IJB		LDP	HGC			TBC[11]							MM
Dementia – Midlothian IJB		LDP	HGC			TBC[11]							EM
Dementia – West Lothian IJB		LDP	HGC			TBC[11]							JF
Patient Experience (9.0/10 – Overall Experience)		Quality	HGC	Limited	Nov 16	Not Met	Improving	Not Applicable	Not Applicable	9 (out of 10)	8.90	Jun 17 (Mthly)	AMcM

Notes
1. Much of this reporting uses management information and is therefore subject to change;
2. 6 Domains of Healthcare Quality http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html
3. This describes the standard type – 'LDP' target/standards are Local Delivery Plan (previously HEAT), target/standards; Quality standards were originally reported under a separate Quality Paper.
4. Performance Against Target/Standard – describes where Latest Performance meets or does not meet Target.
5. Trend - describes Improvement, No Change or Deterioration for Latest Performance, where Performance Against Target/Standard is 'Not Met', against an average of the last two relevant reported data points. Cardiac Arrest and HAI measures (as applicable) use HIS run chart assessment to ascertain trend. (Black cells indicate that a Standard is 'Met' so a Trend is not available).
6. Published NHS Lothian vs. Scotland – describes most recent published Lothian position against the most recent (directly comparable) published Scotland position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest Performance.
7. Date of Published NHS Lothian vs. Scotland – describes most recent published Lothian position against the most recent (directly comparable) published Scotland position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest Performance.
8. Abbreviations – CAMHS - Child and Adolescent Mental Health Services; CDI- Clostridium difficile Infection; SAB Staphylococcus aureus Bacteraemia; IPDC – Inpatient and Day-case; IVF – In Vitro Fertilisation
9. SIMD - Scottish Index of Multiple Deprivation, http://www.gov.scot/Topics/Statistics/SIMD
10. From the start of April 2017 there has been a national change on assessment of the complaints process. As no historical data is available for the proposed metrics, data will only be available covering April onward. Furthermore as a new measure, there will be an absence of comparative data initially in order to consider performance against that elsewhere.
11. ISD have stated in their publication of 24/1/17 "there is no specific threshold or target in which NHS Boards are expected to be attaining to as the PDS services are still within their infancy and it is anticipated there is likely further developments required". Please also see relevant IJB level Proforma below (in Section 6 Exception Proformas).
http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Summary.pdf?

7 Risk Register

7.1 Not applicable.

8 Impact on Inequality, including Health Inequalities

8.1 The production of this update do not have any direct impact on health inequalities but consideration may be required elsewhere in the delivery of the actions identified.

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

9.1 As the paper summarises performance, no impact assessment or consultation is expected.

10 Resource Implications

10.1 The resource implications related to the assurance programme would be considered by Board Committees are consider items under the Programme of Assurance.

Dan Adams, Andrew Jackson and Ryan Mackie
Analytical Services
28th September 2017
Analysts.PerformanceReporting@nhslothian.scot.nhs.uk

Appendices

Appendix 1 – Alignment of Measures to Board Committee

Appendix 2 – Adopted Assurance Gradings

Appendix 3 – Technical Document

Appendix 4 - Quality & Performance Improvement Reporting Repository

Appendix 1 – Alignment of Measures to Board Committee

	Acute Hospitals	Healthcare Governance	Staff Governance
Effective		Delayed Discharges	
Efficient	*Hospital Length of Stay (2)* Hospital Readmission Rate (4)		*Staff Sickness Absence*
Equitable		*Early Access to Antenatal Care* Smoking Cessation	
Person-Centred		*Complaints (2)* Detecting Cancer Early *Dementia Post Diagnostic Support* Patient Experience	
Safe	*Cardiac Arrest Incidence* Hospital Standardised Mortality Ratio	*Falls with Harm* Healthcare Acquired Infection (2)	
Timely	*4 hr Unscheduled Care Wait* Cancer Waits (2) *Diagnostic Waits* Inpatient and Daycase Waits *IVF Waits* Outpatient Waits *Referral to Treatment Wait* Stroke Bundle Compliance *Surveillance Endoscopies Overdue*	*Access to General Practice (2)* Alcohol Brief Interventions *CAMHS Waits* Drug & Alcohol Waiting Time *Psychological Therapy Waits*	

Appendix 2 – Adopted Assurance Gradings

Definition	Most likely course of action by the Board or committee
LEVEL – SIGNIFICANT The Board can take reasonable assurance that the system of control achieves or will achieve the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all. Examples of when significant assurance can be taken are: • The purpose is quite narrowly defined, and it is relatively easy to be comprehensively assured. • There is little evidence of system failure and the system appears to be robust and sustainable. • The committee is provided with evidence from several different sources to support its conclusion.	If there are no issues at all, the Board or committee may not require a further report until the next scheduled periodic review of the subject, or if circumstances materially change. In the event of there being any residual actions to address, the Board or committee may ask for assurance that they have been completed at a later date agreed with the relevant director, or it may not require that assurance.
LEVEL – MODERATE The Board can take reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk. Moderate assurance can be taken where: • In most respects the "purpose" is being achieved. • There are some areas where further action is required, and the residual risk is greater than "insignificant". • Where the report includes a proposed remedial action plan, the committee considers it to be credible and acceptable	The Board or committee will ask the director to provide assurance at an agreed later date that the remedial actions have been completed. The timescale for this assurance will depend on the level of residual risk. If the actions arise from a review conducted by an independent source (e.g. internal audit, or an external regulator), the committee may prefer to take assurance from that source's follow-up process, rather than require the director to produce an additional report.
LEVEL – LIMITED The Board can take some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk which requires action to be taken. Examples of when limited assurance can be taken are: • There are known material weaknesses in key areas. • It is known that there will have to be changes to the system (e.g. due to a change in the law) and the impact has not b • een assessed and planned for. • The report has provided incomplete information, and not covered the whole purpose of the report. • The proposed action plan to address areas of identified residual risk is not comprehensive or credible or deliverable.	The Board or committee will ask the director to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved.
LEVEL – NONE The Board cannot take any assurance from the information that has been provided. There remains a significant amount of residual risk.	The Board or committee will ask the director to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved. Additionally the chair of the meeting will notify the Chief Executive of the issue.
NOT ASSESSED YET This simply means that the Board or committee has not received a report on the subject as yet. In order to cover all aspects of its remit, the Board or committee should agree a forward schedule of when reports on each subject should be received (perhaps within their statement of assurance needs), recognising the relative significance and risk of each subject.	

Appendix 3 - Technical Document

Measure	Target/Standard
Smoking Cessation (quits)	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards).
Early Access to Antenatal Care (% booked)	Percentage of maternities booked for antenatal care within 12 completed weeks - the target is for 80% of women in each SIMD quintile to be booked within 12 weeks.
CAMHs (18 Weeks)	No child or young person will wait longer than 18 weeks from referral to treatment in a specialist CAMH service from December 2014. Following work on a tolerance level for CAMH services waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the target should be delivered for at least 90% of patients.
Psychological Therapies (18 Weeks)	The Scottish Government has set a target for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014. Following work on a tolerance level for Psychological Therapies waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the Psychological Therapies target should be delivered for at least 90% of patients.
Delayed Discharges (over 3 days)	To minimise delayed discharges over 3 days, with a current national standard of none over 14 days.
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)	NHS Boards' rate of Clostridium difficile infections (CDI) in patients aged 15 and over is 0.32 cases or less per 1,000 total occupied bed days.
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)	NHS Boards' rate of Staphylococcus aureus Bacteraemia (including MRSA) (SAB) cases are 0.24 or less per 1,000 acute occupied bed days.
4-hour Unscheduled Care (% seen)	95% of patients are to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. NHS Boards are to work towards 98%.
Cancer (31-day) (% treated)	31-day target from decision to treat until first treatment for all cancers, no matter how patients were referred. For breast cancer, this replaced the previous 31-day diagnosis to treatment target.
Cancer (62-day) (% treated)	62-day target from receipt of referral to treatment for all cancers. This applies to each of the following groups: any patients urgently referred with a suspicion of cancer by their primary care clinician (for example GP) or dentist; any screened-positive patients who are referred through a national cancer screening programme (breast, colorectal or cervical); any direct referral to hospital (for example self-referral to A&E).
Stroke Bundle (% receiving)	The stroke bundle (percentage of initial stroke patients receiving appropriate bundle of care - Stroke Standard is 80%) covers four targets:- 1. Admission to the stroke unit on the day of admission, or the day following presentation at hospital (Stroke Standard is 90%); 2. Screening by a standardised assessment method to identify any difficulty swallowing safely due to low conscious level and/ or the presence of signs of dysphagia within 4 hours of arrival at hospital (Stroke Standard is 100%); 3. CT/ MRI imaging within 24 hours of admission (Stroke Standard is 95%); and 4. Aspirin is given on the day of admission or the following day where haemorrhagic stroke has been excluded, or other contraindication, as specified in the national audit (Stroke Standard is 95%).
IPDC Treatment Time Guarantee (12 weeks)	From the 1 October 2012, the Patient Rights (Scotland) Act 2011 establishes a 12 week maximum waiting time for the treatment of all eligible patients due to receive planned treatment delivered on an inpatient or day case basis.
Outpatients (12 weeks)	From the 31 March 2010, no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic. This includes referrals from all sources.
Referral to Treatment (18 Weeks)	90% of planned/elective patients to commence treatment within 18 weeks of referral.
Diagnostics (6 weeks)	A six week maximum waiting time for eight key diagnostic tests (four for Endoscopy (a) & four for Radiology (b)) from 31st March 2009.
Surveillance Endoscopy (past due date)	No patient should wait past their planned review date for a surveillance endoscopy.
IVF (12 months)	The Scottish Government have set a target that at least 90% of eligible patients will commence IVF treatment within 12 months. This is due for delivery by 31 March 2015.
Drug & Alcohol Waiting Times (3 weeks)	The Scottish Government set a target that by June 2013, 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. This was one of the national HEAT (Health improvement, Efficiency, Access, Treatment) targets, number A11. This target was achieved in June 2013 and has now become a Local Delivery Plan (LDP) standard - that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%).
Detecting Cancer Early (% diagnosed)	The DCE HEAT standard is for NHS Scotland to achieve a 25% improvement in the percentage of breast, colorectal and lung cancer cases (combined) diagnosed at stage 1. This is to be achieved by the combined calendar years of 2014/2015 and is the equivalent of a national rate of stage 1 diagnosis for breast, colorectal and lung cancer (combined) of 29.0%.
Staff Sickness Absence Levels (<=4%)	4% Staff Hours or Less Lost to Sickness
Cardiac Arrest	50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2015 from February 2013 (1.9 per 1,000), baseline.
Falls with Harm	"Harm" is "Moderate, Major Harm or Death". Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level. 20% reduction in inpatient falls and associated harm, on a baseline median of 30 per month, by March 2016.
Hospital Standardised Mortality Ratios (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.
48 Hour GP Access - access to healthcare profession; or GP appointment.	48 hour access or advance booking to an appropriate member of the GP team (90%) - Patients can speak with a doctor or nurse within 2 working days; or Patients are able to book an appointment 3 or more working days in advance.
Alcohol Brief Interventions (ABIs)	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.
Hospital Scorecard - Standardised Surgical Readmission rate 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. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Surgical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Standardised Medical Readmission rate within 7 days	This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Medical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Average Surgical Length of Stay - Adjusted	Ratio of 'observed' length of stay over 'expected' length of stay. This indicator is case mix adjusted by HRG* and 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).
Hospital Scorecard - Average Medical Length of Stay - Adjusted	Ratio of observed length of stay over expected length of stay. This indicator is case mix adjusted by HRG* and 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).
Complaints (3-Day; & 20-Day)	3-Day Response [Acknowledgement] Rate – 100% formal acknowledgement within 3 working days; & 1. 20-Day Response Rate – 85% of complaints responded to within 3 days.
Dementia	1. To deliver expected rates of dementia diagnosis; 2. All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.

N.b. Source for Current Data - with the exception of DCE, 48 Hours & HSMR data for all of the measures reported is management information

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.

NHS LOTHIAN

2.3

Board
4 October 2017

Deputy Chief Executive

INTEGRATION JOINT BOARDS' ANNUAL PERFORMANCE REPORTS 2016/17

1 Purpose of the Report

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires every integration joint board to publish a performance report by 4 months after the year-end (i.e. by 31 July), and provide a copy to the report to the health board and the local authority. The integration joint boards have to comply with regulations on the content of performance reports as well as have regard to the associated guidance from the Scottish Government.

1.2 The above guidance includes the following comment:

"*Performance reports will be of interest to the Health Board and Local Authorities in monitoring the success of the arrangements that they have put in place for integrated health and social care, and in particular in determining whether a review of their integration scheme is required*."

1.3 The integration joint boards have published their performance reports and a copy of each is included in this report for the Board's information.

1.4 Lothian NHS Board's Standing Orders include the following point under "Matters Reserved to the Board".

"Performance Management

6.19 The Board shall approve the content, format, frequency of performance reporting to the Board."

1.5 This report invites the Board to consider how it would like to review and discuss the annual performance reports of the integration joint boards. The outcome of this discussion shall inform the preparation of an appropriate report to the December 2017 Board meeting.

1.6 Any member wishing additional information should contact the Deputy Chief Executive in advance of the meeting.

2 Recommendations

2.1 The Board to accept this report as a source of significant assurance that the four integration joint boards have prepared their 2016/17 annual performance reports and provided a copy to the Board.

2.2 The Board to discuss how it wishes to make use of these performance reports and advise executive management accordingly.

3 Discussion of Key Issues

Provision of Integration Joint Boards' 2016/17 Annual Performance Reports

3.1 The above reports are provided at appendices 1-4 of this report so that Board members are aware of them. Both City of Edinburgh and West Lothian approved their performance reports before 31 July. East Lothian and Midlothian approved their performance reports on 24 August. While Midlothian have published online the report that the integration joint board approved, they are undertaking further work to produce a more user-friendly public version for their website (based on the approved report).

NHS Board consideration of the Integration Joint Boards' 2016/17 Annual Performance Reports

3.2 Integration Joint Boards are separate legal entities with their own distinct systems of corporate governance, which includes oversight of performance management. The NHS Board nominates half of the voting membership of each integration joint board, and also appoints some of the non-voting members. The NHS Board also routinely receives the minutes from meetings of the integration joint boards.

3.3 The NHS Board considers a Quality & Performance Improvement report and has delegated to its committees the detailed oversight of organisational performance. The integration joint boards are required to report on National Health & Wellbeing Outcomes and their performance reports do have to cover prescribed matters. While the two systems of performance management will have some areas of common ground, they are different.

3.4 In response to the Public Bodies (Joint Working) (Scotland) Act 2014, the NHS Board and the respective local authority for each local authority area ("the parties") elected through the integration schemes to set up integration joint boards. The Act obliges the parties to review the integration scheme to determine whether any changes are necessary or desirable by no later than 5 years after the integration scheme was approved (i.e. by 26 May 2020 for Edinburgh, East & Midlothian, by 16 June 2020 for West). The Act also provides that upon request of either the health board or local authority, the parties must jointly carry out a review of the integration scheme.

3.5 It would not be desirable for the NHS Board to duplicate the performance management oversight which the integration joint boards exercise. However the NHS Board does need to monitor the strategic effectiveness of the integration arrangements, both in terms of assessing its impact on functions and outcomes for service users, and with due regard to preparing for the formal review of the integration schemes at a later date.

3.6 The Board is invited to consider the approach it would like to take, and this will inform the preparation of a report for the Board meeting of 6 December 2017. The Board may wish to reflect on the following potential factors:

- ✓ Do the performance reports contain the information the Board requires?
- ✓ What is a realistic timeframe to expect to see evidence of improvement in the National Health & Wellbeing Outcomes?

- ✓ To what extent has the integration model and the integration scheme facilitated improvement in outcomes?
- ✓ To what extent has the integration model and the integration scheme hindered improvement in outcomes?
- ✓ Are there any areas where it is evident that integration model and the integration scheme have not been relevant to what the performance has actually been? e.g. there were service improvements which would have happened anyway, or the integration joint board has not issued any specific directions which impact on the function or service.

4 Key Risks

4.1 The NHS Board does not see the annual performance reports of the integration joint boards, leading to it not having the information to consider the effectiveness of the integration arrangements and their impact on functions, services and outcomes.

4.2 The NHS Board does not consider how it wishes to consider the annual performance reports of the integration joint boards, leading to the development of a process which does not ultimately meet the Board's needs, which could compromise the quality of its decision-making.

5 Risk Register

5.1 The success of the integration joint boards has an impact on a range of risks on the Board's corporate risk register, e.g. timely discharge of inpatients, unscheduled care – 4 hour performance, finance. Additionally there will be impact on operational risks which are held on risk registers at different levels in the organisation.

6 Impact on Inequality, Including Health Inequalities

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

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

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

8 Resource Implications

8.1 This report has been prepared to share information with the Board and to prompt discussion about a future approach. There are no specific proposals at this point with resource implications.

Alan Payne
Corporate Governance Manager
18 September 2017
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Appendices: The four annual performance reports of the integration joint boards.

West Lothian Integration Joint Board Annual Performance Report 2016/17

Foreword

Welcome to the first Annual Performance Report of West Lothian Integration Joint Board (IJB). In this first year of the integration legislation, all Integration Authorities are required to publish an Annual Performance Report. This report will focus on our performance for the period April 2016 to March 2017 in delivering the National Health and Wellbeing Outcomes. The focus on outcomes allows us to think about the things that matter to the people who use our services and throughout the report you will find real life examples of how we are making a difference to the people of West Lothian.

Overall 2016/17 has been a successful year for the IJB. In addition to overseeing the delivery of health and social care services the IJB has progressed major service changes to manage the demands of an increasingly old and frail population through the Frailty Programme, started work to redesign mental health services, and introduced the living wage for social care workers.

There has been increased joint working across health and social care to integrate service delivery in areas such as supporting older people to stay in their homes and to return home from hospital as soon as possible. A local West Lothian Health and Social Care Delivery Plan has been developed setting out the transformational journey across care services that will allow key integration outcomes to be achieved over the medium term.

Careful financial management and close joint working with NHS Lothian and West Lothian Council has allowed the IJB to successfully deliver on a range of outcomes and manage the delegated financial resources within a challenging financial and operating environment. The pace of change will continue to be demanding and a joined-up approach to strategic and financial planning will be key to ensuring the future delivery of quality care services to the West Lothian population is managed within available resources.

We would like to acknowledge the significant effort of all the NHS Lothian and West Lothian Council staff supporting the IJB in its first full year of operation and look forward to building on the progress that has been made during 2017/18.

Jim Forrest
Chief Officer

July 2017

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2016 /17 Performance at a glance[1]

94% of adults are able to look after their health very well or quite well

(Scotland 94%)

85% of adults supported at home agreed that they are supported to live as independently as possible

(Scotland 84%)

79% of adults supported at home agreed they had a say in how their help care or support was provided

(Scotland 79%)

81% of adults supprted at home agreed that their health and scoial care services seemed to be well coordinated

(Scotland 75%)

83% of adults receiving any care or support rated it as excellent or good

(Scotland 81%)

80% of people had a positive experience of the care provided by their GP practice (Scotland 87%)

80% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life (Scotland 84%)

38% of carers feel supported to continue in their caring role

(Scotland 41%)

85% of adults supported at home agreed they felt safe

(Scotland 84%)

Premature mortality rate is 402 per 100,000 persons

(Scotland 441)

Emergency admission rate is 11,775 per 100,000 population

(Scotland 12,037)

Emergency bed day rate is 99,099 per 100,000 population

(Scotland 119,649)

Readmission rate to hospital within 28 days is 104 per 1000 population

(Scotland 95)

87% of the last 6 months of life is spent at home or in a community setting

(Scotland 87%)

Falls rate is 20 per 1000 population over 65 years

(Scotland 21)

83% of care services have been graded "good" (4) or better in Care Inspectorate inspections

(Scotland 83%)

65% of adults with intensive care needs are receiving care at home

(Scotland 62%)

The number of days people spend in hospital when they are ready to be discharged is 822 per 1000 population (Scotland 842)

21% of health and care resource is spent on hospital stays where patient was admitted as an emergency

(Scotland 23%)

[1] ISD (June 2017) West Lothian 2016/17 Performance Core Suite of National Health and Wellbeing Outcome Indicators

Introduction

The IJB was formed in October 2015 to deliver integrated health and social care as set out in the Public Bodies (Joint Working) (Scotland Act) 2014. It brings together NHS, West Lothian Council, communities and other stakeholders to plan and provide or commission services based on the local needs of our population. The NHS and Council functions delegated to the West Lothian IJB include adult community health services, adult social care services and some hospital services.[2]

Our Vision for integration of health and social care is to ***increase wellbeing and reduce health inequalities across all communities in West Lothian.*** Through working with people in their own communities, listening to them and enabling them to be active participants in how care is delivered and using our collective resources wisely will result in better outcomes for people. Our Strategic Plan 2016-2026[3] has been designed to deliver on the nine National Health and Wellbeing Outcomes for integration[4]. These outcomes are set out in the Public Bodies (Joint Working) (Scotland) Regulations 2014 and provide a strategic framework for the planning and delivery of health and social care services and focus on the experiences and quality of services for service users, their carers and families.

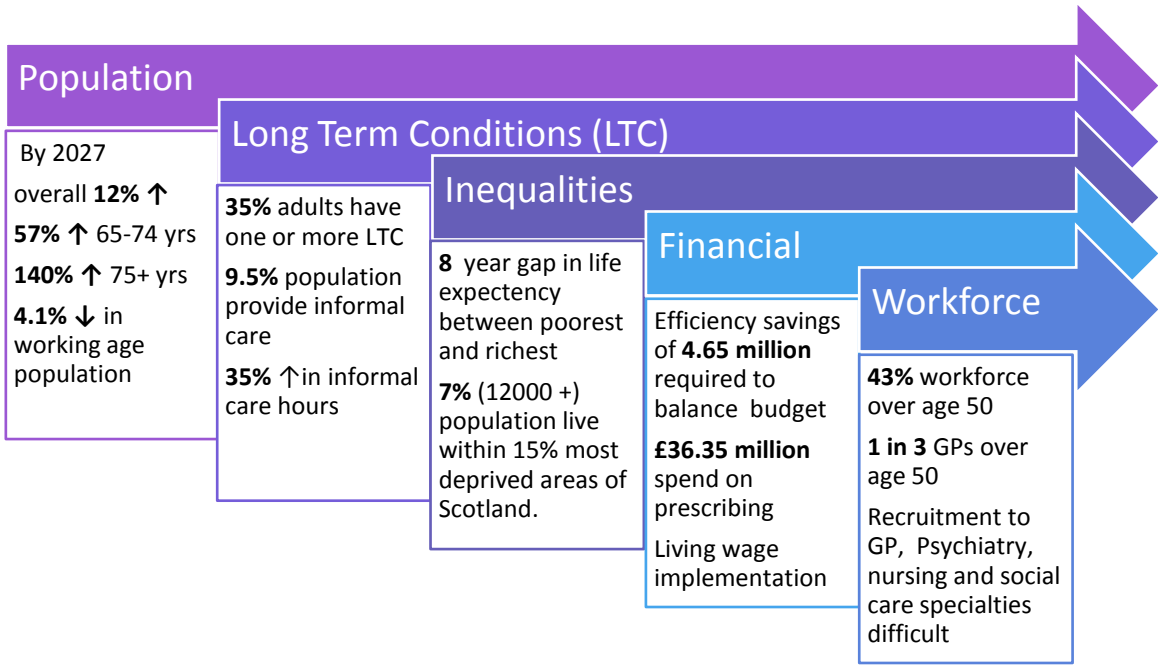
National Health and Wellbeing Outcomes

This performance report describes what the IJB has achieved in its first full year of operation against the National health and Wellbeing Outcomes and sets out a number of important measures of progress. The report reflects on 2016/17 and celebrates the achievements delivered by our employees and partners

[2] West Lothian Integration Scheme http://www.westlothianchcp.org.uk/hsci
[3] Strategic Plan 2016-26 http://www.westlothianchcp.org.uk/media/10225/West-Lothian-IJB-Strategic-Plan-2016-26/pdf/IJB

[4] Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014

and provides an opportunity to think about and appreciate the challenges that face us in terms of performance now and in the months to come. The main challenges are detailed below:



Our health and social care system has to adapt to the needs of our population which is getting larger, older and has more complex conditions and care needs. People who are poor or disadvantaged often have poorer health and tackling inequalities is a fundamental challenge. We have to make substantial efficiency savings to balance the budget, which means doing things differently to make sure we make best use of our resources to deliver the greatest benefit. Our workforce is getting older and we are experiencing issues in relation to recruitment which are having an impact on service delivery. The needs of patients and service users must come first and we are redesigning services to improve their journey through our care services and enhance their experience to achieve better outcomes.

There are 23 National Integration Indicators upon which each partnership is measured and the data provided for these is provided by the Information Services Division (ISD) on behalf of the Scottish Government. Within this report this data along with other local measures is presented and aligned to the outcomes. Our performance has been compared to the Scottish average and where applicable to performance targets. Performance has been rated on a red, amber, green scale as detailed below.

Performance is equal to or better than the Scottish Average or Target

Performance is close to Scottish Average or Target

Performance is below the Scottish Average or Target

People are able to look after and improve their own health and wellbeing and live in good health for longer

There are a range of health improvement activities in place to promote healthy eating, increase physical activity, reduce smoking and improve health in later life. Health improvement priorities have been reviewed and action plans developed with focus on mental health, alcohol use, social isolation, exercise needs and obesity.

The number of adults able to look after their own health and wellbeing is sustained at 94% and there has been improvement in smoking rates which will have long term health benefits.

85.2% of clients referred for alcohol or drug treatment are being treated within 3 weeks; an improvement plan is in place to meet the 90% target.

94% of adults are able to look after their health very well or quite well (Scotland 94%)

85.2% of clients are being seen within 3 weeks of referral to treatment for alcohol /drugs (Access Target 90%)

Adult Smoking Rate reduced by 5% to 19.3% over last 5 years. (Scotland 20.7%)

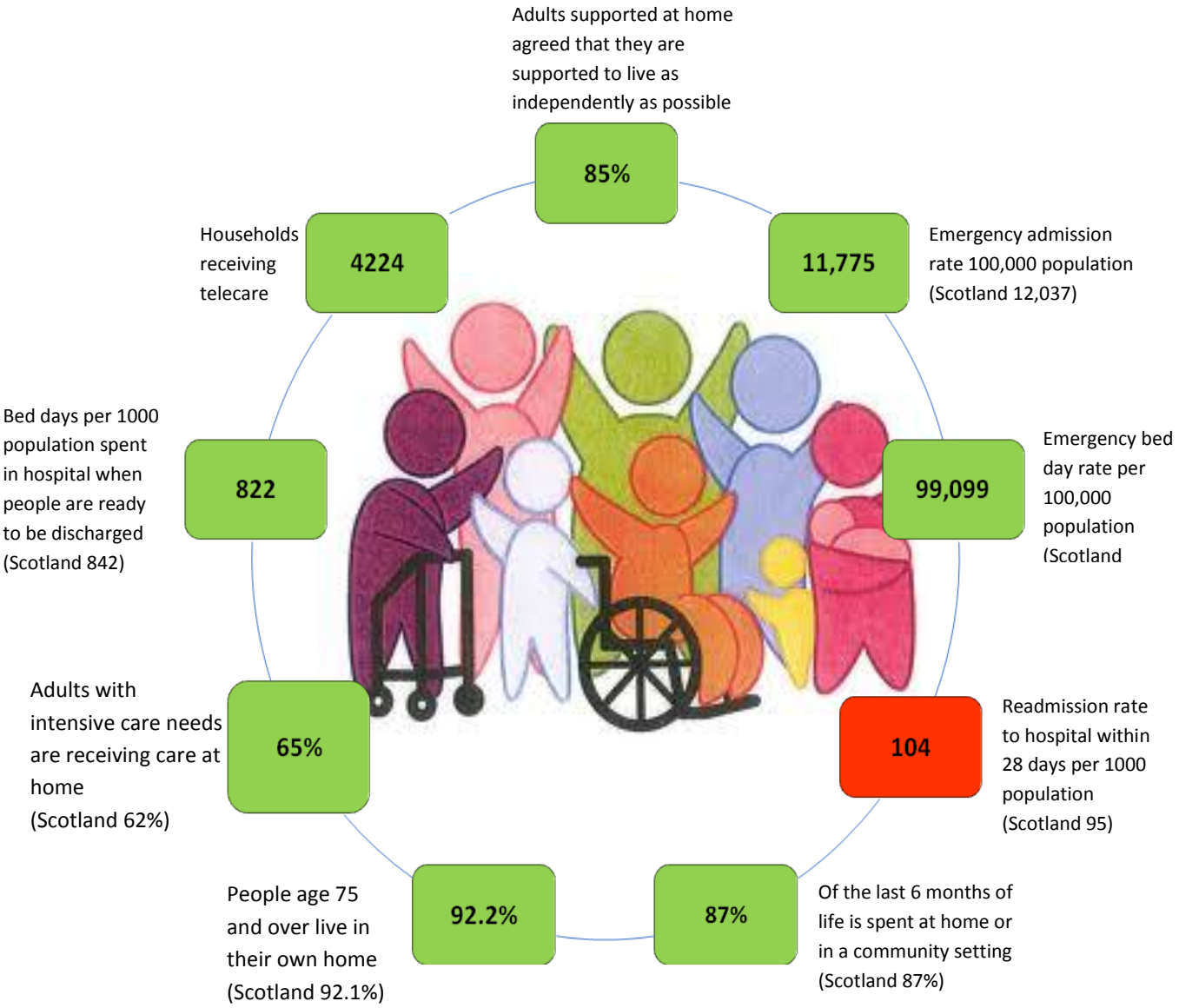
Located close to Bathgate Town Centre, ***Rosemount Gardens*** *is a new purpose built supported housing complex offering 30 tenancies to people over the age of 60 years. In addition to offering comfortable homes for rent and easy access to the town centre a range of on- site facilities and services help to ensure tenants can access all they could possibly need. On site facilities include a well laid out garden area, café, restaurant and hairdressing salon. All are accessible and well used by the public, thus helping to ensure the facility and tenants are engaged with and remain part of the local community.*

Discrete technology is available within each tenancy; this can be customised to individual needs. Core provision includes heat and smoke alarms and a means of summoning help in an emergency via a 24/7 call centre.

On- site assisted living staff offer practical advice and support to maximise choice and independence.

Being able to have friends and socialise plays a major part in an individual's overall quality of life and wellbeing. The staff team have a key role in developing a range of social events and activities which attract friends, family and members of the public to help ensure Rosemount Gardens remains connected to the local community. The facility boasts two activity rooms which are proving popular and are well used by tenants, other organisations and groups /clubs for a range of events and activities.

People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

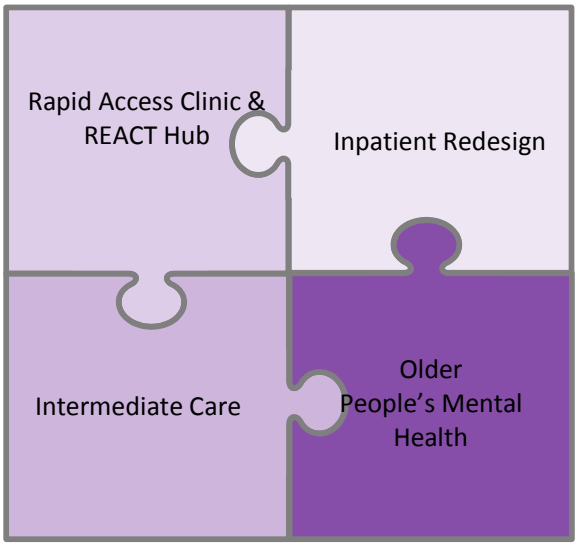


Performance indicates that we are working together well to support people in their own homes or as close to home as possible. 85% of people receiving care felt they were supported to live as independently as possible. This is consistent performance with 2013/14 and slightly above the Scottish average. We have seen a steady improvement in the amount of time spent at home at the end of life (87%) and an increase in the number of people with higher level of care needs receiving care at home.

We have a substantial programme of work in place to address unscheduled care activity across the whole system which seeks to further reduce emergency admissions, readmissions and improve our performance on delayed discharges as we work towards the 72-hour discharge standard.

Focus on Frailty

The population of frail elderly people is expected to increase over the next 10 years along with the projected increase in the older age population. This will increase demand across the whole health and social care system.



The Frailty Programme aims to develop a care pathway that will improve outcomes for older people in West Lothian by joining-up services across health and social care. The frailty programme consists of four main areas of improvement that join up like puzzle pieces to form the overall Frailty Service.

The programme will ensure care is provided in the most appropriate setting be that in hospital, at home or through our community services. Wherever possible people will have their care delivered within the community and when admission to hospital is required then this will be actively managed to promote recovery and enable discharge home as soon as possible. In addition to ensuring rapid access and assessment for those with acute illness the programme also includes mental health with a focus on those with a new diagnosis of dementia to ensure their support needs are met.

Reflective Practice: A Patient Story

I've never been so glad to get home. I'm 91 and don't have any family nearby so Some carers were asked to visit and give me some help.

On my first night home I fell in the hall and was unable to get up. I couldn't call for help as I'd left my alarm by my chair. The carer arrived in the morning; she got me a pillow and blankets and called for help from the district nurse. They helped me up and onto my chair. A physio from the hospital arrived later and for a few days we had some lessons.

The carers continued to visit me in the morning and at night and helped me with washing, dressing and meals. They didn't come in at lunch time but always made sure I had something left for lunch.
The District Nurses also visit to look after my legs. They really know what they're doing you know.

The carers didn't have to do much for me for very long as I was often washed and dressed before they came by. I'm quite fit for my age. The thing I appreciated most was that they made me feel safe. They were there.

I do have my alarm, and know I can contact someone but it was nice to have that extra support. They always reminded me to lock my door as they were leaving and I knew they'd be back to see me

I got to know all the staff. They would tell me about their plans and sometimes their families. One lass was going shopping on Saturday after her shift for holiday clothes. She's going on holiday soon and there's that blonde one who makes me laugh. She sits on that chair every time she's here and makes me laugh. They're a lovely bunch. I couldn't fault any of them. They're all lovely.

People who use health and social care services have positive experiences of those services, and have their dignity respected

Taken from the Health & Care experience survey these measures are directly relevant to our strategic priorities of maximising choice and control, promoting continuous improvement and contribute to our ongoing desire to ensure that personal experience and user voice influence quality improvement.

Results reflect a positive experience with 79% of people having a say in how their care was provided and 83% rating the care they received as excellent or good. People feel they are listened to and treated with respect. Although 80% reported having a positive experience of care within their GP practice this is well below the Scottish average and a key area for improvement.

- 83% of adults receiving any care or support rated it as excellent or good (Scotland 81%)
- 79% of adults supported at home agreed they had a say in how their help care or support was provided (Scotland 79%)
- 80% of people had a positive experience of the care provided by their GP practice (Scotland 87%)
- 94% of service users are treated with respect (Scotland 90%)
- 87% of Service users feel they are listened to. (Scotland 84%)

Signposting

To improve patient experience and ensure people can access the right person first time we have developed Signposting.

All the reception staff within West Lothian General Practices have received special training to enable then to signpost people to the right service to meet their needs.

Posters and leaflets are displayed throughout health centres and other community premises to inform people about how they can directly access a range of services without the need to go through their GP.

This will have positive impact on waiting times and ensure people get faster access to the treatment they need.

Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services

Measures included in this section link to person centered and outcome focused work with people to improve their quality of life.

The Care Inspectorate assess quality among our local providers for care and support, quality of environment, staffing and management and leadership with 83%of providers of care at home, care home, housing support and other services assessed as good or better in West Lothian

83% of care services have been graded "good" (4) or better in Care Inspectorate inspections (Scotland 83%)

80% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life (Scotland 84%)

Project Search *is a year-long, full-time, supported employment programme in West Lothian for young people with a learning disability and/or autism involving a partnership between Jabil (a large electronics manufacturing employer based in Livingston), West Lothian College and West Lothian Council.*

Project Search aims to obtain paid employment for students, or to ensure that they leave the programme ready for work and better placed to secure employment in the future. The programme gives students work experience with the host employer, whilst receiving on-site support from a job coach from West Lothian Council and a lecturer from West Lothian College. Students take part in three twelve week work place rotations which are designed to build skills and confidence whilst studying for a SCQF Level 4 qualification. Students have undertaken a wide variety of roles, for example, in production, assembly, testing, stores, facilities, finance and reception as well as attending business meetings and social events.

The first year of the programme has been very successful and has demonstrated that young people with a developmental delay, who historically have faced significant barriers to employment, are able, with the right support and in the right environment, to develop the skills necessary for future employment.

In April, three students were successful in securing full-time employment with two electronics companies, and a further two moved to jobs in May: one to a warehouse position and the other to a post in retail. One further student is awaiting the outcome of the recruitment process for a Lab Technician, and the others are attending interviews. All the positions secured were advertised through the open job market.

Jabil has reported that the programme has had a very positive impact on organisational culture with employees embracing the opportunity to be workplace mentors to the students. Sadly, Jabil will close its Livingston operation later this year therefore a new business partner is being sought for Project Search.

Health and social care services contribute to reducing health inequalities

Tackling health inequalities is a cross cutting priority for the IJB and Community Planning Partnership. The measures inform progress on tackling poverty, deprivation and inequality. The Strategic Plan 2016-26 outlines our approach to mitigating, preventing and undoing the causes and effects of inequality.

The core integration measure of premature mortality among people aged 75 and under shows positive progress with a reduction from 484 to 402 deaths per 100,000 populations over 5 years.

Male life expectancy at birth 77.9 years (Scotland 77.1 years)

Female life expectancy at birth 80.5 years (Scotland 81.1 years)

Premature mortality rate 402 per 100,000 population (Scotland 441)

Male Life expectancy has improved by 4.9% over the past 10 years and at 77.9 years is higher than the Scottish average of 77.1 years. Female life expectancy has improved by 3.3% over the same period and at 80.5 years is slightly lower that the Scottish average of 81.1 years.

West Lothian Alcohol and Drug Partnership commissions and works with many partners to help adults and families address problematic substance use and to achieve sustainable recovery. The current ADP Commissioning Plan 2015-18 was developed with the collaboration and support of all the partners and as is now standard approach for strategic commissioning in the IJB, the plan was informed by an independent needs assessment. The plan has four main themes aligned to the seven national ADP outcomes and other local priorities based on the needs assessment: Prevention; Early Intervention; Recovery; Community Safety. Activities include:

- *Specialised support and help to those experiencing difficulties with alcohol and drugs;*
- *Individual counseling and psychosocial interventions for those affected by alcohol use;*
- *Working closely with people in prison and custody on alcohol use;*
- *Providing family support to parents experiencing addiction issues; offering relapse prevention support.*

The Cyrenians Recovery Service uses a Public Social Partnership model to provide a moving on/after care service for those in recovery who wish to build a non-substance using lifestyle. Interventions aim to support service users to maintain their positive relationships and to contribute to and support the recovery of others and at the same time gain skills to support their future employability.

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

79% of adults agreed they had a say in how their help care or support was provided (Scotland 79%)

51% of carers said they have a say in the services provided for the person they look after (Scotland 50%)

66% of carers have a good balance between caring and other things in their life (Scotland 68%)

38% of carers feel supported to continue in their caring role (Scotland 41%)

Caring without enough support in place can have a huge impact. Whether caring is full-time, or it is part of a stressful mix of work and other family responsibilities, many carers find they do not have the time or energy to maintain relationships, stay in work, or look after their own health and wellbeing.

The 2011 Census indicated there had been a 9.9% increase in the number of carers in West Lothian to 16,645 and a 60% increase in care provided for 20-29 hours per week and 22% increase in those providing over 50 hours per week.

We are working with our partners to prepare for implementation of the **Carers (Scotland) Act** which will come into force on April 1, 2018. The Act is designed to support carers' health and wellbeing with provisions including requirements for local authorities to provide support to carers, based on their identified needs and local eligibility criteria; specific Adult Carer Support Plan and Young Carer Statement to identify carer's needs and personal outcomes and an information and advice service for carers which must include emergency and future care planning, advocacy, income maximisation and carers' rights.

Carers of West Lothian (CoWL) *provide support and services to unpaid carers of all ages and in all caring situations throughout West Lothian. In 2016/17 the number of carers registered with them increased by 10.4% to 4949. In addition to increased numbers of carers being supported, CoWL has seen a marked increase in the complexity of the caring role, and rise in demand for support for carers, for working carers, young adult carers, parent carers and bereaved carers.*

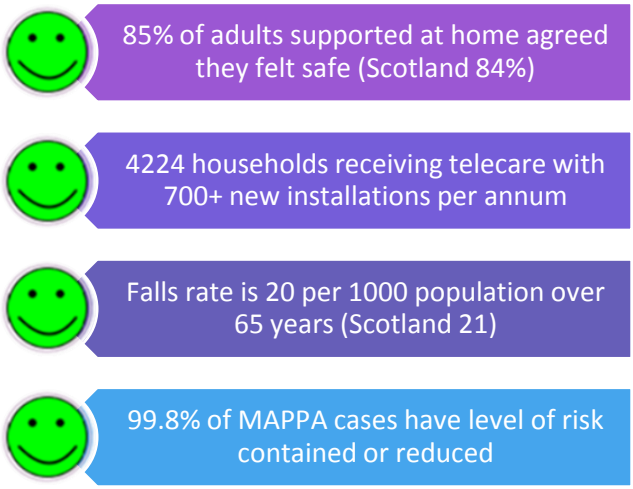
They offer a wide range of support tailored to individual's needs including:

- *Emotional support and counselling,*
- *Practical information,*
- *Financial advice*
- *Peer support groups and*
- *Training*
- *Quarterly newsletter and daily social media updates support carers to engage in their local communities.*

CoWL have recently been awarded a Big Lottery Fund Grant of £372,437 for 3 years which will enhance the level of support they can provide and are the 1st Scottish organisation to be accredited withPQASSO Quality Mark at the highest Level in 2017

People using health and social care services are safe from harm

Measures associated with supporting people to be safe from harm are strongly linked to integrated work undertaken in respect of protection of adults at risk and in the prevention of potentially avoidable harm such as falls.



The core integration indicators demonstrate positive performance with 85% of people supported at home feeling safe and the falls rate among people aged 65+ stable at 20 per 1000. Our well-established falls pathway is supported through interagency working with Scottish Ambulance Service, Crisis Care and community health teams with aim to assess and maintain people who have fallen and are uninjured at home and prevent unnecessary journeys to hospital.

Telecare is an important element of our strategy to support older people for as long as possible in their own home. Our ***Technology Enabled Care*** programme has been awarded Scottish Government funding to extend the use of home and mobile health monitoring, videoconferencing and uptake of Telecare with focus on prevention, transitions in care & dementia.

Case Study – Mrs Jones

Mrs Jones lived independently in supported accommodation. She had previously been active in the local community, attending the church and community events. Family reported that she was suffering from extreme exhaustion, was listless during the day and was reluctant to engage with people or any of her social activities. Mrs. Jones had a formal diagnosis of vascular dementia. Her daughter has Power of Attorney and had needed to take time off work due to her concerns about her mother. Based on Mrs. Jones diagnosis and recent health issues it was considered possible that she may require long-term residential care.

Actions taken

Staff undertaking the assessment process requested the installation of activity monitoring equipment for six weeks (Just Checking). Data from the monitoring showed that Mrs. Jones, having been a shift worker prior to retirement, was very active during the night – consequently when disturbed during the day she was disoriented and unwilling to engage with family and friends. The data provided sufficient confidence in her ability to prepare food and undertake activities of daily living.

Outcomes:

Mrs. Jones still lives in supported accommodation, and has become involved in her community activities again and her health and wellbeing has improved. The introduction of Activity Monitoring has meant that the need for residential care was avoided making a net saving of £26,250 per annum.

The data produced by the Activity Monitoring process may also be used as benchmark in the future.

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Workforce engagement, participation, training and development is at the centre of our plans for the partnership. Arrangements are in place to address consultation, communication, wellbeing, health and safety.

Our staff survey indicates 75% of employees would recommend West Lothian as a good place to work. We continue to strive towards 85% of our staff having an annula performance review and for staff to receive recognition and reward for good performance.

75% of staff say they would recommend their workplace as agood place to work

80% of staff have had an annual performance review

5% staff absence rate across all services

75% staff say they receive reward and recognition for good performance

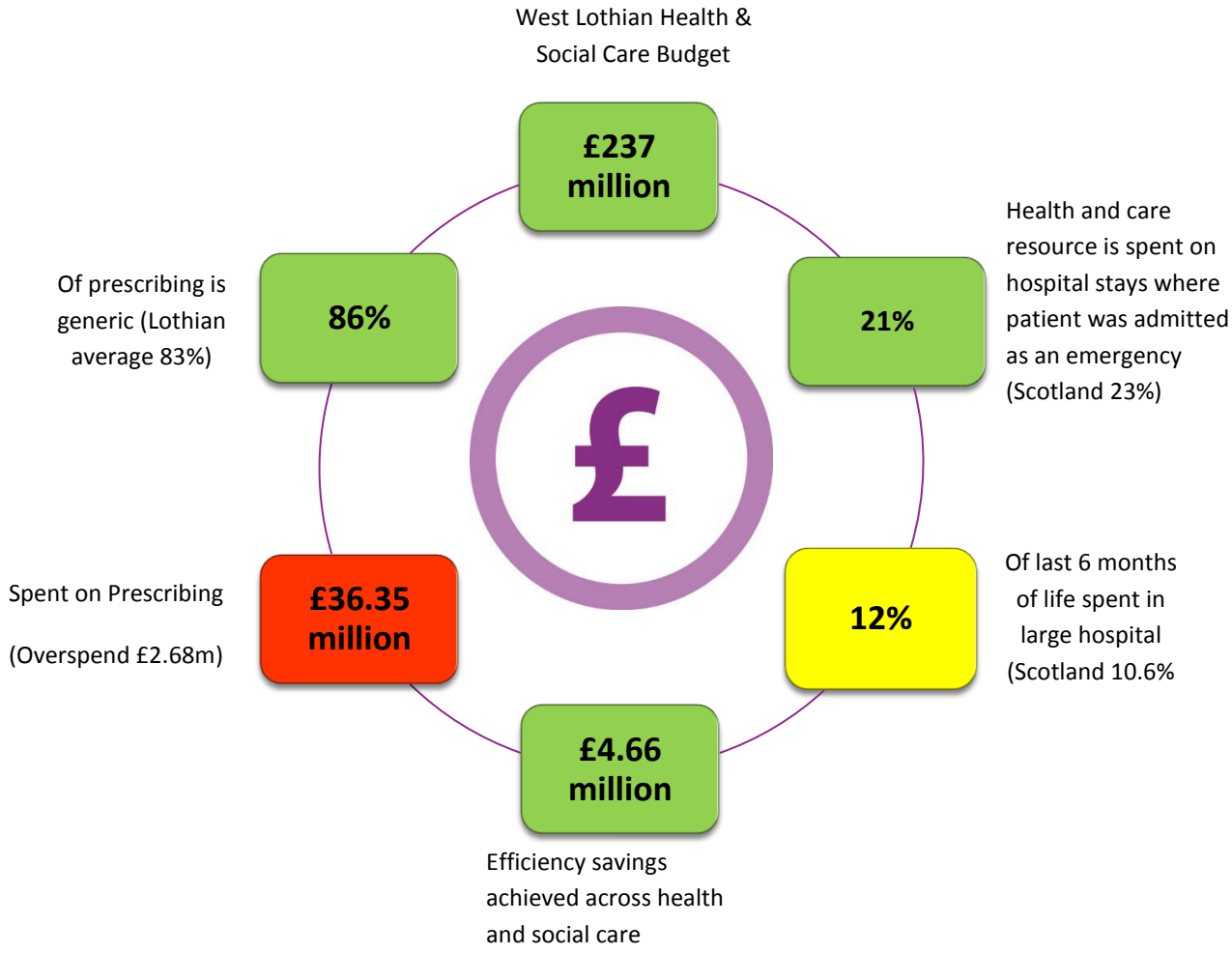
Promoting attendance at work is a key priority and we continue to focus on management of absence and to reduce this further. Main causes of absence relate to mental wellbeing and musculoskeletal issues and we have established proactive approaches to improve health and wellbeing with focus on managing stress, promoting *Health Working Lives*, access to Occupational Health support and implementation of policies to support employees to return to work as early as possible.

*Our **Healthy Working Lives** programme promotes health and wellbeing at work and at home. The programme is delivered throughout West Lothian with staff able to access a range of initiatives and support including:*
active travel; physical activity; healthy eating; smoking cessation; carers information; alcohol awareness; slips, trips and falls; blood pressure checks; mental wellbeing.

Joint quality and performance arrangements support integration of health and social care. Our Quality Improvement approach is based on the business excellence model which supports effective partnership working with "Sharing what works" at the heart what we do.

Our staff have been working hard to identify and implement quality improvement initiatives with focus on improving patient and service user experience. Already holding Quality Scotland's ***Committed to Excellence Award*** we have continued our Excellence Journey and have achieved the prestigious ***Recognised for Excellence Award*** in 2017.

Resources are used effectively and efficiently in the provision of health and social care services



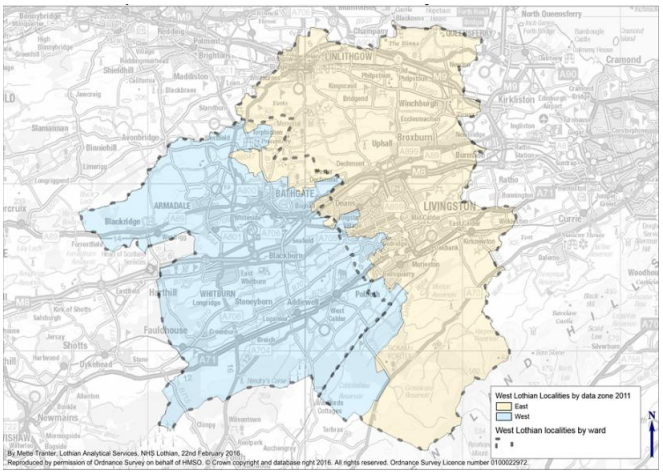
In 2016/17, we achieved a balanced budget position on the £237 million health and social care budget.

At 21% the level of health and care resource spent on emergency hospital care is below the national average of 23% and we have seen the percentage of the last 6 months of life spent in a large hospital reduce from 13.7% to 12% with a corresponding increase in percentage of time spent in the community from 85.9% to 87.7% demonstrating a positive shift in the balance of care.

The spend on prescribing is our main financial pressure which had an overspend of £2.68million in the year. The level of generic prescribing remains high at 86% and the average cost per patient is £192 which is comparable to Scotland level of £191 per patient.

Successful implementation of the Social Care (Self Directed Support) (Scotland) Act 2013 has resulted in growth in Self Directed Support which promotes more individual choice and control over how services are delivered.

Locality Planning



Within West Lothian we have defined two localities across which health and social care services will be planned and delivered. The localities provide a key mechanism for strong local, clinical, professional and community leadership and will ensure services are planned and led locally in a way that is engaged with the community and contributing to effective strategic commissioning. Locality groups have been formed with agreed terms of reference and membership from a broad cross section of the identified key stakeholders. The main function of the locality groups is to be responsible for the planning, design and delivery of the Locality Plan, in line with the IJB's Strategic Plan and Scottish Government Locality Guidance. The East and West Locality Groups have been working to:

- Build relationships with partners across the localities
- Develop profiles of the localities and map out what is already happening
- Clearly define how we will consult and engage with the communities.
- Determine how we can work with communities to build resilience and take an asset based approach to planning.

In general, the issues of an aging population, poor health, deprivation and unemployment are more significant in the West than the East with differences in life expectancy, life chances and health and well-being. It is also important to recognise for planning purposes that significant differences also exist within each of the localities. The table below outlines the estimated level of investment in each locality for primary care, community care and some aspects of acute services.

	2016/17	***East***	***West***
	£'000	**£'000**	**£'000**
Core West Lothian Community Health Services	104,600	59,076	45,524
NHS Hosted Services	20,058	11,488	8,570
NHS Set Aside Services	33,647	19,197	14,450
Non-Cash Limited Health Services	18,221	10,550	7,671
Adult Social Care Services	60,584	34,135	26,449
Total Health & Social Care Budget	**237,110**	**134,446**	**102,664**
Population	**177,850**	**101,658**	**76,192**
£ per head of population	**£1333**	**£1322**	**£1347**

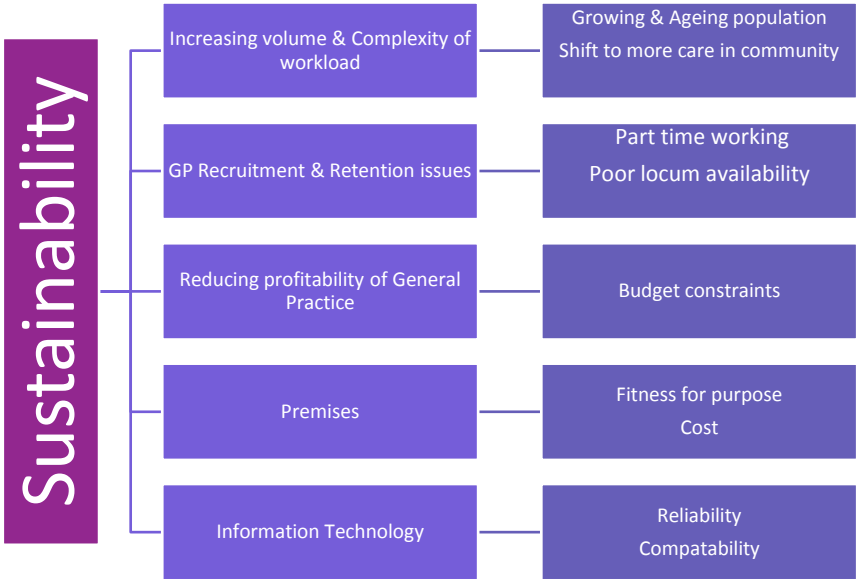
Next Steps

An engagement plan has been developed with a clearly defined stakeholder list and action plan to support consultation and engagement with the communities using a wide variety of engagement methods. Consultation will commence over the coming months and the output from this will inform the development of the Locality Plans.

Primary Care

The responsibility for Primary Care is shared between the NHS Lothian and the IJB.

In recent years General Practices have been under increasing pressure due to workload, workforce and other issues. As GPs retire it is becoming increasingly difficult to recruit and sustain the current model of care.



We held a Primary Care Summit in February 2017 to consider how we can support and sustain Primary Care in West Lothian. This involved over 80 key stakeholders and the output has shaped our priorities and has been developed into a local Primary Care Plan. The themes emerging from the summit highlighted the need for:

- Workforce and skill development including expanding the multidisciplinary team to support delivery of Primary Care ,
- Enhanced public information and education;
- Improved use of Information Technology and better sharing of information;
- Improvement in collaborative and integrated working.

A summary of initial work underway is provided below:

Information Technology	Primary Health Care Team	Maximise Capacity for Patient Care	Support Training & Development
• Invest in software to support direct patient care • Text bundles to remind patients of appointments and reduce missed appointments	• Increase number Advanced Nurse Practitioners • Develop new roles e.g. Paramedics • Support recruitment and retention	• Business support • Modelling new systems • Productive General Practice • Performance support	• Skills & competencies • Support new ways of working • Signposting

Inspection of Services

The Care Inspectorate undertook both scheduled and unscheduled inspections across a range of IJB services during 2016/17. The overall quality of care is assessed as good or better in all services for the reporting period.

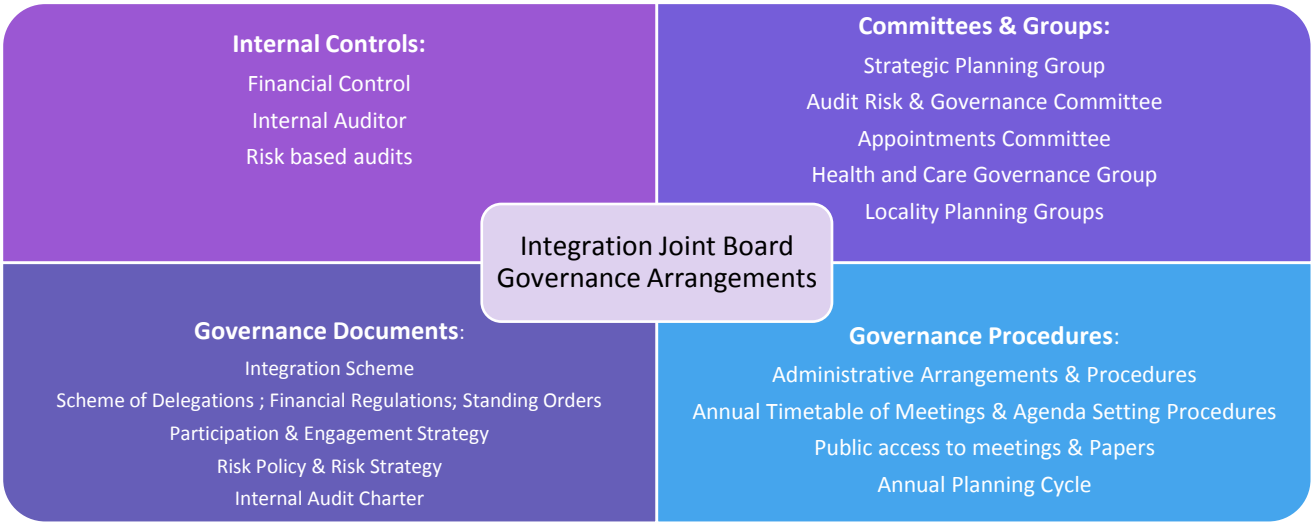
The Mental Welfare Commission undertook two inspections within mental health inpatient facilities during 2016/17. Recommendations from these inspections relate to improving the quality of care plans, psychology provision and improving environment for patients. These recommendations are being taken forward by the Mental Health Management Team

Integration Joint Board Governance and Decision Making

The Board and its members have overall responsibility for good governance arrangements including:

- establishing its values, principles and culture,
- ensuring the existence and review of an effective governance framework, and
- putting in place monitoring and reporting arrangements.

The Board has adopted key documents which support and inform their governance arrangements.



The Board and its committees have engaged in matters relating to good governance through consideration of reports and decisions on a wide variety of issues including:

- Public sector duty & equalities mainstreaming report
- Chief Social Work Officer's Annual Report
- Adult Support & Protection Committee Report
- Review of Board & Strategic Planning Group Membership
- Board members induction and training
- System of internal control
- Annual governance statement
- Board's unaudited accounts
- Audited accounts and the external auditors report
- Monitoring implementation of Integration Scheme
- Strategic Plan Impact Assessment
- Strategic Plan Review
- Internal audits of strategic planning &financial assurance

Audit, Risk and Governance

The IJB have established an Audit, Risk & Governance Committee to monitor the effectiveness of the Internal Audit service, approve an annual audit plan, receive reports about its completion and consider reports in relation to audits undertaken. The reports determine whether controls are satisfactory or require improvement with the findings, actions and timescale for completion presented for committee approval.

The committee also receives reports in relation to governance issued by the Accounts Commission and/or Audit Scotland in relation to the Board or the health and care sector. The annual reports on corporate governance and annual governance statement have been prepared for 2016/17.

Formal arrangements have been made for liaison and information-sharing between the Internal Auditors for NHS Lothian, West Lothian Council and the other Lothian IJBs.

Health and Care Governance

The IJB have established a Health and Care Governance Group to provide assurance to patients, service users, clinical and care staff, managers and Board members that:

- Quality of care, effectiveness and efficiency drives decision making about the planning, provision, organisation and management of services
- The planning and delivery of services take full account of the perspective of patients and service users
- The professional standards of staff working in integrated services are maintained and that appropriate professional leadership is in place
- Unacceptable clinical and care practice will be detected and addressed
- Staff are supported in continuously improving the quality and safety of care.

The Health and Care Governance Group provides advice to the Strategic Planning Group and Locality Planning Groups within the partnership and will consider the potential health and care governance impact of any service redesign or development proposals.
Arrangements for monitoring and scrutiny of progress and performance will be developed in line with the review of integration structures and processes and will be embedded within the community and locality planning mechanisms.

Participation and Engagement

Increasing wellbeing and reducing health inequalities depends on patients, carers, other service-users, groups, staff and partners being kept up-to-date on service developments and being able to influence changes to services. The IJB have approved their Participation and Engagement Strategy which sets out the IJB's long-term commitment to effective participation and engagement.

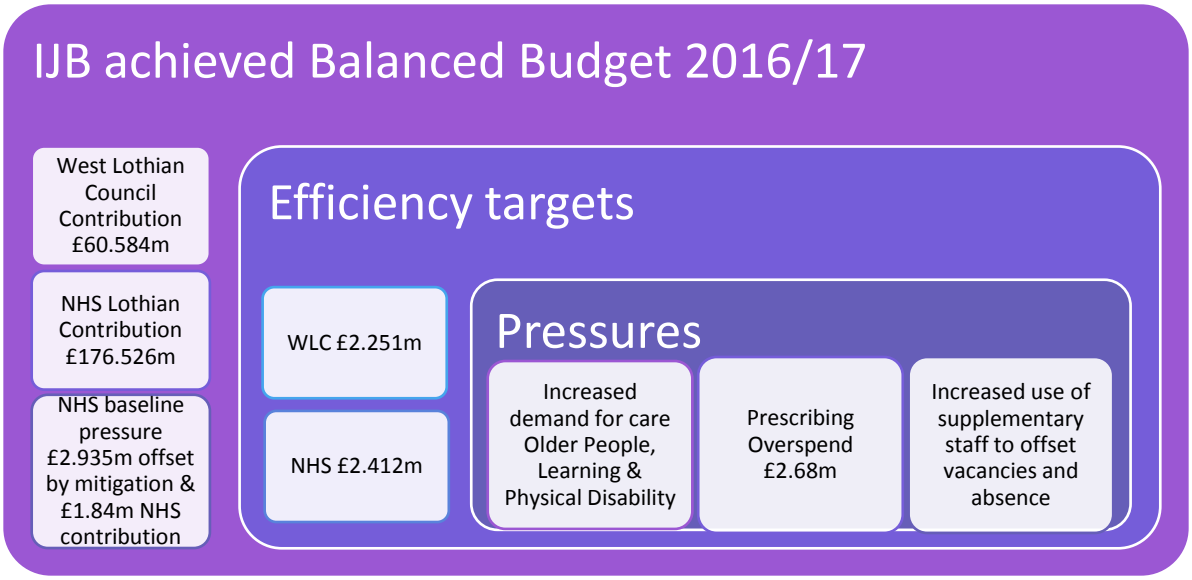
The strategy is designed to help health and social care officers plan community engagement and to show communities and staff what they can reasonably expect from the IJB in terms of being kept informed and being able to make their views known.

The strategy is accompanied by an annual action plan which details the participation and engagement planned by the IJB in the current year.

The Participation and Engagement Strategy can be accessed here:
http://www.westlothianchcp.org.uk/media/15085/Participation-and-Engagements-Strategy-2016-

Financial Performance and Best Value: Summary

Financial management, governance and accountability arrangements for IJB delegated functions are set out in the West Lothian Integration Scheme, and by the IJB Financial Regulations approved by the IJB on 23 March 2016.



Summary of Financial Position.

In 2016/17 the IJB has achieved a balanced budget position despite there being many pressures on the system. We have worked closely with NHS Lothian to mitigate the funding shortfall down to £1.84 million with this balance being funded by NHS Lothian through their achievement of an overall breakeven position.

Prescribing is our main pressure which had an overspend of £2.68 million. Substantial work has been undertaken to improve the prescribing budget position for 2017/18 including prioritisation of additional funding and the introduction of a new effective prescribing fund of £2 million for 2017/18 across Lothian. There has also been significant pressure in mental health due to difficulties in recruitment resulting in high agency and nurse bank costs. In addition, there has been a continued demand growth across our care services related to the aging population and need for more complex care and growth in

demands within learning and physical disability care reflecting an increasing shift in balance of care to community settings.

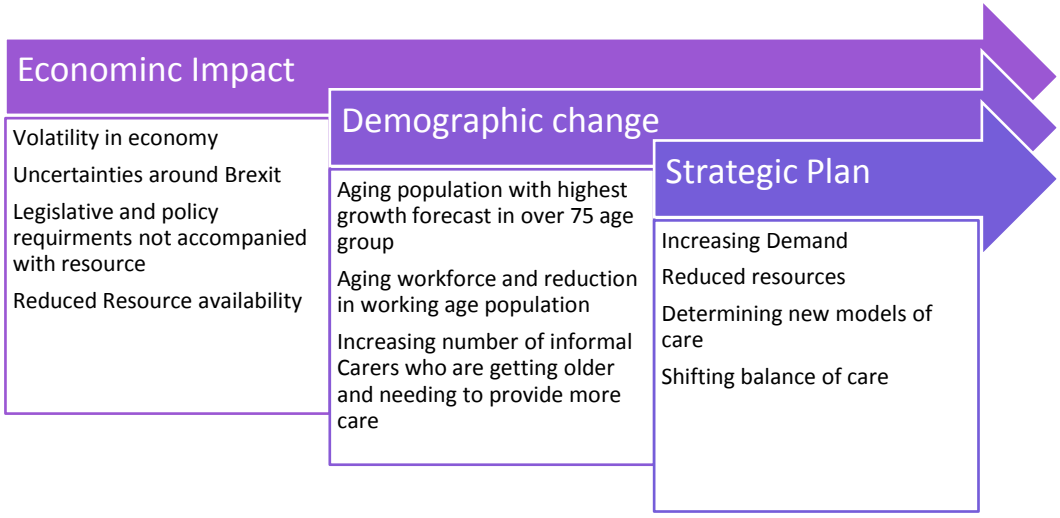
The IJB has the same duty as the Council and Health Board to achieve Best Value. West Lothian IJB therefore expects that the partners will adhere to the principles of Best Value to secure continuous improvement in performance whilst maintaining an appropriate quality to cost balance and maintaining regard to economy, efficiency and effectiveness in carrying out the Directions of the Board.

The unaudited accounts for the IJB are available here- :
http://www.westlothianchcp.org.uk/media/16441/West-Lothian-IJB-Unaudited-Annual-Accounts20162017/pdf/IJB_201617_Unaudited_Annual_Accounts_to_EY_(30_June_2017).pdf

Future Financial Plans and Outlook

The IJB has a statutory responsibility for delegated health and social care functions in relation to the strategic planning of future health and social care delivery. The IJB's Strategic Plan and Strategic Commissioning Plans inform decisions around prioritisation of resources, new models of service delivery and disinvestment decisions, all of which will be necessary in the medium term financial planning for health and social care services.

There are significant risks over the medium terms which are summarised below:



It is important moving forward to 2017/18 and in future years that expenditure is managed within the financial resources available and this will require close partnership working between the IJB as service commissioner and NHS Lothian and West Lothian Council as providers of services. The risks highlight the requirement for robust financial planning which is integrated with strategic commissioning plans. Based on Directions issued to partners it is anticipated that a financial strategy over a minimum three-year period will be developed over the course of 2017.

First Annual Review of Strategic Plan

The Strategic Plan 2016-26 sets the direction for integrated delivery of services. During 2016/17 the Strategic Plan was reviewed to ensure it remained consistent with the policy, economic and social context and ongoing accordance with values, resources, appropriateness, feasibility and desirability. The review determined that the strategic priorities remain constant and it was assessed that no replacement plan was required.

The mechanism for delivery of health and social care was reviewed and a health and social care delivery plan was developed which details out the priority actions to support the changes required in delivery of the Strategic Plan. This was approved by the IJB in March 2017.

Key priorities for 2017/18

Looking ahead for 2017/18 the key priorities are set out below:

Financial	•Establish financial plan for 2017/18 taking account of pressures and available resources •Develop medium term 3 year Financial Strategy
Primary Care	•Promote sustainability in Primary Care •Support implementation of new GMS Contract •Support development of cluster working
Workforce	•Develop medium term workforce development plan •Establish Organisational Development approaches to support integrationand new ways of working
Change Programmes	•Frailty Programme •Mental Health Redesign •Learning Disability •Unscheduled Care
Engagement & Communication	•Enhance capacity for engagement with key stakeholders and wider communities •Engagement and Participation Strategy
Locality Plans	•Locality Profiling •Locality engagement and consultation •Develop locality plans
Carer Support	•Prepare for implementation of Carers Act 2018 •Work with partners to identify carers
Inequalities	•Establish data set for monitoring of inequalities •Promote prevention and early intervention activities to improve health and wellbeing

MIDLOTHIAN INTEGRATION JOINT BOARD

Annual Performance Report

2016-17

Ratified by IJB on 24th August 2017

Foreword

Integration is important but hard to do well. At its heart is the need to ensure that people who use our services get the right care and support whatever their needs, at any point in their care journey. In our first year as Midlothian Integration Joint Board (IJB), we have been getting to grips with this work.

- We have improved our understanding about the needs of our communities;
- We are reviewing our services so we can identify the potential for re-design and start to make changes that will have a positive impact on people's health and wellbeing.

Finances, population and workforce challenges mean that the transformational change required is considerable but necessary.

'Integration' for us is about transforming services and how we work, so that we have high quality care that is community-based, puts the person's needs at the centre and is accessible. It means investing in prevention to encourage peer support and self-management to keep people well. This is the right emphasis to have as it is estimated that 40% of our spending is currently accounted for by interventions that could have been avoided by prioritising a preventative approach. We must work in partnership across organisations, not just in health and social care, but more widely with other services as well as communities and individuals to recognise the importance that housing, finance, and employment has on our health and wellbeing. What we have been charged with doing requires change but it will also take courage. Put simply, staying still and doing more of the same is not an option open to us. The formation of Midlothian Integration Joint Board (IJB) has enabled us to approach the challenges we are faced with in different ways from before.

For example:

- Develop a local Primary Care Strategic Programme, which allows us to focus on the demands our teams face and work on solutions together with staff and patients
- Taking responsibility for developing a deeper understanding of how people in Midlothian use our acute hospitals like the Royal Infirmary and the Western General. Working with our hospital colleagues should result in a shift in resources so that we can do more for people locally to avoid hospital admissions as well as get people home more quickly
- Acting more quickly as opportunities arise to plan and provide services jointly that meet the needs of our local population and address health inequalities
- Maintaining our commitment, despite the financial pressures to focus on prevention so that we make the best use of the resources available

Without the formation of the IJB, some of these things may not have happened at all, or the pace of change would have been slower - important points to highlight. These are early days and there is still much to do. In this first annual report, we have reported on our progress against the national outcomes that all IJBs are measured against, but we have also tried to explain who we are as an organisation and share the stories of the successes and challenges over 2016/17. Our thanks to you all who contribute so much to the work we do.

Eibhlin McHugh, Chief Officer Midlothian IJB

CONTENTS

1. STRUCTURE OF THE REPORT

We have measured our progress, impact and performance in different ways.

Section 4 Scottish Government's National Health and Wellbeing Outcomes
This looks at the nine national outcomes and within that, the 23 indicators which provide evidence of progress. These are used by every IJB in Scotland, so you can see how Midlothian compares against the national average.

Section 5 Our Strategic Plan
This sets out some of the key things we said we would do in our Strategic Plan. In some cases, reference is made to 'Directions', which sets out what we wanted Midlothian Council and NHS Lothian to undertake.

Section 6 Locality Planning and Integration Principles
This documents how we work as an organisation and with examples, shows how we are following the principles of integration.

Section 7 Finance
Financially 2016/17 has been a challenging year and we have detailed our financial position and showed how we have delivered best value.

Section 8 Summary of inspections of services
This summarises the inspections undertaken by the Care Inspectorate and Mental Welfare Commission across a range of services during 2016/17.

Section 9 Integration Functions
This section itemises the key decisions taken by the Integration Joint Board

The annual report shows some of the highlights as well as the challenges of planning and delivering services across Midlothian. Throughout you will see other reports and strategies referenced. For more detailed reading, please see Appendix 1 for a list of these additional documents.

2. EXECUTIVE SUMMARY

As we reflect on our first full year of operation as Midlothian Integration Joint Board (IJB), the words that come to mind are transformation and partnership. We are working in a challenging financial environment, but close joint working with NHS Lothian and Midlothian Council has allowed the IJB to successfully deliver on a range of outcomes and manage our delegated financial resources. The financial pressures facing Midlothian Council and NHS Lothian mean that we must accelerate our programme of change in coming years.

We have seen successes and made progress, but have experienced challenges too, as we have taken on full responsibility for health and social care services for adults as well as services for offenders.

Successes in terms of working differently, always with the person at the centre of our plans as well as in partnership so that we can better meet people's needs- the Wellbeing Service and the Mental Health Access Point offering two excellent examples. Our challenges include the increasing demands on our services brings as our population grows and we all live longer. The on-going workforce issues that we have seen in Primary Care and Care at Home services amongst others have brought difficulties that we have not yet been able to resolve and we are very aware of the impact this has had on people living in Midlothian.

Colleagues across health and social care are working hard to integrate service delivery for the benefits of patients as well as the public purse. We have committed to a way of working which considers the whole person and our 'House of Care' approach can be seen across a range of services for the benefits of people with a long term condition, including cancer and mental health problems.

Change is also underway as we work with our hospital colleagues to shift care and resources from hospitals into the community, which is of particular relevance to our increasing number of older people. Of particular note is our MERRIT Team (Midlothian Enhanced Rapid Response and Intervention Team) whose range of health and social care expertise helps support older people to stay in their homes and to return home from hospital as soon as possible. While partnership working is not new, we are keen to look at opportunities to bring colleagues together and Midlothian's Joint Dementia Team is an excellent example of how working together across health and social care services can improve the quality of care.

More detail can be seen in our Strategic Plan, which sets out the journey we want to make over the next two years and how we intend to redesign services. This includes supporting people to stay healthy and enabling people to recover or live well with their long-term condition. We will give a strong emphasis to helping people to manage their own health, recognising the uniqueness of each individual. We will also pay particular attention to addressing the unfair health inequalities in our communities which are often linked to poverty and unemployment.

The pace will not be easy and a joined up approach to strategic and financial planning will be key as we aim to deliver services that are accessible and of a high quality to everyone in Midlothian, within these challenging financial times.

Some of our key achievements in our first year are:

- The Community Planning Partnerships and area targeting work which brings services and communities together across Midlothian to tackle inequalities and create solutions for local health and care needs.

- Developing our House of Care approach across a range of services for people with mental health problems, people affected by cancer, vulnerable communities and people with long term conditions. All of these services give people time and space to think about what matters to them.

- Investing in joint teams that have an impact on hospital admissions and delayed discharges, like MERRIT.

- Bringing services closer to home with the move of rehab services from Liberton Hospital to Midlothian Community Hospital.

We will publish an Annual Performance Report each year to share with you what we have achieved as well as our challenges and the impact these have for everyone in Midlothian.

3. INTRODUCTION – OUR VISION

Midlothian Integration Joint Board brings together NHS Lothian, Midlothian Council, third sector partners and communities to plan and provide services to meet the needs of our population. Our vision is that:

"People will lead longer and healthier lives by getting the right advice, care, and support, in the right place, at the right time

We want everyone living in Midlothian to be as healthy and well as possible and respect that people should have control over their lives. However, when help is needed, our services and the care and treatment we provide should be of a high standard, easy to use and accessible.

In terms of how we measure impact, our Strategic Plan sets out how we will deliver on the nine national health and wellbeing outcomes for integration. This Annual Report describes our progress against them and to help illustrate where we think we have made a difference, some key areas of work are highlighted.

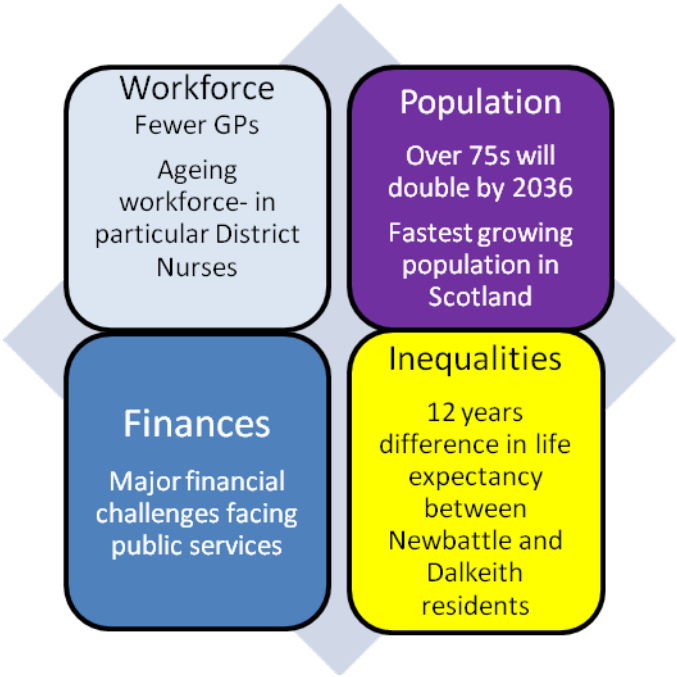
National Health and Wellbeing Outcomes

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
7	People using health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

Scottish Government identified 23 indicators (4 still being developed) that were felt evidenced the nine national health and wellbeing outcomes and 19 of these are set out in Section 4. In addition, the IJB agreed on two additional 'weather vane' indicators- the rate of over 75s admissions and delayed discharges (over 3 days).

The Strategic Plan sets out how we want to re-design services and engage with our communities as part of this journey. Put simply, there are neither the finances nor the staff to keep providing services the way we have been doing and so change, collaboration and innovation are required for us to meet the challenges ahead. Through a new programme board-Realistic Care- we will make the shift to care models that are sustainable, fair and provide better outcomes for all.

Our challenges



As our population grows and gets older, people have more complex health and social care needs and so our services must change. We also need to work in ways that make the best use of our resources. Finally, we need to pay particular attention to addressing the unfair health inequalities in our communities which are often linked to poverty and unemployment.

We are fortunate in Midlothian to have a wide network of user groups who have already influenced the Strategic Plan. We will continue to listen to our communities, developing trust and respecting each other's perspectives, as we build on the good work which has taken place in recent years in neighbourhood planning. For our staff, we will support them to have the skills and confidence to work in a more holistic way and in partnership with other agencies and with the unpaid family carers whose role cannot be overestimated.

Looking wider than Midlothian, the re-organisation of our health and social care systems mean that there is complex work going on 'behind the scenes' with our colleagues in hospitals and other IJBs across the Lothians to ensure that we make the best use of resources to meet the needs of our communities.

The challenges facing both NHS Lothian and Midlothian Council in trying to meet increasing demand with reducing budgets will be equally felt by the IJB in planning how to deliver health and social care services in Midlothian. Key to our financial strategy is ensuring that we are rebalancing services by shifting spend from hospital and other institutional care to more robust and responsive services in the community.

In this, our first annual report, we want to look back over the work from 2016/17. We describe what the IJB has achieved against the health and wellbeing outcomes as well as some of the main areas we have been working on and the difference this has made.

In brief, you will find examples that focus on:

- Older People
- Primary care
- Hospitals
- Health inequalities
- Long term conditions
- Mental Wellbeing

Our work is set out more fully in our Strategic Plan and Delivery Plan. Please see Appendix 1 for a list of links to key documents and reports.

The annual report offers an opportunity to reflect on what went well, but also to acknowledge the challenges we have faced and how, as an organisation we have chosen to respond to difficult circumstances and learn from these experiences.

4. NATIONAL HEALTH AND WELLBEING OUTCOMES-OUR PERFORMANCE

The following indicators evidence the nine National Health and Wellbeing Outcomes.

2016 /17 Performance at a glance[1]

[1]ISD (June 2017) Midlothian 2016/17 Performance Core Suite of National Health and Wellbeing Outcome Indicators

4 (a)

Outcome 1- Improved health and wellbeing
People are able to look after and improve their own health and wellbeing and live in good health for longer

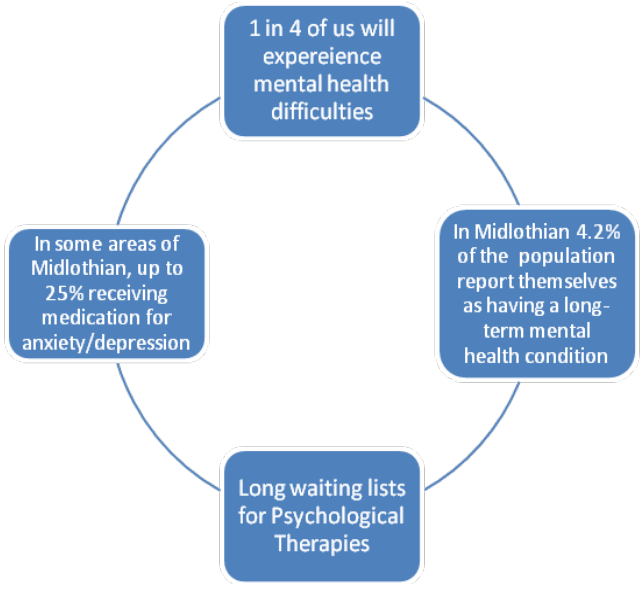
Indicator
93% of adults are able to look after their health very well or quite well (Scottish rate 94%)

Supporting people to stay healthy is not new, but encouraging people to live well needs a range of approaches, services and amenities. For example, being more active is easier if there are safe streets, cycle paths and affordable leisure services. Eating well includes access to affordable fruit and vegetables. Our partnership working with the Food Alliance, Council Services such as Leisure and Recreation and the voluntary sector are crucial to these issues.

Our emphasis on prevention can only work if we have strong relationships in place so that we can support people in a holistic way. We know that lives are complex and that the challenges people are dealing with such as unemployment, money worries and managing long-term health conditions all have an impact on mental and physical health and the ability to make choices that help us to live well. If we have confidence to look after ourselves and have more control in our lives, this enhances our sense of wellbeing, but we recognise that for some people in our communities, this is difficult, so finding ways that we can support people to do this is important.

We know that mental health issues are common reasons why people see their GP. But quite often, because of the many different issues that contribute to someone's difficulties, GPs are not always the best placed to help. We wanted to develop services that could offer a different approach from prescribing medication and had the time and skills required to support individuals to find the solutions that felt right for them.

The Challenges:



Progress in 2016/17

Wellbeing Service – in partnership with the Thistle Foundation

The Wellbeing Service has grown and is now available in eight of our GP practices. It gives people time and space to consider what is going on in their lives and to develop their own ways to feel better. The 'good conversation' demonstrates our 'House of Care' approach to seeing the whole person.

The top issues reported are:

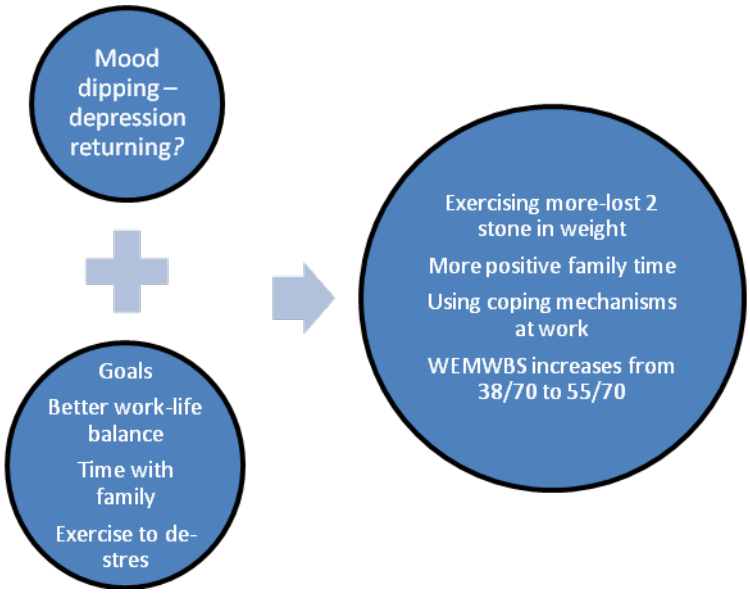
- Family
- Relationships
- Money worries
- Housing issues
- Long term mental health issues

Data to end March 2017 identified that:

- 809 people referred – more likely to be living in an area experiencing multiple deprivation than the population of Midlothian as a whole.
- 508 people supported via 1648 appointments
- There is a significant increase in people's WEMWBS over time (this measures general wellbeing). On average, people have moved from a score of 35 at first appointment to 49 on discharge. This is just over the population average score.

Health Economics work is on-going as part of the full evaluation which will cost outcomes such as weight loss, in terms of saved GP appointments and impact on prescribing.

Case Study - John's story. 52 years old and has lost a close family member

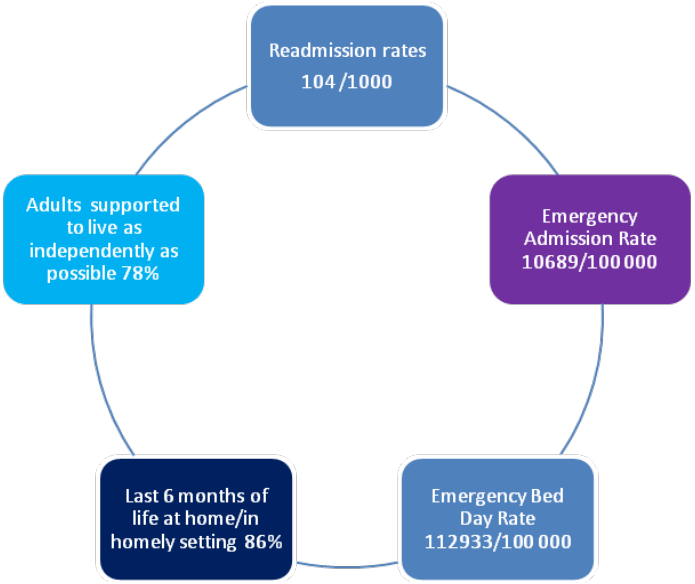


4 (b)

Outcome 2- Support to live in the community
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Although services are working hard to support people in their own homes, or as close to home as possible, some areas have been challenging for Midlothian and some of our performance indicators are below the Scottish average.

Emergency admission and bed day rates are both lower than the Scottish average, however the readmission rate is higher. The number of days people spend in hospital when they are ready to be discharged is also higher than the Scottish rate. Our plans to address unscheduled care and to ensure people are discharged within the 72 hour target remains a top priority for the Partnership.



Progress in 2016/17

Whilst the lack of capacity in 'care at home' services is a major problem, we further invested in the **Midlothian Enhanced Rapid Response and Intervention Team (MERRIT).**

This aims to prevent avoidable admissions to hospital, help achieve a speedier discharge home, provide an intensive rehabilitation service either in the home or within the intermediate care unit at Highbank, and provide an alternative to hospital admission for older adults in Midlothian.

With extra investment, the "Hospital at Home" service now operates 7 days per week. In addition, a new post to support people with advanced Chronic Obstructive Pulmonary Disease (COPD) so they avoid hospital admission is in place. These developments mean that more people can be looked after at home. It also means more people can leave hospital quickly. As a result Midlothian has a low rate of people who are unable to leave hospital because the necessary care is not in place.

4 (c)

Outcome 3 – Positive experience and treated with dignity

People who use health and social care services have positive experiences of those services, and have their dignity respected

Feeling involved in your own healthcare is important. In Midlothian, 85% of people agreed that they had a say in how their care was provided, which is higher than the Scottish average. However, ratings for health and care services and the care provided by GP practices were lower than the Scottish average. Finding it hard to see a GP has been raised by people across Midlothian and probably contributes to our lower than average score.

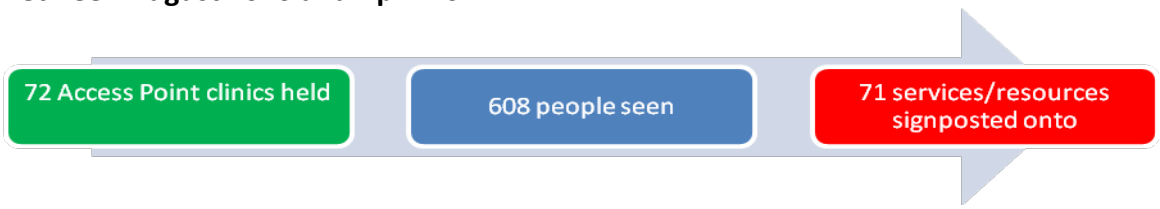
We also recognise that many people in Midlothian experience difficult times, struggling with addictions, mental health problems or are at risk of offending. Approaches focusing on peer support, such as the Recovery Cafe and SPRING are part of our commitment to having the appropriate support and pathways in place for those at particular risks. Communities also benefit from Unpaid Work projects undertaken as part of community based sentencing.

Progress in 2016/17

Access Point – in partnership with Health in Mind

We are aware that it takes courage to seek help and that long waits for services such as Psychological Therapies can create barriers to people coming forward. As a Partnership, we wanted to offer a responsive and accessible service and in mid-2016, launched the Midlothian Wellbeing Access Point. The service operates as a drop-in, so no referral is needed. This is an important feature, as the service is available when the person feels ready to seek help and it takes away the delay usually associated with accessing a service. Based at the Midlothian Community Hospital and Eastfield Health Centre, the service offers time with a Nurse Therapist to help people decide what they need to increase their mental wellbeing – reducing low mood, feelings of stress; increasing confidence and self-esteem.

Between August 2016 and April 2017:



Common themes emerging from the Access Point

- Referrals to Psychological Therapies more appropriate
- Higher percentage attending assessment appointments and a higher percentage of men attending who have not used mental health services before
- People signposted / referred onto services that were not known to them

What people said….

"Worker was very kind and took time to really listen to my situation."

"Range of options for help. Felt listened to and acknowledged"

"Able to offer me another appointment quickly to go into what I needed."

4 (d)

Outcome 4- Improved quality of life
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

The Performance Indicators relating to maintaining quality of life (**86**%) and the percentage of service graded 'good' or better by the Care Inspectorate (85%) were both higher than the Scottish average.

Progress in 2016/17

- **Highbank Care Home** provides 27 intermediate care beds. These beds are for people leaving hospital but not yet ready to go home or people who would otherwise have needed to go to hospital. After a stay at Highbank, 80% of people have higher independence and 53% are able to return home instead of going to a hospital or care home

- Midlothian now has an integrated **Dementia Team** who provide an immediate response to emergencies for people with dementia.

- **Midlothian Active Choices (MAC)** supports people with mental health, obesity or long-term health conditions. Alongside this, the **Ageing Well** programme, with its bank of volunteers offers a range of activities that enables older people to stay active and is now available in care homes and sheltered housing complexes

- Tackling isolation remains a high priority. We made some improvements to day care with a new service established in the Community Hospital and a redesigned day care service the **Grassy Riggs** - provided in Woodburn

4(e)

Outcome 5- Reduced health inequalities
Health and social care services contribute to reducing health inequalities

It is well recognised that vulnerable individuals and those from a disadvantaged background are more likely to suffer from ill health, complex health issues, and require greater resources to keep them healthy. The core integration measure of premature mortality among people aged 75 and under is lower than the Scottish average. This shows positive progress over the last 5 years from 414 to 396 deaths per 100,000 population over 5 years.

Investment by the IJB in services for offenders and for people with mental health and substance misuse problems reflects that reducing health inequalities is a priority for the IJB and the Community Planning Partnership. The Community Planning Board has developed a set of indicators that tell us whether we are making progress in reducing health inequalities and this work has been recognised as good practice in other parts of Scotland.

Progress in 2016/17

The IJB elected to include services for offenders in its scope to strengthen the local approach to addressing the health and care needs which are often the root causes of offending behaviour. **SPRING** supports women with complex needs who are at risk of or have been involved in offending. **Fresh Start** engages with individuals at the point of arrest and links them into relevant services such as substance misuse and mental health services.

The **Community Health Inequalities Team (CHIT)** launched a new service back in March 2016. Vulnerable individuals, such as carers, veterans and people experiencing homelessness have an opportunity to meet with a nurse for up to an hour to discuss what matters to them and what they would like to happen to help them lead healthier lives. The team also run a pre-diabetes programme for anyone at high risk of developing type 2 diabetes. Analysis of where people live demonstrates that the service is reaching people from more deprived areas.

Between April 2016 and March 2017:

4 (f)

Outcome 6- Support for carers
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

As a Partnership, we could not do what we do without the contribution made by unpaid carers. We estimate that @10% of our population have some form of caring role. In the national indicators, 40% of carers feel supported to continue in their caring role (Scottish rate 41%)

Financial security, physical health and emotional wellbeing are key issues. We have worked in partnership with VOCAL (Voices of Carers Across Lothians) and CAB to develop targeted services to meet these needs.

Progress in 2016/17
VOCAL has partnered with local agencies to develop peer support groups, monthly carer health surgeries and counterweights classes at the Midlothian Carers Centre. It has also assisted carers in receiving over £227,000 through advocacy for PIP (Personal Independence Payments) and ESA (Employment Support Allowance) assessments.

A Respitality scheme for carers to access hospitality sector opportunities for short breaks.
The providers make a 'gift' to a carer (plus companion) so they can have a short break away from the often heavy demands of their caring responsibilities, to recharge their batteries and have some 'me time'

Links between VOCAL and Health and Social Care services
Primary care and VOCAL Midlothian have been undertaking a pilot project in Dalkeith Health Centre in an attempt to support GPs in the service they offer to unpaid carers, helping them address issues which may be due to their caring role.

A multi-agency led Power of Attorney (POA) promotional campaign ran in November 2016 and resulted in a number of local people applying for POA and most people receiving a beneficial discount or access to Legal Aid to cover the costs. VOCAL runs monthly Power of Attorney surgeries for carers to create POAs for carers and the person that they care for – in the last year 120 carers received support to set up a POA.

The Community Health Inequalities Team (CHIT) provide surgery appointments to unpaid carers to discuss their health needs and find ways to address issues which may be affecting their health and wellbeing.

4 (g)

Outcome 7- Safe from harm
People using health and social care services are safe from harm

Good joint working is strongly associated with supporting people to be safe from harm, as well as helping prevent avoidable risks. The East Lothian and Midlothian Public Protection Office involves health, social care and Police working together to support and protect adults and children who may be at risk of harm.

On the core integration indicators performance is positive with 82% of people supported at home feeling safe (Scottish average 84%) and the falls rate among people aged 65+ has reduced from a high of 23 in 2012/13 to 19 in 2016/17, which reflects the well-established falls pathway we have in Midlothian.

Progress in 2016/17
We will provide support to help keep people safe. Specific examples include:

Ensuring Midlothian services have a better understanding of domestic violence. Midlothian has the sixth highest rate in Scotland, but our services are becoming more aware. This issue comes up frequently with the new Wellbeing Practitioners based in eight of our Health and can often be the starting point people need to take positive steps.

We have worked in partnership with Women's Aid and Midlothian Council to increase refuge capacity within Midlothian. An additional flat was secured that we can specifically use to meet the needs of women with co-occurring substance misuse and domestic abuse. The substance misuse project worker will work closely with the accommodation team workers in developing our capacity to support women with complex needs within this unit.

Telecare is an important element of our strategy to support older people for as long as possible in their own home, maintaining independence, managing risk and reassuring families. Discrete sensors are placed around the home that can create automatic alerts or the individual can press a button to signal that there is a problem like a fall.

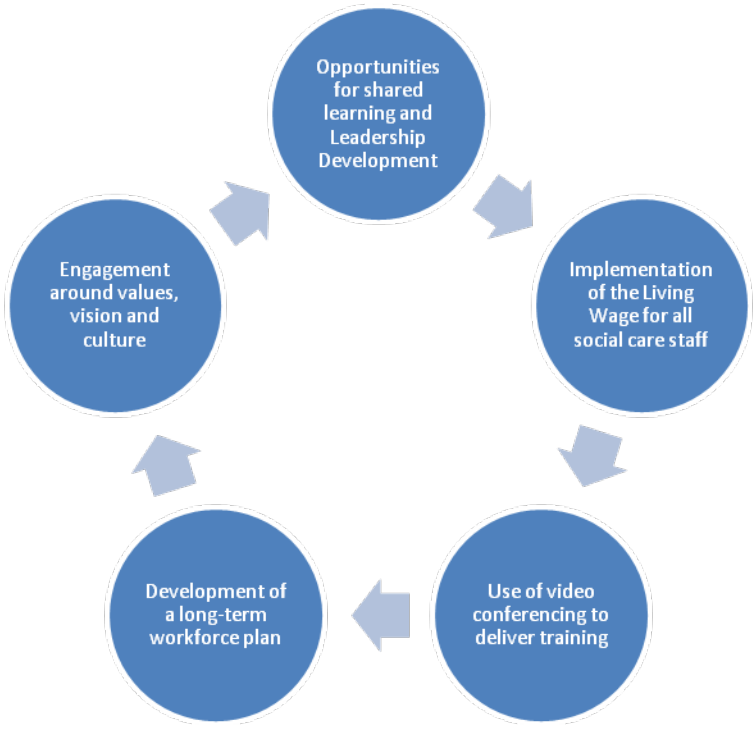
4 (h)

Outcome 8 – Engaged and supported workforce
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

To support the changes we want to see happen in Midlothian, our staff are crucial. Integration brings opportunities for professionals to work more closely together and is also critical to addressing staff shortages. Our staff need support too and opportunities to learn together so that they have the skills and confidence to work in a more holistic way is important.

In terms of staff surveys, iMatters is being rolled out to all Health and Social Care Partnership staff for the first time this year, so will include social care staff. This will provide a quantified indicator of our performance in this key area.

Progress in 2016/17



4 (i)

Outcome 9- Efficient and effective use of resources
Resources are used effectively and efficiently in the provision of health and social care services

In 2016/17, we have achieved a balanced budget position.

At 23% the level of health and care resource spent on emergency hospital care is the same as the national average. 85% of people spend the last 6 months of life at home or in a community setting, rather than in hospital, which is lower than the national average of 87%.

Prescribing is the main pressure which had an overspend of £1.3m in the year. Medication is vital in helping people recover and keeping people well. However the costs are high; almost £17m of the total £86.7 million budget for NHS Services in Midlothian is spent on prescribing. Considerable effort is being made to reduce these costs safely whilst developing alternatives.

Successful implementation of the Social Care (Self Directed Support) (Scotland) Act 2013 has resulted in growth in Self Directed Support which promotes more individual choice and control over how services are delivered

5. OUR PROGRESS AGAINST THE STRATEGIC PLAN 2016-2019

Our key priorities for change were as set out in our Strategic Plan were:

We said that we would provide services differently so that:

People are treated as individuals and have the confidence to look after themselves where they can

- Technology is used to help efficiency
- They are more easily accessible
- People know what services are available and have access to good information
- We help people to think about their future needs

Acknowledging the challenges of finances, the changes in our demographics and the persistent inequalities that exist, the Partnership's approach has centred on re-framing our expectations of the health and social care system and as part of this, testing out new ways of working. The Partnership issued its Directions, which sets out the things that we said Midlothian Council and NHS Lothian must undertake and these map onto the Strategic Plan. For a link to the Strategic Plan, please see Appendix 1.

The following section highlights some key areas of work.

Key Area 1 Older People

Directions 1, 2 and 5
What we wanted to do:
Have more services delivered locally
Prevent unnecessary hospital stays, especially for people with complex needs such as dementia

Over the next 20 years, the number of people aged over 75 will double in Midlothian. Many older people live well and remain independent, as well as making a significant contribution to Midlothian through volunteering or as informal carers for family and friends. But we know that there can often be issues such as feeling lonely that can impact on people's sense of wellbeing.

Reducing isolation and ill health- our services support people to stay active and encourage social interaction, like Ageing Well and Midlothian Active Choices (MAC) and a new day centre in Woodburn, one of our most deprived communities- Grassy Riggs – brings people together to tackle isolation.

For those who need input as they get older, we want to be able to care for more people at home, or in a homely setting, rather than in hospital. The skills and expertise of our health and social care teams, working in partnership with the voluntary sector and unpaid carers, means that we can do this. But to provide community-based alternatives, we also need to develop a better understanding of how the Midlothian population uses acute hospitals.

- Admission Prevention

We are giving priority to developing services which reduce the need for people to go into hospital, like 'Hospital at Home' (part of the MERRIT service).

- Facilitating Early Discharge

Delayed discharge, even for a day is in no-one's interests and while Midlothian has consistently met national discharge targets in recent years, we should be working towards the complete elimination of delays in hospital. Our performance in relation to repeat emergency admissions, whilst improving, remains relatively poor. We are taking further action to reduce unnecessary admissions including more intermediate care beds.

Our 'Care at Home' service has faced significant difficulties over the last year. Home carers play a vital role in terms of day to day tasks as well as responding to emergency situations such as falls and across Midlothian provide 820 hours of care each day. But we have faced great difficulties in recruitment, while at the same time, knowing that more people need the service. This has led to people having to wait to receive care at home, which is very distressing. The situation has also impacted on other services, such as Re-ablement and caused pressures in the system so that people are unable to come home from hospital. As a result, we have taken steps to improve the situation, such as making sure care is given to

those who most need it and looking at how to attract more people to work for Care at Home services.

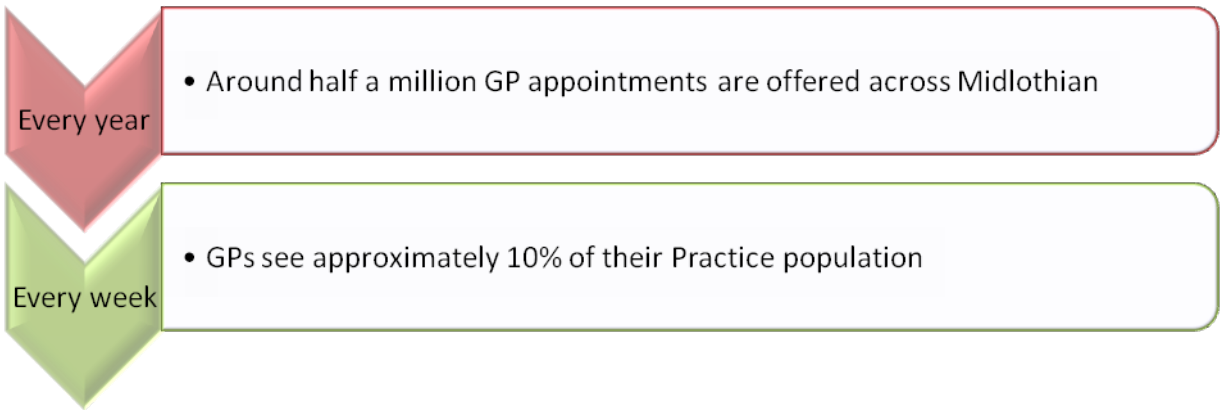
What we did:

Our Older People's Strategy sets out our plans for 2016-2019 and can be found here:

https://www.midlothian.gov.uk/download/downloads/id/2249/the_joint_strategy_for_older_people.pdf

Key Area 2 Primary Care

Direction 4
What we wanted to do
Ensure that General Practice is sustainable and is resilient to current and future demand. We also wanted to deliver better care for individuals and populations at a lower per capita cost.



We know that our practices are under pressure and that there is more demand on services. We also recognise that our workforce is changing.

The move to restricted lists for several of our practices was something we did not expect to happen on the scale it did and managing the demand on primary care has been and remains a challenge.

It has focused our minds to come up with solutions that will increase capacity in the system, by investing in premises, looking at the workforce in terms of training and new roles, such as extending pharmacist input into five practices across Midlothian.

We are also working with our partners in planning at Midlothian Council so that we take a pro-active approach to the impact housebuilding will have on services.

We know that 80% of GP visits and 60% of all hospital admissions related to long term conditions and we wanted to be able to respond in a better way to people's needs. The Wellbeing Service is currently delivered in 8 GP practices (as of January 2017). They provide intensive person centred support to people who are identified by GPs and others across the system as being in need of support to improve aspects of their health and wellbeing.

Monitoring data indicates a 'highly significant' improvement noted in scores related to WEMWBS (a tool that measures general wellbeing). Further evaluation will bring in health economics expertise to value other outcomes, so for example, if as a result, a person loses weight, how much money does this save, in terms of GP visits and prescribing?

Key Area 3 Prescribing

Prescribing- Direction 6
What we wanted to do
Take measures that support a reduction in spend

Five pharmacists are now working with Health Centres in East and Midlothian to support GPs on issues such as reviewing medication of patients discharged from hospital.

We developed a local Prescribing Action Plan to manage the expenditure on medicines (approximately £17m per annum) within the allocated budget.

Key Area 4 Substance Misuse Services

Direction 9
What we wanted to do
Take measures that support a reduction in spend

Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) is an integrated service with a focus on prevention, early intervention and recovery. Since April 2016, funding that from Scottish Government was reduced by 23%. We established a partnership group to make recommendations on how to make these savings while protecting the integrity of the service. Funding has been agreed to extend the GP peer support pilot into 6 additional practices for a 1 year period.

Work is continuing to develop a recovery hub within Dalkeith where both health and social care staff across Mental Health and Substance Misuse Services can be co-located and jointly managed.

Key Area 5 Health Inequalities

Focus on Health Inequalities- what we wanted to do
Change deep-seated, multigenerational deprivation, poverty and inequalities

There are unfair and avoidable differences in people's health across Midlothian. Although health is improving for most people, it is not improving fast enough for the poorest and most disadvantaged sections of our society. This is known as *health inequalities*. Put simply, those who have lower incomes, poorer housing and less access to paid work experience poorer health. It also means that when difficulties come along, they may feel less able to cope, both physically and emotionally. When we look at the information across Midlothian, we can see that there are clear inequalities related to health, educational

achievement, pay and employment. For example, there is a 12 year difference in life expectancy between Newbattle and Dalkeith (men live 12 years longer in Newbattle), a stark reminder of the unfairness that exists.

Midlothian Community Planning Partnership (CPP) made a commitment to tackle these inequalities as its priority for three years (2016-2019). In addition, addressing health inequalities is a priority for the IJB.

This is a long-term challenge and needs action and decisions across areas such as employment, education, health, early years services, welfare support and housing as part of the relevant strands of the Community Planning Partnership.

Work has been undertaken to develop a set of indicators which will help us monitor changes to the gaps between the most and least deprived communities in Midlothian. These include life expectancy, prescribing rates for anxiety and depression, primary school attendance and working age population in receipt of benefits. What we want to see is this gap between the most and least deprived communities get smaller. A full list of indicators which have been adopted by the Community Planning Partnership, can be seen in Appendix 2.

What we did:
Area targeting is an approach to target the three areas in Midlothian with the highest levels of deprivation in terms of educational attainment, income, health, and access to services. The aim is to reduce the life outcome gaps for residents in Gorebridge, Mayfield, and Dalkeith/Woodburn. See Sections 4 and 6 for more information on this and the Community Planning Partnership.

Our ambition to deliver person-centred integrated care is captured in our 'House of Care' model. This concept is based upon creating space for people to have "a good conversation" about what is important to them and delivering a plan that will help people to live well.

We wanted to establish person-centred and accessible services for our most vulnerable communities including unpaid carers, the homeless and people with mental health problems. Services such as the Access Point and the Community Health Inequalities Team (CHIT) are designed to proactively engage people who might not attend their GP practice and are at most risk of having poor health outcomes.

Key Area 6 Hospitals

Focus on Hospitals- what we wanted to do
Reduce avoidable use of hospital beds
Understand more about how people in Midlothian use our acute hospitals

In seeking to change the model and balance of care, we wanted to understand how the Midlothian population is using acute hospitals like the Royal Infirmary and the Western General, so that we can plan safe and effective community-based alternatives.

In particular, we wanted to strengthen our capacity to provide community based services out of hours and at weekends.

We recognise that there is no one 'silver bullet', but rather a range of evidence-based interventions that have a cumulative effect of ensuring people can be cared for in their own home or community setting wherever possible. In addition, that we can ensure that people can come home from hospital when they are ready to do so.

What we did:

- Further investment made in the Hospital at Home Service-increasing capacity to supporting 15 patients at any one time.

- We continue to develop joint work with the Ambulance Service for people who have fallen and those with dementia.

- A new Physiotherapy post created to support people with advanced respiratory illness (COPD) and manage their condition without needing hospital admission.

- To ensure people are discharged quickly, we strengthened the In Reach Team.

- We maintained the Assisted Discharge Service provided by Red Cross.

- In relation to younger people who attend the hospital regularly, some work undertaken to ensure a proactive approach to addressing their needs such as contact with the Homelessness Service.

- The joint dementia team increased its capacity with an additional social worker and introduced a duty system that works in partnership with MERRIT to enable GPs to phone directly when there is a crisis/emergency. This is to avoid going to the Community Care duty team and ending up on a waiting list.

6. PERFORMANCE – LOCALITY PLANNING AND INTEGRATION PRINCIPLES

Community Planning and Area Targeting

Midlothian is small, both geographically and in population terms and overall, has lower than Scottish average levels of social exclusion and deprivation.

We have formally established two localities- East and West, but as these are newly defined, many national data sources cannot provide data at this level.

However, we do know that East Midlothian has three areas of multiple deprivation, particularly in Dalkeith & Woodburn, Mayfield & Easthouses, and Gorebridge. In addition, individuals and smaller groups who suffer from deprivation are spread throughout the small towns and villages in Midlothian.

Area Targeting is an approach to target the three areas in Midlothian with the highest levels of deprivation in terms of educational attainment, income, health, and access to services. The aim is to reduce the life outcome gaps for residents in Gorebridge, Mayfield, and Dalkeith/Woodburn.

This work requires a Community Planning Partnership approach if we are to improve the outcomes for these communities. Midlothian Health & Social Partnership contributes to this work; both in the planning and targeted delivery of certain services, for example the Wellbeing Service is now available to residents of all three areas.

Involving People

If we are to successfully redesign health and care services, the Partnership needs the support and participation of the public. We look to our local communities to find ways to work with them, recognising the key role they play, not only in helping us to plan services, but also the resources they offer that support wellbeing. We seek as a partnership to embed community engagement in the foundations of our organisation, so that working with the community is business as usual.

In order to engage with people at the right time, in the right place we undertook a variety of activities in 2016-17. We have long-established relationships with “communities of interest” such as unpaid carers, older people, and people with disabilities and we work closely with them to identify priorities, develop action plans and deliver projects.

In 2016-17 we held a large event to launch the older people’s strategy attended by 60 older people. Another event was held to launch the physical disability directory in February 2017. We also engage with groups in an ongoing way – for example the TCAT patient advisory group has met 8 times throughout the course of 2016-17. We fund collective advocacy for both mental health and learning disabilities. As an illustration of this work People First held 94 community group meetings across Midlothian. In creating our new autism strategy “Two Trumpets” we held 4 workshop events. This process of engagement is now being continued as the strategy is delivered.

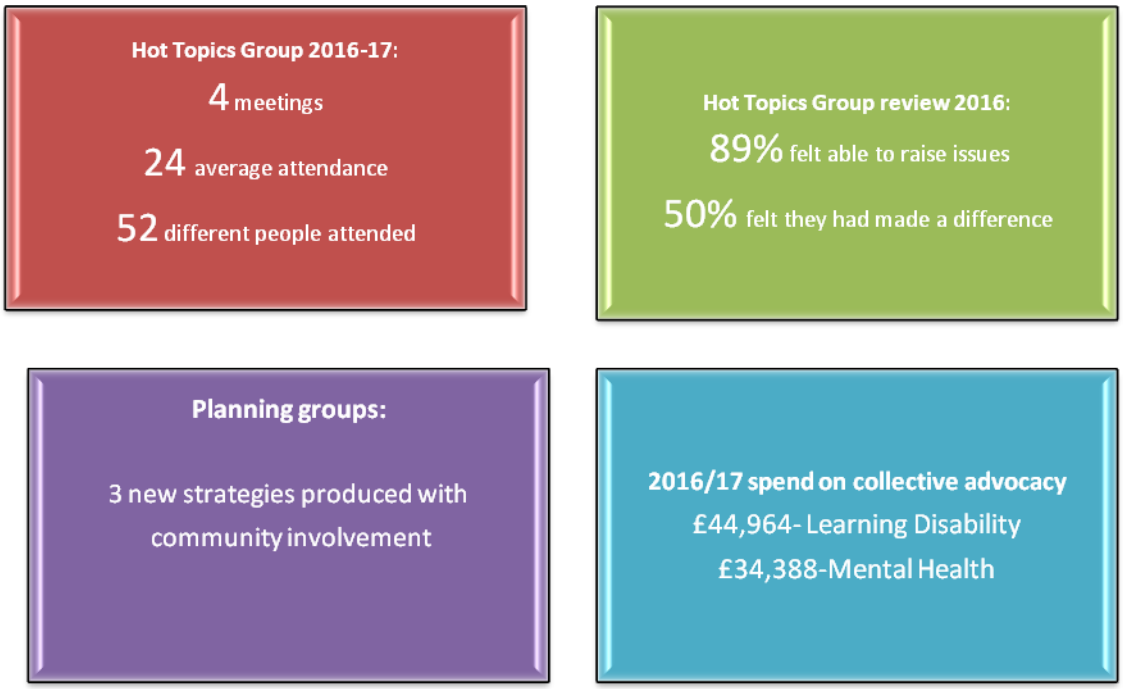
We have also established an open forum for dialogue between our management team and community members, the Hot Topics Group, which meets regularly to debate key issues. In 2016-17 the Hot Topics group met 4 times with an average attendance of 24 people.

In addition we regularly seek feedback from service users via surveys and other mechanisms. The annual social work service user and carer survey was carried out in February 2017 in which a total of 199 service users participated.

The Community Planning Partnership supports the development of strong links with geographical communities through a process of neighbourhood planning, and we are actively participating in work to improve outcomes in Midlothian's three areas of multiple deprivation – Woodburn, Mayfield and Gorebridge.

One of the big messages that came out of our engagement with communities was that services should support people to live well with long term conditions and that we need to work with the whole person. These aspects are encompassed in the 'House of Care' approach we have adopted. Other stand out issues reported to the IJB in August 2016 included access to primary care, home care and home adaptations, access to community space, physical activity and financial inclusion. The Health and Social Care Partnership are taking action to address these issues and this will be reflected in the updated Strategic Plan.

All of this work contributes to getting to know our communities and the uniqueness that exists across different parts of Midlothian. By understanding issues and needs on an area by area basis we can design services in a locally responsive and inclusive way.



Integration Principles

This is 'how we do things round here'. It is not easy to get this right. It is about the culture of the H&SCP and *how* we do things being more important then *where* we get. It would be easier for us to plan services from our perspectives, to put new services in place and be pleased with the result without really knowing what we did was the best we could do – if this is *how* we do things round here then we will get it wrong.

Culture change happens a conversation at a time. Good conversation and listening is fundamental to make the right changes and ones that will work.

We are actively doing the following in Midlothian to help us listen and understand.

- Listening and talking with 'natural communities'. The Community Planning Partnership is developing strong links with local communities through neighbourhood planning groups.
- Thinking about service planning from the perspective of localities
- Trying to see people in terms of not just their health issues, but as a whole person, part of a family or community with complex lives and that our services work hard to understand 'what matters', rather than 'what is the matter' to help people live well
- Bringing people together to share their perspectives and work together to find solutions.

No one service or individual can make these shifts to how we work or re-design what we offer, so partnership is central- with individuals, families and communities, as well as our colleagues across health and social care and the voluntary sector.

As an organisation, we want to be outward looking and listen to our communities and our staff. We are committed to using information intelligently to help us make the best decisions, to work proactively and respond to challenges and changing needs.

7. FINANCE

Background and Summary

The first year that funding was transferred to the IJB was 2016/17. The IJB undertook a detailed financial assurance process in March 2016 to review the Midlothian Council proposition along with the working proposition from NHS Lothian. The IJB then undertook a further financial assurance process – including a review of the in-year 16/17 financial information from both partners – on receipt of the NHS Lothian proposal. NHS Lothian did not set a budget formally until June 2016- three months after the IJB was established.

There were significant financial challenges in both budget offers. The IJB was keen to progress with the delivery of its strategic plan and to further the transformation process and accepted these budgets contingent on a financial risk sharing agreement with Midlothian Council and NHS Lothian.

The IJB agreed a financial risk sharing arrangement for 2016/17 with NHS Lothian and Midlothian Council, which meant that any overspends incurred in the delivery of the delegated functions by both NHS Lothian and Midlothian Council would be covered by both NHS Lothian and Midlothian Council.

The IJB was overspent by c. £1.5m in 2016/17, but additional resources were made available by the partners.
The actual position was as follows :-

	MLC	NHSiL
	£m	£m
Opening Budget	37.25	78.69
Social Care Fund		3.59
Add'n budget in year	0.41	4.41
2016/17 budget	37.66	86.69
NCL		8.70
Additional n/r Support	0.74	0.86
Net charge to IJB	**38.24**	**96.25**
Total	**£134.49 million**	

The charges made by Midlothian Council to the IJB are the net direct costs incurred in the delivery of social care services in Midlothian. The health services managed by the Joint Director are charged to the IJB directly. Charges for services not managed by the Joint Director are estimated using the Health Budget Setting Model. Midlothian's charges are generally 10% of the Lothian spend.

The pressures driving the overspends (before the non-recurrent support) fall into three broad areas:

- Overspend in social care services for adults.
- Overspend in the GP prescribing budget.
- Incomplete delivery of planned recurring savings by NHS Lothian and Midlothian Council.

2016/17 Financial Performance

The table below lays out more of the details behind the financial performance in 2016/17 :-

	Budget £000's	Actual £000's	Variance £000's
Older Peoples Services	24,789	24,497	292
Children's Services *	1,322	1,473	-151
Learning Disabilities	15,150	16,319	-1,169
Physical Disabilities	4,127	4,731	-604
Mental Health	8,738	8,607	131
Primary Care**	41,094	42,225	-1,130
Other	14,850	13,742	1,108
Acute Set Aside***	19,315	19,390	-74
Integrated Care Fund	3,505	3,505	0
Non-Recurrent Support	1,597	0	1,597
Total IJB spend	**134,488**	**134,488**	**0**

*	children's services are health visitors managed by the partnership
**	Primary care expenditure covers all of the programmes above and includes: GPs Opticians (where there may be patient charges) Community Pharmacy Dentists (where there may be patient charges) Prescribing by GPs
***	Acute set-aside - mostly in-patient bed costs but there is a small element of out-patient services depending on how the delegated function is delivered. This includes the Accident and Emergency service at the RIE

The IJB's expenditure in 2016/17 for both services delivered by Midlothian Council and by NHS Lothian has been split into programmes as far as is possible. Another way to look at our spend is as follows (see Figure 1 overleaf):

	£m
Hospital Services for In-patients	22.69
Expenditure on health services excluding above	73.56
Expenditure on social care services on care homes or adult placement	16.60
Direct expenditure on social care services to support Carers*	0.30
Other Social Care Expenditure	21.34
Total	**134.49**

*It should be noted that support to Carers is a thread that runs through most services, there is not a specific carers budget not expenditure identified. The value above is the contract with VOCAL.

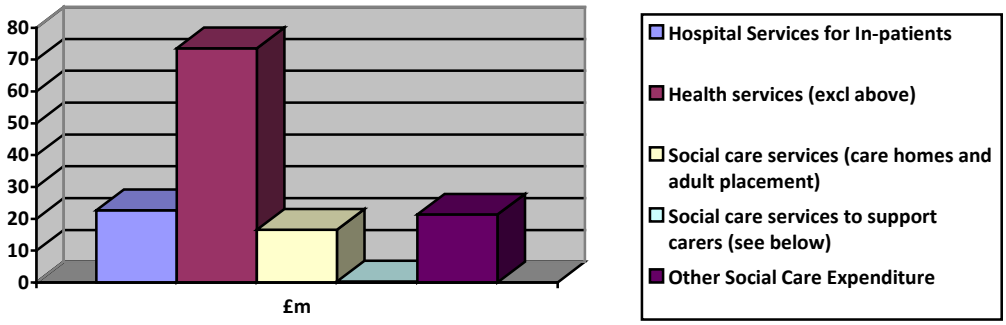


Figure 1

Social Care Fund

In 2016/17, the Scottish Government announced an 'Integration Fund' of £250m nationally which was to be directed by Integration Authorities to develop social care. Half of this fund was to be used to underpin existing pressures including the delivery of the living wage to be paid to all staff who delivered social care regardless of who employs them and half to deliver additionality – that is to be invested in delivering further social work capacity and supporting the transformation of the delivery of the service. Midlothian IJB's share was £3.59m and this was used per the Scottish Government's ambitions. The IJB has been developing, in line with the Act and its regulations, two localities within Midlothian. However, this work is at an early stage and it would not be meaningful to provide any financial analysis at a locality level for 2016/17.

2017/18 – Financial Challenges and expectations

In March 2017 IJB undertook a financial assurance process to review the budget propositions for 2017/18 from Midlothian Council and NHS Lothian. Again this process identified significant challenges but the IJB has accepted this budget although is clear that a financial risk sharing agreement similar to that in 2016/17 will not be possible. NHS Lothian has identified in its financial plan for 2017/18 (as at April 2017) a significant budgetary pressure for which there are, currently, no final plans to manage.

As part of the financial planning process for 2017/18, the financial issues identified above in 2016/17 have been addressed – NHS Lothian has uplifted the GP Prescribing baseline to the 2016/17 expenditure level and the social care management team has developed a clear plan to rebalance the budget for learning disabilities services. That said, the financial assurance exercise identified pressures within the IJB of c. £4.4m of which there are clear plans to deliver £2.8m with further plans being developed to balance the budget.

The challenge is, in financial terms, to continue the transformation of the services that deliver the IJB's delegated functions whilst continuing to deliver high quality health and social care to the population the IJB supports. The IJB has developed an outline financial strategy and this will be developed further into a detailed multi year financial strategy which will lay out how the IJB will deliver its strategic plan.

The IJB continues to develop a multi-year financial plan that will clearly articulate how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan.

8. SUMMARY OF INSPECTIONS OF SERVICES

The Care Inspectorate undertook both scheduled and unscheduled inspections across a range of IJB services during 2016/17. The overall quality of care as assessed as good or better in 19 out of 27 services for the reporting period.

4 of our community-based services were rated adequate or lower as were 3 of our Care Homes.

Overall, 85% of care services graded 'good' (4) or better in Care Inspectorate inspections (Scottish rate 83%)

See Appendix 3 for a comprehensive list. Full reports can be viewed at http://www.careinspectorate.com/index.php/care-services

The Mental Welfare Commission undertook two inspections within mental health inpatient facilities during 2016/17.

Rossbank Ward, Midlothian Community Hospital
26th May 2016 (Announced)- no recommendations made

Glenlee Ward, Midlothian Community Hospital
12th January 2017 (Unannounced)- action plan prepared with a focus on sustaining improvements made in the ward recording/ documentation processes. Other recommendations around Activity are in place

Full reports can be viewed at:
http://www.mwcscot.org.uk/publications/local-visit-reports/nhs-lothian/

The Care Inspectorate was commissioned by Scottish Government to undertake validated self-evaluation of Drug and Alcohol Partnerships (ADPs) against the Quality Principles in 2016. This included MELDAP (Midlothian and East Lothian Drug and Alcohol Partnership) which was given feedback on its performance in terms of its strengths and areas for improvement. The local Peer Support Project was highlighted as an area of good practice.

9. INTEGRATION FUNCTIONS AND SIGNIFICANT GOVERNANCE DECISIONS –

The Board and its committees have engaged in matters relating to good governance through consideration of reports and decisions on a wide variety of issues e.g.

April 2016
- Directions to Midlothian Council and NHS Lothian
- Code of Conduct
- Risk Register

June 2016
- Equality Outcomes and Equality Mainstream Reports

August 2016
- Public Engagement Plan

October 2016
- Financial Strategy

March 2017
- Delivery Plan Health and Care 2017-18
- Performance Targets for IJB

Appendix 1 List of Key Documents and Reports

Midlothian Health & Social Care Partnership

- **Delivery Plan (2017)**
- **Strategic Plan and Strategic Plan-Easy Read version (2016-2019)**
- **Newsletters:**

https://www.midlothian.gov.uk/info/200276/strategies_policies_and_campaigns/200/health_and_social_care_integration

- **Joint Strategy for Older People In Midlothian (2016-2019)**

https://www.midlothian.gov.uk/info/200276/strategies_policies_and_campaigns/490/joint_strategy_for_older_people

- **Community Planning in Midlothian**

https://www.midlothian.gov.uk/info/200284/your_community/214/community_planning_in_midlothian

Appendix 2

Summary of Gap Inequality Indicators adopted by the Community Planning Partnership

Theme	Proposed Midlothian Indicator	Explanation
Health		
Life Expectancy for Males and Females		How long children born in a specified year can expect to live. Looking at the gap between the least and most deprived people across the Midlothian population.
16-75 years Mortality Rate (*or 0 – 75yrs)		Early deaths are linked to socioeconomic position
16-75 years Preventable Admissions		Hospital admissions that might have been avoided by preventive care in the community.
Type 2 Diabetes prevalence		Good example of a chronic disease with a socioeconomic gradient and is influenced by life circumstance and lifestyle factors. Can be delayed or prevented – investment in appropriate support can be influential.
(Mild to moderate) mental health prescriptions		Investigating use of prescription data
Education		
27-30 month check – language acquisition		Measure of early years development. We are particularly interested in language acquisition.
PIP Entry Score		Measure of readiness for school. Links to early years development.
Primary School Absence		Education (adults and children) has the potential to transform lives - attendance can vary according to socio-economic gradient and can be related to home circumstances.
S4 Average Tariff Score		This illustrates the variance in academic achievement by secondary school pupils in S4. Socioeconomic gradient is evident.
Adult Qualifications		Adult learning can transform lives – of the learner and their family. Impact on health, income, economic circumstance, etc
Employment and Income		
Unemployment % (ONS model-based method)		Impact on individuals, families and communities. Socioeconomic gradient.
Household income less than 60% median		Living on low income
Gross weekly pay		Inequality exists by gender at present. Also, in Midlothian weekly pay is lower than other LA areas. Poverty and income impact on health, learning and economic circumstance - well documented.
Percentage of Population Income Deprived		Gradient exists between intermediate zones in Midlothian.

Appendix 3 List of Inspections 2016/17

		Care & Support	Environment	Staffing	Management & Leadership
Extra Care Housing	Cowan Court	5		4	5
	Hawthorn Gardens	5		5	5
Community Based	Midlothian Homecare	3		3	3
	Carewatch	2		2	2
	Mears Homecare West	1		2	1
	Mears Homecare East	3		4	4
	McSence	5		5	5
	Carr Gomm	4		4	5
	Places for People	5		5	5
	Link Living	5		5	5
	Aspire	1		2	2
	St Joseph's	5		5	5
	St Joseph's Circle 1	5		5	5
	St Joseph's Circle 2	5		5	5
	St Joseph's Circle 3	5		5	5
	Elcap	5		5	
Care Homes	Nazareth House	3	3	4	4
	Springfield Bank	2	3	2	2
	Thornlea	5	5	4	4
	Drummond Grange	3	3	3	3
	Pittendreich	3	3	3	3
	Aaron	4	4	3	4
	Archview Lodge	5	5	5	6
	Highbank	5	5	5	5
	Newbyres Village	4	4	4	4
	Rosehill	5	5	5	5
	Pine Villa	4	4	5	4

ANNUAL REPORT 2016-2017

East Lothian Integration Joint Board

Achieving best care, best health and best value for our communities

East Lothian
Integration Joint Board

Contents

Foreword

'Welcome to the first annual report of the East Lothian Integration Joint Board (IJB). This was formed on 1 July 2016, taking on responsibility for the planning and delivery of a wide range of adult primary and community health and social care services in East Lothian, as well as some acute hospital services.

'This report looks at the period between April 2016 and March 2017. During this time we focused on integrating our health and social care management and service teams and we reshaped the commissioning and delivery of services in line with our strategic vision.

'We also laid the groundwork for the way that we want to work with our stakeholders. We spent all of 2016 engaging with providers, service-users and advocacy groups on a wide range of projects. Stakeholder feedback was instrumental in shaping the procurement process for our new care at home framework, our day centre strategy and our primary care strategy.

'This annual report shows what we achieved in 2016-17. Much of it is very positive but there are also areas where we want to do better. Therefore, we have included information about what we want to do next. Planning and delivery doesn't stop and start with each new financial year, but is a continuous process.

'Integrated working has huge potential benefits, for example, sharing knowledge and skills and making better use of resources to secure better outcomes for people in East Lothian. One of the great strengths of health and social care integration in Scotland is that it also provides the opportunity to engage in longer-term, sustainable planning, which, in East Lothian, will help us to achieve our vision of best health, best care, best value for our communities.'

'We look forward to working with our partners in coming years to deliver this vision.

Peter Murray, East Lothian Integration Joint Board Chair

David Small, Chief Officer, East Lothian Integration Joint Board

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About East Lothian Health and Social Care Partnership

East Lothian Integration Joint Board (IJB) was formed on 1 July 2015, with a responsibility to plan for the delivery of the functions delegated to the IJB by East Lothian Council and NHS Lothian. These functions are:-

- Adult social care
- Primary care services (GP practices, community dentists, community pharmacists and community optometrists)
- Mental health services
- Physical disability and learning disability services
- Community health services
- Community hospital services
- Unscheduled care services (services that are generally delivered from the Royal Infirmary of Edinburgh and the Western General Hospital)
- Community Justice.

The IJB assumed formal responsibility and associated budget for these functions on April 2016. The IJB published its 2016 to-19 Strategic Plan for these functions in March 2016, in line with the processes set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

This report looks at our performance during the first full year of operation and how we have delivered the vision in the IJB's Strategic Plan of best health, best care and best value.

Our vision - Best health, best care, best value for our communities

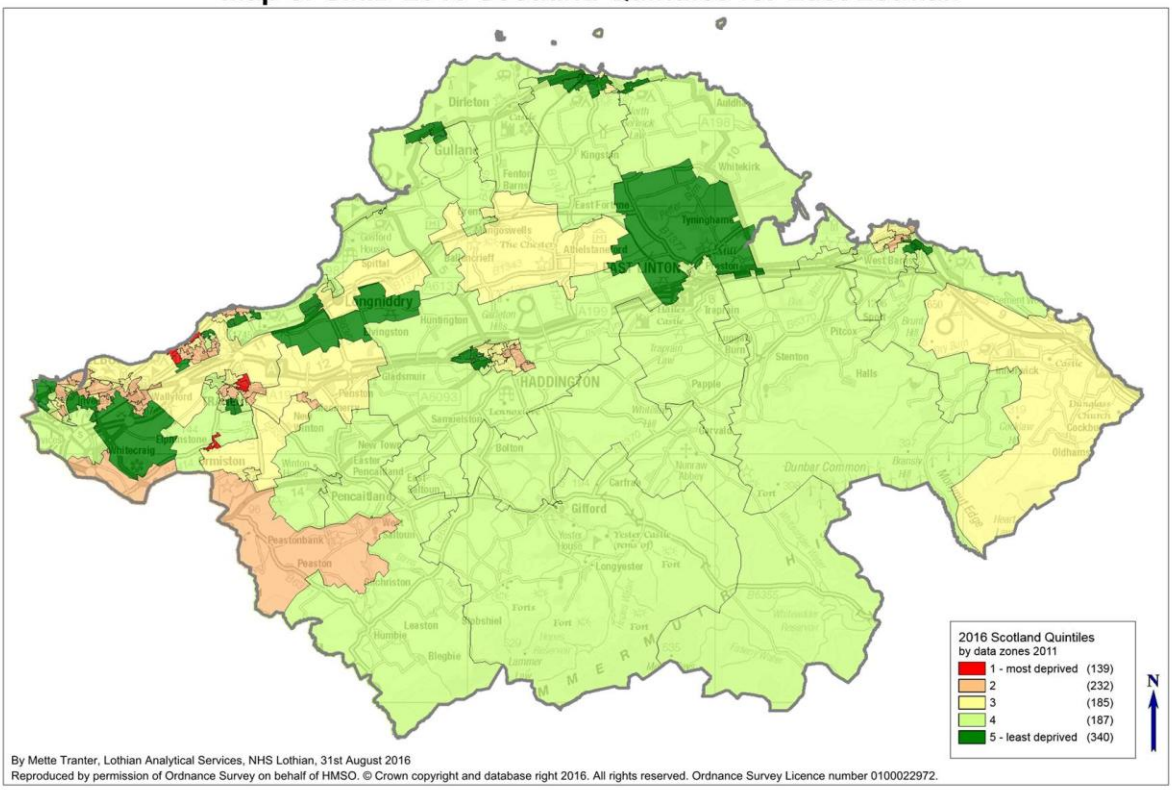
We want to make sure our services:

- are joined-up for service-users
- take account of the particular needs of individual service-users and their circumstances in different parts of the county
- respect our service-users' rights and take account of their dignity
- take account of the way that our service-users participate in their communities
- protect and improve our service-users' safety
- improve the quality of our services and ensure that they are planned and delivered locally in a way that is engaged with our communities
- anticipate needs and prevent them from happening
- make the best use of the available facilities, people and other resources.

You can find out more about our vision for health and social care in East Lothian over the next few years in our strategic plan on www.eastlothian.gov.uk/elhscp.

The strategic plan underpins all our decision making, focuses on delivery of the nine National Health and Wellbeing outcomes set out in the 2014 Act and seeks to address health inequalities across the county (see following map). As the strategic plan notes, across East Lothian people living in the poorest neighbourhoods, can on average, expect to die four years earlier than people living in the richest neighbourhoods and spend more of their lives with ill health.

Map of SIMD 2016 Scotland Quintiles for East Lothian



Locality planning

The HSCP has established good relationships with East Lothian's six local area partnerships. As set out in the Strategic Plan, it was decided to have two localities – East and West – as this model best reflects the county's demography. Initial locality work on primary care is already underway and this approach will be further developed within the Strategic Groups.

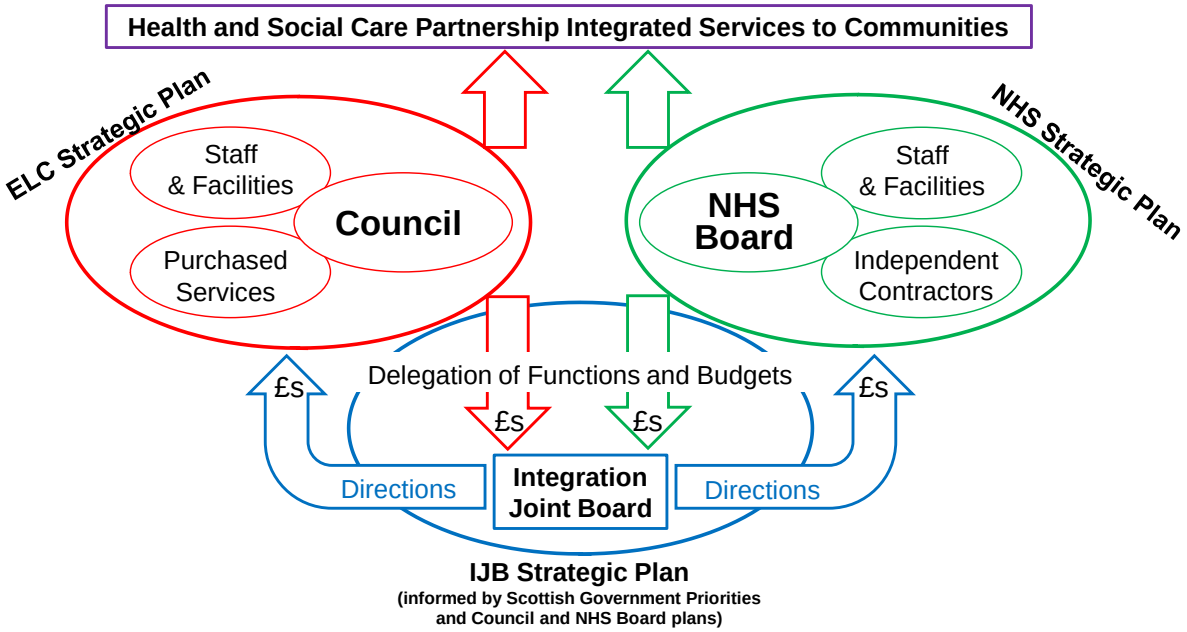
What is a 'locality''?

Localities should, as far as possible, reflect natural communities, boundaries and established service operating boundaries, focussing on populations and service design to meet their needs.

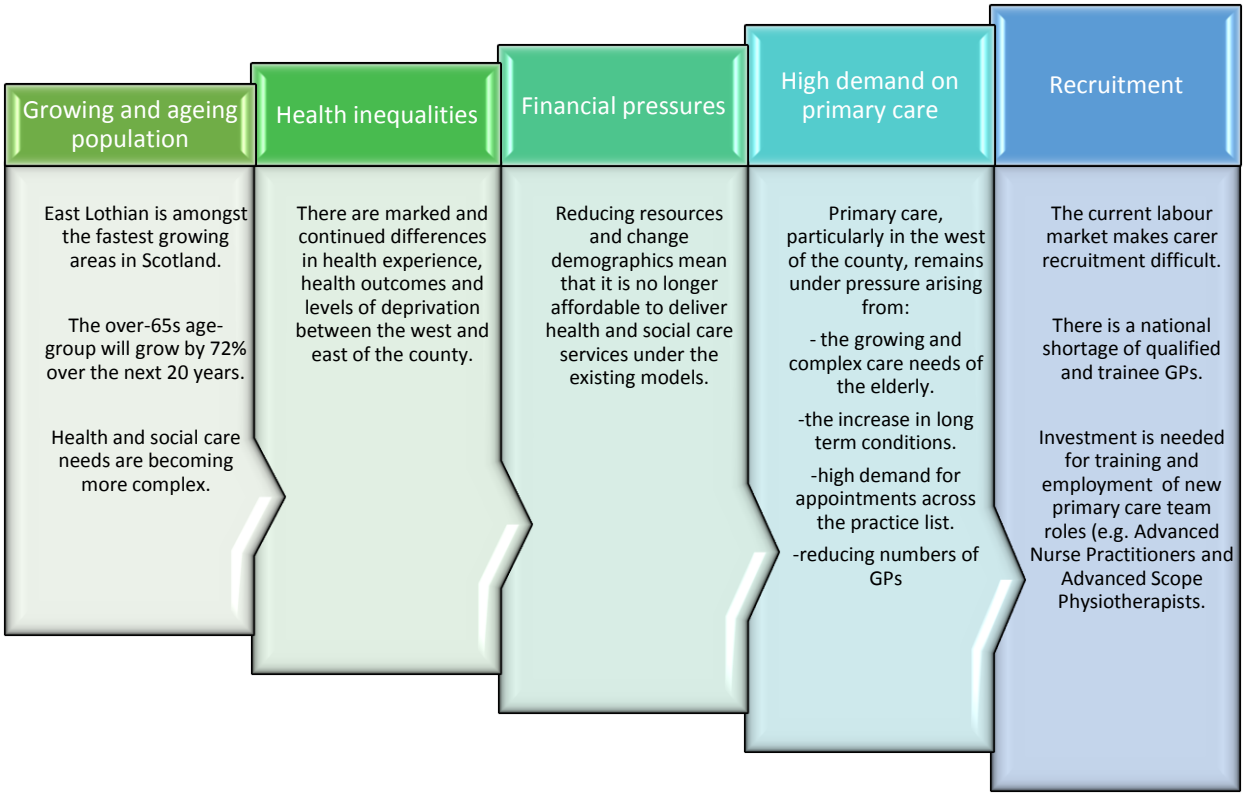
Planning and delivery structures

The Public Bodies (Joint Working)(Scotland) Act 2014 sets out the process by which an Integration Joint Board delivers its Strategic Plan by issuing 'Directions' to the Local Authority and the Health Board as appropriate. Directions are issued for each delegated function and for the allocation of the associated financial resource to support delivery of

directions. The graphic below shows the relationship between the IJB, Council, NHS Board and Health and Social Care Partnership and the table highlights the key challenges facing the HSCP.



Key challenges for East Lothian Health and Social Care Partnership



Performance against Directions

At its meeting of 31st March 2016 East Lothian IJB agreed its 2016-17 directions, aligned to the Strategic Plan and reflecting the nine National Health and Wellbeing Outcomes and the 23 performance indicators and covering all the functions delegated to the IJB. These were issued to East Lothian Council and NHS Lothian in March 2016 for the financial year 2016/17.

At its last meeting of 2016/17 the IJB agreed its 2017/18 Directions and which of the previous year's Directions would end, be replaced by alternatives, or continue into the following year. This was intended to ensure the 2017-18 Directions focused on a smaller number of areas compared to the preceding year.

During the year, progress against Directions was monitored and reported to the IJB.

National Health and Wellbeing Outcomes

How we monitor our performance

The Scottish Government established a suite of 23 performance indicators to enable health and social care partnerships across Scotland to demonstrate how well they are achieving a variety of measures related to the nine National Health and Wellbeing outcomes. East Lothian's performance against the 19 measures for which data are available is shown below.

In looking at performance between different IJB areas across the country it is important to remember that:

- Priorities are locally set by IJBs, reflecting national and local strategic issues and local needs assessments
- IJBs face differing challenges, demands and availability of resources
- Other areas of activity that also help to deliver National Health and Wellbeing outcomes are not represented in these performance indicators.

National health and wellbeing outcomes for East Lothian HSCP

95% of adults are able to look after their health very well or quite well (Scotland 94%)

86% of adults supported at home agreed that they are supported to live as independently as possible

(Scotland 84%)

83% of adults supported at home agreed they had a say in how their help care or support was provided

(Scotland 79%)

82% of adults supprted at home agreed that their health and socialcare services seemed to be well coordinated (Scotland 75%)

84% of adults receiving any care or support rated it as excellent or good

(Scotland 81%)

85% of people had a positive experience of the care provided by their GP practice

(Scotland 87%)

92% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life (Scotland 84%)

48% of carers feel supported to continue in their caring role

(Scotland 41%)

88% of adults supported at home agreed they felt safe

(Scotland 84%)

Premature mortality rate is 320 per 100,000 persons

(Scotland 441)

Emergency admission rate is 9,398 per 100,000 population

(Scotland 12,037)

Emergency bed day rate is 114,152 per 100,000 population

(Scotland 119,649)

Readmission rate to hospital within 28 days is 95 per 1000 population (Scotland 95)

85% of the last 6 months of life is spent at home or in a community setting (Scotland 87%)

Falls rate is 19 per 1000 population over 65 years

(Scotland 21)

77% of care services have been graded "good" (4) or better in Care Inspectorate inspections

(Scotland 83%)

66% of adults with intensive care needs are receiving care at home

(Scotland 62%)

The number of days people spend in hospital when they are ready to be discharged is 1,164 per 1000 population (Scotland 842)

23% of health and care resource is spent on hospital stays where patient was admitted as an emergency

(Scotland 23%)

How we performed compared to seven 'peer group' local authorities and the national average

INDICATOR	East Lothian	*Peer Group Average*	*Scotland*
1. Percentage of adults able to look after their health very well or quite well	95.2%	*94.6%*	*94.0%*
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.	86.3%	*81.9%*	*84.0%*
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	83.4%	*77.6%*	*79.0%*
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.	81.7%	*76.7%*	*75.0%*
5. Percentage of adults receiving any care or support who rate it as excellent or good	83.9%	*80.7%*	*81.0%*
6. Percentage of people with positive experience of care at their GP practice.	84.7%	*86.7%*	*87.0%*
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	92.4%	*83.7%*	*84.0%*
8. Percentage of carers who feel supported to continue in their caring role.	47.7%	*42.6%*	*41.0%*
9. Percentage of adults supported at home who agree they felt safe.	87.9%	*82.9%*	*84.0%*
10. Percentage of staff who say they would recommend their workplace as a good place to work.	*Not yet available.*		
11. Premature mortality rate (per 100,000 population)	319.9	406.5	440.5
12. Rate of emergency admissions for adults (per 100,000)	9,398.0	12,373.4	12,037.0
13. Rate of emergency bed days for adults (per 100,000)	114,152.0	121,572.1	119,649.0
14. Readmissions to hospital within 28 days of discharge (per 1,000)	95.20	101.09	95.30
15. Proportion of last 6 months of life spent at home or in community setting.	86.20	87.54	87.50
16. Falls rate per 1,000 population in over 65s.	18.50	19.94	20.90
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	77%	82%	83%
18. Percentage of adults with intensive needs receiving care at home.	66%	64%	61%
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000)	1164.0	879.6	842.0
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	23.3%	23.9%	22.8%
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.	*Not yet available.*		
22. Percentage of people who are discharged from hospital within 72 hours of being ready.	*Not yet available.*		
23. Expenditure on end of life care.	*Not yet available.*		

Shaded data cells show where the most recent Scotland figure is not yet available, so the Scotland figure for the previous year is shown
Data shown above is for the most recent year available

Delayed discharge performance

East Lothian's performance for hospital delayed discharges has steadily improved since August 2016. The actions taken to achieve this improvement include:

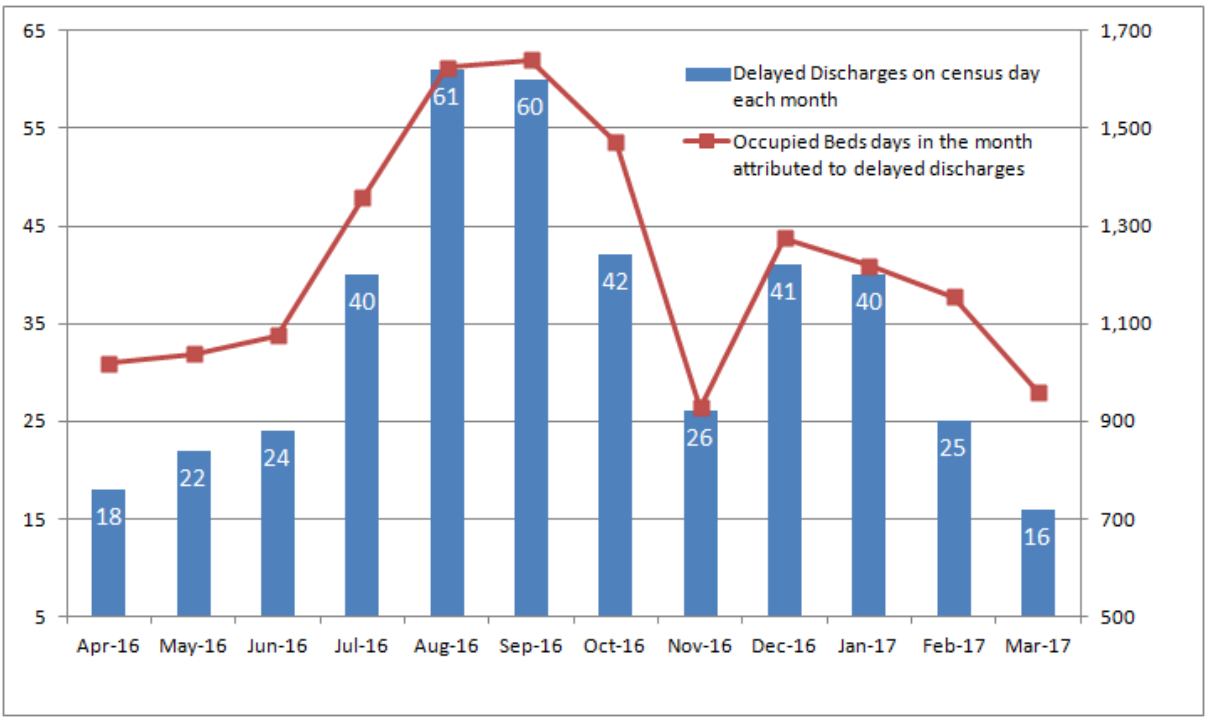
- A 20% increase in the Hospital to Home team to avoid unnecessary hospital admissions
- Implementation and continued support by the Partnership of the Living Wage, helping to stabilise workforce numbers within the home care sector
- A weekly Delayed Discharge Task group and daily HUB and patient flow meetings to assist in finding next stage of care solutions for all patients/clients with a delayed discharge
- A 20% increase in capacity of ELSIE (East Lothian Service for Integrated Care for the Elderly), to further improve its effectiveness in avoiding admission and in supporting the return home of patients
- Continuing use of the Partnership's step down capacity to enable patients to be moved out of acute hospitals expeditiously.

What is 'delayed discharge'?

A delayed discharge is any hospital inpatient who is ready for discharge but is delayed in hospital care because they don't have care in place to return home or to a homely care setting.

Being delayed in hospital can be debilitating, reduce independence and slow down ongoing recovery.

The graph below shows the number of inpatients recorded as a delayed discharge at each monthly census point (blue column). The red line shows the cumulative number of bed days occupied in a month by all patients whose discharge was delayed. Both measures have improved across the last year.



Public Health and Health Improvement

The IJB worked closely with partners in identifying and addressing population health needs. The public health professionals supporting this work include: a Public Health Practitioner; a number of Health Promotion experts; Public Health Consultants and Public Health Policy Officers.

All HSCP activity influences population health either directly or indirectly. However, many of the broader determinants of health and wellbeing sit outwith the HSCP (see figure below). To address these, public health colleagues work with partners across East Lothian's wider Community Planning Partnership and other settings. They provide health improvement and health intelligence expertise and support partners in taking an evidence-informed, person-centred approach which considers the impact of policy and interventions on health and health inequalities.

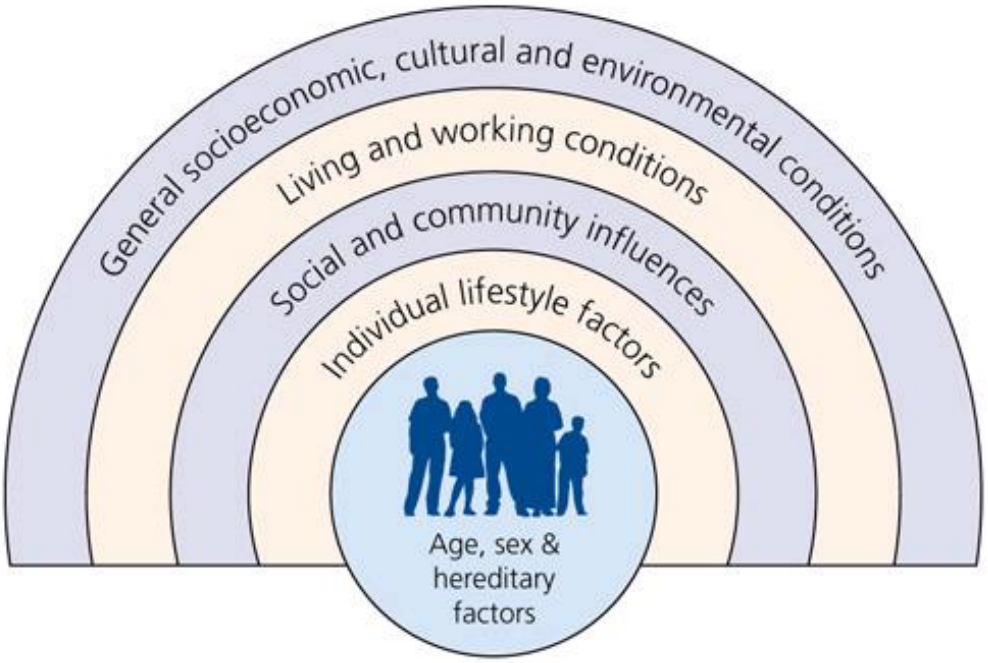


Figure: The Broader Determinants of Health and Wellbeing, Dhalgren and Whitehead, 1991

Health improvement and health inequalities work in East Lothian is often (but not exclusively) co-ordinated through the East Lothian Health Improvement Alliance. This group brings together organisations from the public, community and third sectors with an interest in improving health and reducing inequalities. The group reports to, develops and presents papers to the Resilient People Partnership, one of the community planning groups. Public health colleagues are also represented at a strategic level on the HSCP Strategic Planning Group and HSCP Strategic Plan Programme Board and the various strategy groups which sit under these.

National Health and Wellbeing Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer

95% of adults are able to look after their health very well or quite well (Scotland 94%)

84% of adults receiving any care or support rated it as excellent or good (Scotland 81%)

85% of people had a positive experience of the care provided by their GP practice (Scotland 87%)

Health improvement

Physical activity

In East Lothian, there are sports and leisure centres in each of the six main towns and well-maintained pitches and greens. The county also offers numerous cycle trails, walking and hill walking opportunities. The HSCP has a strong working relationship with East Lothian Council's Sport, Countryside and Leisure service and has worked with them to develop a Physical Activity Framework and Action Plan 2016-19. The service runs a number of walking groups through Ageing Well, walking football for the over-50s and has recently installed outdoor gym equipment along the River Tyne Walkway in Haddington.

We promote physical activity for older people through our physiotherapy services and place emphasis on physical activity in our care homes (both our own and partner providers').

Physical activity indicators

	Indicator	Weighted count	East Lothian proportion	Scotland average	Scotland Local Authority lowest	Scotland range	Scotland Local Authority highest
7	Recreational walking participation in adults	243	66	65	55		83
8	Frequency of active participation	154	52	48	33		70
9	Active recreation in older people*						
10	Attendance at leisure facilities	146	40	30	23		44
11	Active travel to school*						
12	Satisfaction with leisure facilities	210	57	53	37		87
13	Greenspace accessibility	308	84	68	52		89
14	Adult active travel	119	66	67	39		86
15	Community safety for play*						
16	Safety of neighbourhood for walking	554	73	74	65		89
17	Active volunteering workforce*						
18	Sports participation - adults	213	58	52	41		62

East Lothian Citizens' Panel Results

A Citizens' Panel survey in 2016 with a total of 795 respondents had a number of physical activity related questions. 67% of respondents thought they would benefit from slightly (43%) or significantly (24%) increasing their levels of physical activity.

The majority of respondents said that the following benefits of physical activity would motivate them to do either a lot or a little more physical activity:

- *Benefits overall health (94%)*
- *Improves sleep (82%)*
- *Maintains healthy weight (92%)*
- *Benefits mental health (86%)*
- *Improves quality of life (92%)*

The majority of respondents (74%) said they were aware of the benefits of physical activity. Related to the percentage reduction in risk of specific conditions, 42% of respondents indicated the risk reduction was higher than they expected whilst 55% said it was what they expected. 71% of respondents said that seeing the percentage risk reduction in specific conditions would encourage them to increase their levels of regular physical activity.

The biggest reason cited that would encourage respondents to increase their levels of physical activity was having more time (60%) followed by having cheaper local facilities/activities (42%) and having better local facilities that meet their needs/reflect their interests (40%).

Both East Lothian Council and NHS Lothian promote health and wellbeing activities for staff through initiatives like Healthy Working Lives.

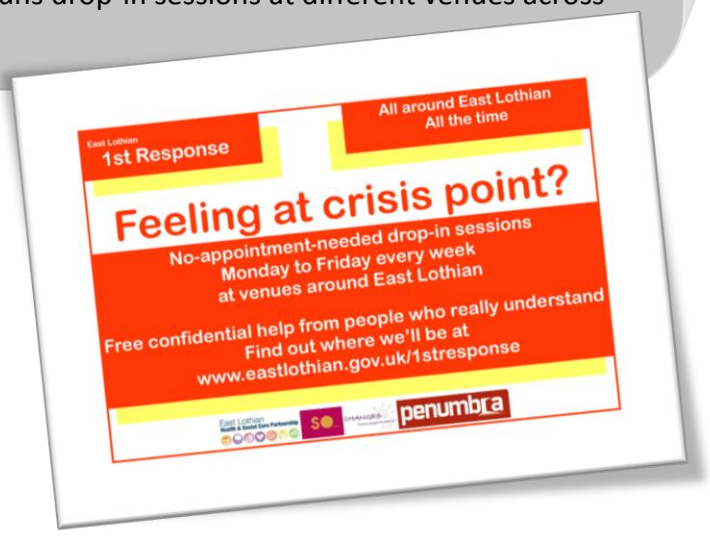
Good mental health

We work with key partners, such as CHANGES in Musselburgh, to help people achieve better mental health, and we also provide counselling and other therapies at Herdmanflat Hospital in Haddington. People can refer themselves to counselling and other therapeutic services at CHANGES but must be referred to NHS services. The demand for these services is high and there are waiting lists.

In 2016-17, we reviewed mental health services. This underlined both growing demand and too great a centralisation of services. This is exacerbated by patchy public transport, financial pressures on people affected by welfare reform/poverty, the financial impact of unpaid caring and the current focus on austerity in relation to public sector funding.

ELHSCP supports CHANGES to deliver ASIST programmes that help workers and members of the public to be better able to identify when people are at risk of suicide and what they need to do to support them and get professional help quickly.

1st Response – Penumbra, Changes and Stepping Out, with funding from East Lothian Health and Care Partnership, launched the new 1st Response service for people who feel they are reaching crisis point. 1st Response provides face-to-face support throughout East Lothian. The project helps people resolve their crisis through sensitive and non-judgmental support based on individual needs, and helps people to access other services. It provides information about other organisations which could help (such as health services, social work, benefits advice and other support) and helps people to develop skills to manage their mental health. It runs drop-in sessions at different venues across East Lothian five days a week.



Health promotion

We actively supported health improvement initiatives to promote healthy eating, smoking cessation, physical activity and sensible drinking.

Substance misuse

While the misuse of alcohol and drugs affects all communities the negative impact is greatest in our most deprived communities. It is estimated that annually for East Lothian between 20 and 50 children are born with Foetal Alcohol Spectrum Disorder. Over 2016-17 a total of 333 Alcohol Brief Interventions were conducted. In that period there were 412 alcohol related hospital stays and 14 alcohol related deaths.

It is estimated that 880 individuals in East Lothian have problem drug use (580 males 300 female). Access to treatment services was good with some 88% of clients being seen with 3 weeks from initial referral (HEAT A11 Standard). East Lothian services provided treatment for 376 (187 drugs and 189 alcohol) clients and 10 East Lothian clients were offered a place at the residential Lothian and Edinburgh Abstinence Programme.

At the January 2017 IJB meeting, it was agreed to refocus the work of Midlothian and East Lothian Drugs and Alcohol Partnership (MELDAP) onto promoting recovery through the commission of services such as the Recovery College, Starfish Recovery café and Recovery Connections. This is now underway and we hope to be able to report the initial impact of this work in next year's Annual Report.

Self-management

HILDA

The HILDA (Help with Independent Living and Daily Activity) website provides its users with information they can trust on equipment that they can buy or borrow to help them maintain and improve mobility. It offers an easy to follow online self-assessment to help pinpoint what kind of support would be useful and puts people in touch with activities, exercise and advice to help keep them moving and enjoying life.

Registering enables users to get the most out of HILDA. This means they can plan and set goals that will help improve their mobility. They can change their goals as their needs change and

they can also create a plan for friends or relatives. Assessments, advice and details of equipment can be 'pinned' to their plan for future reference.

Accessing primary care

We began work aiming to get people to rethink how they use primary care services. Instead of routinely seeking a GP for health concerns, we aimed to offer appropriate access to other clinical professionals, to make them aware of services to which they can self-refer and to make more use of NHS Inform and NHS 24 to help in self management. It has been agreed to take this forward with NHS Lothian to ensure consistency of message across the Lothians.

Developing primary care

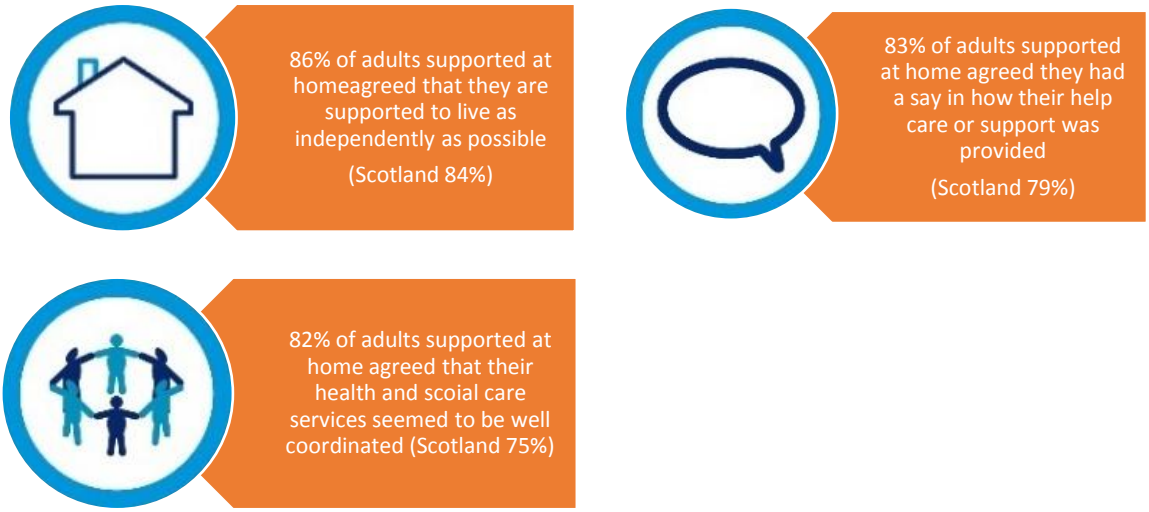
In 2016/17, we started work to develop a new primary care telephone triage service in partnership with NHS 24. In the first instance this will operate out of Musselburgh Primary Care Centre. It is intended to begin a pilot project in autumn 2017.

Looking ahead

It is planned to establish a Mental Health Strategy Group, comprising of key stakeholders, to work on a mental health strategy. This will involve active engagement with a wide range of stakeholders during its development. The planned strategy will focus on how to deliver more resource closer to home, enabling people to manage better mental health for themselves and providing earlier intervention and support.

National Health and Wellbeing Outcome 2

People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.



Older Peoples' Day Care Review

The project, to review day care provision for older people examined a number of the challenges linked to long standing care at home provision such as a lack of capacity, some low Care Inspectorate grades attainment by providers and coverage across the county.

Throughout 2016/17 a co-production approach was taken to the review, which involved HSCP officers working with the East Lothian Association of Day Centres, the ten third sector day centres and other stakeholders including elected members. The project looked at key elements of day care provision including the model of care, training, transport, data collection and the role of the association. Several events were held where these were explored in detail and reported back.

In early 2017, following conclusion of the review, the IJB accepted a proposal to develop day centre provision for a three year period in the first instance. The proposal was to develop the centres as health and social care centres with more formal links to in-house teams to provide opportunities to improve service delivery by taking pressure off care at home provision, providing one stop shops to allow centre users to access a range of professions and services, providing respite opportunities for carers and preventing delayed discharge through the use of emergency places.

Further investment arising from the review will ensure all ten day centres are funded more equitably based on the number of registered places they offer and their occupancy rate. As all day centres are registered to provide complex personal care it is important to support them equally. Building quality, leasing and maintenance arrangements have also been broadly standardised as a result of the project. This ensures the buildings they are operating in are fit for purpose.

It is planned to develop the centres over the next 6-12 months in order to support what could well be a unique model in Scotland by which ten small charities (each led by a committee whose members are all over 65) run all older peoples' day care provision. This means older people provide support to other older people with increased needs in very local communities.

Review of Care at Home Provision

The review allowed us to move from two service delivery frameworks, one providing care at home to older people over 65 and the other providing care at home to adults with specialist support needs to a single framework providing care at home support to all clients regardless of age or support need.

The project also developed a client focused approach by providers to provide tailored care and support to achieve personal outcomes agreed between the provider and the client and funded through a Personal Budget. This exciting development is a departure from previous approaches which directed how support was delivered by the day and hour and provides Self Directed Support style independence for those opting for option 3.

The personal budget model will drive up quality as only providers with grade 4 or above Care Inspectorate assessments will qualify to work in this way. The linkage of support to an improvement in quality is crucial not only for the service the client receives but also reduces the need to provide resource intensive support to providers whose grades fall or who end up under close monitoring or large scale investigation.

Under the contract providers are asked to identify ways of delivering efficiencies. Should they successfully identify and achieve a reduction in costs then they are eligible to receive a share of the savings. This incentivises the achievement of efficient service delivery on an ongoing basis.

Hospital at home and hospital to home

Hospital to Home is a proactive and flexible service to support patients care need. If a patient's needs alter once home, then the service can increase their care until things improve and they return to their normal. It works on a re-ablement model that leads to a reduction in the need for care through time. It maximises, maintains and can improve on a person's

independence by empowering them to manage their activities of daily living. The service has received excellent feedback from patients, relatives and other professionals, with the most recent patient satisfaction audit scoring 96.7%.

Hospital at Home seeks to avoid unnecessary hospital admissions and support patients' prompt discharge from hospital back to their own home in the community. Its multi-disciplinary team implements a care plan for each patient that is reviewed and monitored on a daily basis at the morning 'huddle'. To date the team have supported over 774 patients since February 2014, the average length of stay depends on the patients presenting condition this can be from 1 Day to up to 50 days. The team will support the patients in the community to remain in their own home and environment. The benefits of this approach include:

- Patients remain in their own home, surrounded by their family and carers.
- Patients are not admitted and therefore do not lose their package of care and have a further delay of having to be reallocated a package further down the line when available, if a complex package of care patients can wait some considerable months.
- Reduced bed days allowing the service to close 13 beds.
- Allowing the service to ensure that the patient receives the right treatment in the right place at the right time.
- The patient benefits from a multi-professional approach to care.
- Strengthened links with social care and mental health.

This model was cited as a national good practice case study by the Accounts Commission as an example of 'overcoming workforce challenges to providing new care models'. (*Changing models of health and social care*, prepared by Audit Scotland, 2016).

Telecare

In 2016/17, we focused on

- Supporting service redesign to ensure technology enabled care (TEC) is embedded at all key points in the integrated care pathway
- Increasing the number of awareness sessions for staff and stakeholders to incorporate and promote the use of technology to improve outcomes
- Identifying limitations of certain TEC solutions and reinforcing that technology augments but does not replace human intervention
- Encouraging a shift from the technology itself to care supported by technology.
- Trialing new digital equipment to prepare for the transition from analogue to digital technology
- Supporting people to make greater use of mainstream technology where possible utilising their own devices or advice regarding possible options.

The HSCP received an award of £50,000 from the Scottish Government to develop a strategic partnership approach to technology enabled care, which is intended to fund a 12 month development post

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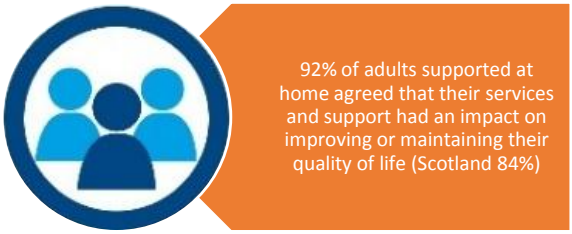
National Health and Wellbeing Outcome 3

People who use health and social care service have positive experiences of those services, and have their dignity respected



Patient/service-user feedback

East Lothian Council received 57 complaints between April 2016 and March 2017 about its Adult Social Care Services and it received 49 written unsolicited compliments.

East Lothian Health and Social Care Engagement Group

East Lothian Health and Social Care Partnership, East Lothian Council Community Learning and Development and the Scottish Health Council worked together to develop an independent service-user group to provide feedback on their experience of using HSCP services.

Big Conversation

Since the establishment of the HSCP, we have held an annual strategic engagement event called 'The Big Conversation'. We held Big Conversation 2 - #OverToYou our second annual consultation event for stakeholders in health and social care integration in East Lothian in October 2016. Our keynote speaker Professor Brendan McCormack from Queen Margaret University spoke about developing a 'culture of generosity' in integrated health and social care. Participants used a series of case studies to examine approaches to meeting client needs. Some outcomes of the event can be seen on the Big Conversation video channel.

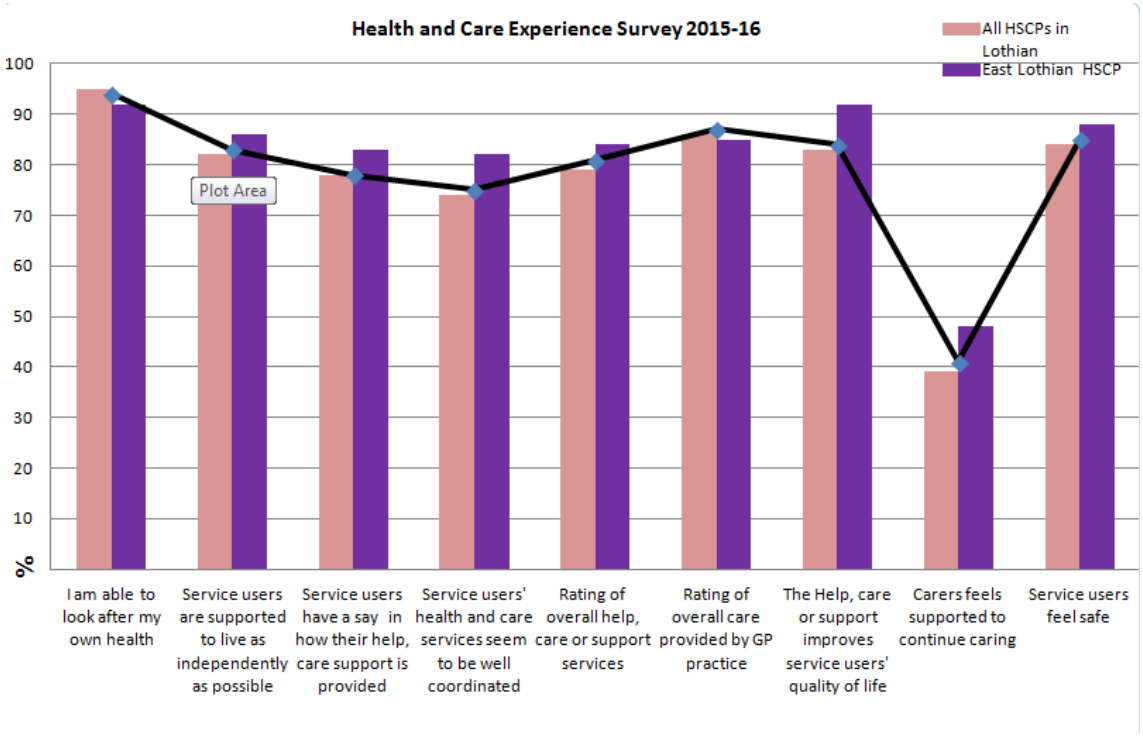
Allied events

We also supported and/or hosted events on themes that inform our wider strategic planning, for example, carer identification and the East Lothian Autism Strategy – one year on.

Health and Care Experience Survey

This national survey, published in 2016 and covering the 2015/16 period focuses on patients' experiences of their GP practice, out of hours health services and care and support.

East Lothian had the most favourable responses in Lothian and was better than the National average.



Patient Participation Groups (PPGs)

There are three PPGs already operating in GP practices across East Lothian. However, we would like to stimulate development of further primary care patient groups. The HSCP is currently negotiating the establishment of further groups at Eskbridge and Riverside medical practices in Musselburgh. Eventually, we would like to arrive at model for all practices in East Lothian to consider, enabling patients to comment on practice matters at local meetings and to come together to engage on HSCP strategic matters at larger joint meetings.

Looking ahead – East Lothian strategy groups

East Lothian Health and Social Care Partnership has set up seven new strategy groups to help it to deliver its strategic directions. The new strategic groups each comprise a multi-stakeholder themed Strategic Group and a corresponding Working Group, which consists of key officers from the Partnership. Each group has a proposed-focused remit as set out below. Remits will be finalised and agreed when each group is established and the first meeting held. The groups are:

1. **Dementia Strategic Group and Dementia Working Group** - remit focus: Development of a local Dementia Strategy and work plan
2. **Carers Strategic Group Carers Working Group** - remit focus: Development of a local Carers Strategy and work plan
3. **Mental Health Strategic Group and Mental Health Working Group** - remit focus: East Lothian Mental Health Strategy/Develop links with local Autism Strategy/Develop Suicide Prevention Strategy and work plan
4. **Learning Disability Strategic Group and Learning Disability Working Group** - remit focus: East Lothian Learning Disability strategy and work plan.
5. **Physical Disability and Sensory Impairment Strategy and Working Group** - remit focus: East Lothian Physical Disability & Sensory Impairment strategy and work plan

> *'This is a real milestone in ELHSCP's development. It means that we can start working closely with stakeholders to plan for what's happening this year, next year and for years ahead. Working strategically will help us to make the best of our resources, which is critical in the current financial climate. More importantly, the planning groups give us the opportunity to make sure that stakeholders are equal partners in planning, enabling us to develop innovative, flexible and responsive answers that really meet the health and social care needs of people in East Lothian.'*
>
> **David Small, Director, ELHSCP**

6. **Palliative Care Strategic Group and Palliative Care Working Group** - remit focus: This will focus on the target 'That no more than 10% of the last six months in life is spent on average in the large hospital setting by 2018/19'.

7. **Primary Care Strategic Group and Primary Care Working Group** - remit focus: Produce a strategy to support and develop work within the quality clusters and to develop service delivery models to support primary care services across the county.

National Health and Wellbeing Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

85% of the last 6 months of life is spent at home or in a community setting (Scotland 87%)

77% of care services have been graded "good" (4) or better in Care Inspectorate inspections (Scotland 83%)

66% of adults with intensive care needs are receiving care at home (Scotland 62%)

Inspections

Care Inspection Grades

Care homes

70% are graded at level 4 (good) or above

24% are graded at level 3 (adequate)

6% are graded at level 2 (weak)

0% are graded at level 1 (unsatisafactory)

Care at home services

92% are graded at level 4 or above

8% are graded at level 3

None is graded below level 3

Day Centres

6 out of the 10 day centres have had grades awarded, with the remaining 4 to still be inspected. Of the 6 available, all are now listed at grade 4 or above.

Older People's Services Inspection Action Plan

East Lothian Health and Social Care services for older people were inspected by the Care Inspectorate in October 2015 and the findings (shown below) were reported in May 2016.

Quality indicator	Evaluation
1 Key performance outcomes	**Adequate**
2 Getting help at the right time	**Adequate**
3 Impact on staff	**Good**
4 Impact on the community	**Adequate**
5 Delivery of key processes	**Adequate**
6Policy development and plans to support improvement in service	**Good**
7Management and support of staff	**Adequate**
8 Partnership working	**Adequate**
9 Leadership and direction	**Good**

We agreed an action plan with the Care Inspectorate in August 2016 and through the remainder of the year focused on delivering against all the actions. Our ongoing focus will continue to be consolidation of this plan to enable us to deliver consistent good quality experiences and outcomes for older people in East Lothian.

National Health and Wellbeing Outcome 5

Health and social care services contribute to reducing health inequalities

Households in poverty in East Lothian (Source: East Lothian Poverty Report)

Health services located in Edinburgh are more difficult for non-car owners in East Lothian to access because of expense and, in some cases, lack of public transport, particularly from outlying areas.

De-centralising services

Against this background, one of the major contributions that ELHSCP can make is to bring care closer to home or deliver care at home.

East Lothian Community Hospital

Work started on the new East Lothian Community Hospital in October 2016 after extensive consultation with stakeholders about the design of the facility and what services it should provide.

The consultation is now focusing on the interior design of the hospital. The conversation will continue throughout construction and delivery and thereafter. By 2020, the hospital will be fully operational and able to deliver a range of services previously delivered by hospitals and clinics in Edinburgh.

Public health initiatives

During the year, the public health team led on or contributed to numerous strands of work including:

- Participating in the physical activity strategic group and physical activity implementation group:
    - Working alongside East Lothian Council and QMU developed a physical activity programme plan for East Lothian
    - Developed an application for the Health Improvement Fund and allocated money to physical activity in East Lothian via the Start Well project.
- Supported the East Lothian Ageing Well, East Lothian Start Well and East Lothian Roots and Fruits projects and participated in the respective project steering groups
- Provided expert input to the East Lothian Poverty Commission
- Facilitated an Integrated Impact Assessment for the HSCP Strategic Plan

- Developed and delivered training to council elected members on health inequalities, co-facilitated a workshop regarding health inequalities with Day Centres and delivered a Health Literacy awareness session for Primary Care
- Supported workplace health, enabling two companies to maintain their Healthy Working Lives gold awards and one to maintain their bronze
- Supported other companies through training and health and safety visits.

Measuring the impact of public health activity on health and wellbeing

As the benefits of health improvement work and health inequalities input to policy and interventions is often diffuse, it is challenging to measure outcomes. The public health team will continue active working with colleagues to identify improved measures of the impact of health improvement work.

Link workers

We commissioned STRiVE, East Lothian's 3rd Sector interface organisation, to provide link workers in 4 surgeries in the east of the county. These workers are based in the surgeries and help patients access a wide range of advice and support relating to their health condition or that of someone that they care for. This includes advice on housing, benefits, specialist health support agencies and local organisations that can provide further support. They offer in-depth support, extended consultations and follow-up meetings.

Looking ahead

There are a number of work-streams in East Lothian which Public Health partners actively lead or contribute to on an ongoing basis. These will continue into 2017/18 and include:

- Violence again women:
    - Working with the Violence Again Women Group Delivery Group East & Midlothian to deliver on Equally Safe, the Scottish Government's framework to address violence against women and girls. Current work includes: supporting delivery of the SMILE service; delivering awareness raising training to frontline staff; leading on a short-life working group to assess the extent of and address commercial sexual exploitation across the region; supporting the development

of work in primary schools to raise awareness around gender inequality and its links to gender based violence

- Gypsy Travellers:
    - Leading on work to to coordinate and support activities aimed at improving the health and wellbeing of Gypsy Travellers in Lothian
- Smoking prevention and cessation work including the ASSIST programme with schools, work with Edinburgh college (which has a campus in East Lothian) and smoke-free homes
- Children and young people's health and wellbeing including working with education and the third sector
- Mental Health and Perinatal Mental Health:
    - Involvement in the coordination of suicide prevention locally, linked to Lothian wide programmes
    - Providing input into development of local crisis service development, as an early intervention model
    - Co-leading / providing input to group supporting young people's mental health
    - Co-leading development work focused on rehabilitation and mental health – in part using an early intervention model
    - Focusing on young people, transition and mental health with particular attention to Looked After and Accommodated Children
    - Focusing on mental health in minority ethnic communities
    - Working with Queen Margaret University to raise awareness of mental health/ wellbeing
- Working with East Lothian Housing colleagues on joint strategic needs assessment.

There are also a number of other ongoing work-streams, some of which focus on the broader determinants of health, and some of which focus more on individual lifestyle factors (including: Active Travel, Alcohol including the Alcohol Licensing Forum, Community (and Criminal) Justice, Early Years, Food and Health and the Game Changer Public Social Partnership).

National Health and Wellbeing Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce the impact of their caring role on their own health and wellbeing

48% of carers feel supported to continue in their caring role (Scotland 41%)

Carer identification

In 2016, ELHSCP began work on how we could encourage:

- people to identify as themselves as carers
- professionals to recognise/identify carers for the people they support and make sure that they were recorded as carers so that they had better opportunities to receive appropriate support.

Feedback from our 2016 Carer Identification Stakeholder Engagement Event Has been enormously helpful.

East Lothian Carers' Strategy

Our East Lothian Carers' Strategy Implementation Team, which is overseeing the introduction of the new Scottish carers' legislation coming into effect in April 2018, was set up in October 2016, following on from completion of the project specification for the new East Lothian Carers' Strategy by March 2016. This identifies project goals and a full communications and engagement process.

Carers of East Lothian

Carers of East Lothian (CoEL) is funded by the Health and Social Care

... really helped me find a pathway and supported me with information and encouragement so that I finally got help in place accepted by my father. She put things into perspective when I was overwhelmed and gave me practical solutions, thank you, thank you!"

Partnership to provide support to unpaid carers, including helping them to look after their own wellbeing.

CoEL's input with unpaid carers is wide ranging including the provision of information, advice, practical and emotional support on an individual and group basis; workshops, events and specialist sessions e.g. setting up Powers of Attorney; organising and facilitating short breaks for carers including the distribution of grants; financial advice and assistance in claiming entitlements. Other achievements are:

- CoEL has increased the identification of carers in East Lothian by 76% in the past 4 years and directly supported 993 carers last year.
- 84% of carers supported by CoEL report feeling better able to cope with their caring role as a result
- Specific examples of good practice include:
    - ✓ Joint working with the Health and Social Care Partnership on developing a new, outcomes and strength focused tool to pilot the new Adult Carer Support Plans
    - ✓ Generation of £626,267 in annual increased welfare benefits for 182 carers.
    - ✓ Embedding of specialist carer support worker within the HSCP Mental Health Team to provide support for carers of people with mental health issues.

"Because of the information I received from Carers of East Lothian it prompted me to make decisions I would still be pondering over. Carers of East Lothian have been encouraging, exceptionally helpful and very approachable. I feel comfortable knowing I have a contact with people who are caring but also professional. I was a complete stranger to Carers of East Lothian, but after my first telephone conversation and subsequent meetings I knew I was in good hands. Thank you so much"

National Health and Wellbeing Outcome 7

People using health and social care services are free from harm

Keeping our service-users and patients free from harm is central to everything that the East Lothian Health and Social Care Partnership does. In East Lothian, the East and Midlothian Public Protection Office provides leadership across Adult Support and Protection, Child Protection and Violence Against Women. Our Public Protection Structure is based on close collaboration and partnership working with service-users, partner agencies and our communities and is focused on improving outcomes for those in need of support and protection throughout East Lothian.

National Data Set

East Lothian Council/East Lothian HSCP received 509 referrals in 2016/17, an increase of 5% from 493 in 2015/16. Police Scotland continues to be the main referrer. This is reflective of the data collated by Scottish Government with Police Scotland being the biggest referrer to local authorities.

	2014/15	**2015/16**	**2016/17**
Referrals	427	493	520 (5% increase)
Investigations	125	69	151 (119% increase when compared to 15/16, 21% increase when compared to 14/15)
Protection orders	3	3	1
Number of Large Scale Investigations	3	2	2

Frontline practice

Performance Quality Indicators continued to show improvement. Opportunities through joint working to streamline process were identified and developed. Along with immediate changes to processes, longer term initiatives were delivered through the transformation of core process project along with the redesign of care at home project.

Looking ahead

Reviews

The partnership faces continued challenges in undertaking number of social work reviews currently required. For this reason, there will be a whole-system assessment of the current processes, identifying challenges and opportunities to develop more timely and efficient reviews of client care and support needs as well as exploring how these reviews can be undertaken and shared collaboratively between partnership staff and third sector organisations. The project will analyse reviews in care homes, care at home, as well as Direct Payments/Option1 and Adults with Incapacity.

National Health and Wellbeing Outcome 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

New ELHSCP management structure

East Lothian and Social Care Partnership engaged with staff regularly over a period of two years from 2014 on the shape and function of its new management structure. Consultation approaches included focus groups, workshops, surveys, information meetings and regular newsletters. Our staff provided a great deal of useful feedback. The consultation influenced changes in the structure, including which senior posts were suitable for particular disciplines – the consensus was that our original vision was too restrictive.

The new structure was finalised in July 2016 and took effect in October that year. The change process will continue through 2017 as we pull teams together in line with the new management structure and we will continue to listen to what staff have to say as this is happening.

Looking ahead

Planning and Performance Team Restructuring

The restructuring of planning and performance commenced in late 2016 to finalise the support and monitoring arrangements for all of the partnership. The areas focused on and being worked on further in the coming year are:

- supporting strategic development
- supporting internal delivery
- supporting external delivery,
- supporting Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP); and
- supporting service improvement.

We will engage with staff in a planned process to develop the necessary team roles to deliver the wider work and priorities.

Staff satisfaction

National Health and Wellbeing Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services

Through the year we used our resources wisely and well. Some examples are:

Care at Home Provision

A £20 million Care at Home re-modelling and procurement project ran throughout 2016/17. Key phases of the project during this year included:

- Finalising the scoping phase
- Stakeholder engagement
- Pilot modelling
- Specification development
- A formal procurement exercise
- Assessment of tenders
- Award of new contracts.

Section 10 grant funding

We undertook an audit of services funded though Section 10 grant funding. This provided an opportunity to review a number of the services currently funded and to make adjustments to that funding where appropriate to reflect differences in how support is paid for linked to Self Directed Support. A range of improved processes and paperwork also resulted from the audit.

Scoping of business support in Adult Social Care

To support the teams in the new HSCP structure a scoping exercise was undertaken on adult social care business support functions

E-invoicing

A pilot during the year introduced a new way for providers to invoice us for the care and support they deliver on our behalf. This has greatly improved the efficiency of financial processing and has freed up staff time. It will also help to support timely and accurate year end forecasting.

Care Homes

We amalgamated the Care Home assessment workers with the Care Home Review social workers/community care workers to develop one streamlined team/process resulting in a more efficient services for users.

Looking ahead

Two of the major challenges facing the partnership are:

- Being able to support our care providers to meet the current Living Wage and any further Living Wage increases
- Staffing, recruitment and retention – both within ELHSCP and partner providers.

We plan to conduct a Best Value and Strategic Fit review in 2017 as well as a community needs assessment with regard to ensuring that the services commissioned in the community of El are providing value for money within the best model of service delivery.

IJB Finances

Financial allocation

In 2016/17 East Lothian IJB received its first financial allocation in respect of the functions delegated to it by East Lothian Council and NHS Lothian. Although East Lothian Council set a 2016/17 budget in February 2016, NHS Lothian did not formally set a budget until June 2016. The IJB undertook a detailed financial assurance process in March 2016 to review the East Lothian Council proposition along with the working proposition from NHS Lothian. The IJB then undertook a further financial assurance process – including a review of the in-year 2016/17 financial information from both partners.

This work highlighted significant financial challenges in both budget offers but as the IJB was keen to progress with the delivery of its strategic plan and to further the transformation process it accepted these budgets contingent on a financial risk sharing agreement with East Lothian Council and NHS Lothian.

Financial risk sharing

The IJB agreed a financial risk sharing arrangement with its partners in 2016/17. This ensured that any overspends incurred in the delivery of the delegated functions by NHS Lothian would be covered on a non recurrent basis. East Lothian Council made an additional £1.0m available to cover any overspends with adult social care.

At 2016/17 year end the IJB was overspent by around £1.649m against its base budgets. NHS Lothian contributed additional resources of £1.054m and East Lothian Council contributed £0.595 million of the £1 million to bring the IJB to a break-even position.

The charges made by East Lothian Council to the IJB are the net direct costs incurred in the delivery of social care services in East Lothian. The charges from NHS Lothian are based on the health budget setting model as agreed by the IJB. That is, charges for the core services are based on the net direct actual costs incurred in East Lothian but charges for hosted and set aside services are based on the total actual costs for these service shared across the IJBs per the budget setting model. East Lothian's share of the total actual costs incurred in 2016/17 for hosted services is 12% and, generally, 12% of the Lothian element of the set aside budgets

The pressures driving these overspends fall into two broad areas:

- Significant overspends against the GP prescribing budget
- A lack of recurrent delivery of efficiency schemes and recovery plans both within those services managed by the partnership (that is the local services delivered

by the Council and NHS Lothian) and the services managed by other teams within NHS Lothian.

2016/17 out-turn – financial performance

The table below provides detail on financial performance in 2016/17:

East Lothian IJB - Budget Performance in 2016/17

	Budget £000's	Actual £000's	Variance £000's
Health Services for inpatients	29,895	29,905	(10)
Primary care	45,135	47,418	(2,283)
Other community health services	33,512	32,273	1,239
Social care services	43,682	44,277	(595)
Non-recurrent support	1,649		1,649
Total	**153,873**	**153,873**	**0**

(Note - variances are underspend/(overspend))

Primary Care expenditure includes:

- GMS – the costs of running the GP service in East Lothian
- GOS – support to the delivery of community ophthalmic (optician) services
- GPS – support to the delivery of community pharmacy services
- GDS – support to the delivery of community dental services
- GP Prescribing – the costs of prescriptions for the 16 East Lothian GP practices.

Part of the budget above includes the Acute Set Aside budget (£21.4m). Acute set aside is the expenditure on functions that are delegated to the IJB but managed by the NHS Lothian acute management team, these budgets being 'set aside' on behalf of the IJB. These are mostly inpatient bed costs but there is also a small element of outpatient services depending on how the delegated function is delivered. This includes the Accident and Emergency service at the RIE.

Included in the social care services above is:-

- Expenditure on social care services on care homes or adult placement - £6.4m
- Expenditure on social care services to support carers – £0.3m

It should be noted that support to carers is a thread that runs through all services, there is not a specific carers budget, nor expenditure identified. The value above is the total of specific providers and workers who provide direct support to carers.

In 2016/17, the Scottish Government announced an 'Integration Fund' of £250m nationally for Integration Joint Boards to develop social care. Half of this fund was allocated to existing pressures, including the delivery of the living wage to be paid to all staff who delivered social care regardless of who employs them. The remaining half was intended to deliver additionality) to provide further social work capacity and to support service transformation. East Lothian IJB's share was £4.37m, supporting the introduction of the living wage for providers of care at home.

Looking ahead

2017/18 – financial challenges and expectations.

In March 2017 the IJB undertook a financial assurance process to review the budget propositions for 2017/18 from East Lothian Council and NHS Lothian. Again this process identified significant challenges but the IJB has accepted this budget although is clear that a financial risk sharing agreement similar to that in 2016/17 will not be possible. NHS Lothian has identified in its financial plan for 2017/18 (as at April 2017) a significant budgetary pressure for which there are, currently, no final plans to manage.

As part of the financial planning process for 2017/18, the financial issues identified above in 2016/17 have been addressed, NHS Lothian has uplifted the GP prescribing baseline to the 2016/17 expenditure level and the social care management team has developed a clear plan to rebalance the budget for learning disabilities services. Despite this, the financial assurance exercise identified pressures within the IJB of around £3.8m of which there are clear plans to deliver £3.2m with further plans being developed to balance the budget.

The challenge is, in financial terms, to continue the transformation of the services to deliver the IJB's delegated functions whilst continuing to deliver high quality health and social care to the population the IJB supports. The IJB has developed an outline financial strategy. This will be developed further into a detailed multi-year financial strategy which will lay out how the IJB will deliver its strategic plan.

Delivering Health and Social Care in Edinburgh

Edinburgh Integration Joint Board Annual Performance Report 2016/17

Contents

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Foreword

This is the first Annual Performance Report of the Edinburgh Integration Joint Board (EIJB). The report provides a review of the progress made during 2016/17, the first year of operation of the Edinburgh Integration Joint Board and Health and Social Care Partnership.

In line with the expectations set by the Scottish Government the report considers our performance from several different perspectives:

- the progress we have made in:
    - achieving the nine national Health and Wellbeing Outcomes and the related key priorities of the Integration Joint Board;
    - moving to a locality based model of planning and delivering services;
    - making our strategic plan a reality;
- the way in which we have managed our finances and delivered best value; and
- how other people see us based on feedback from people who use our services, unpaid carers and staff and external organisations who inspect and regulate health and social care services

As anticipated we have faced many challenges during 2016/17 to improve the quality of services at a time of significant resource reduction, whilst moving to an integrated four locality model of operation.

The major challenges we faced included:

- too many people in Edinburgh waiting too long to receive the support they need to help them live independent and healthy lives at home; making a significant reduction in the number of people waiting for support and the length of time they are waiting will be an absolute priority during 2017/18;
- a significant proportion of the GP practices in Edinburgh are operating with restricted lists and there are significant difficulties recruiting and retaining care workers in a city with virtually full employment;
- the Joint Inspection of Services for Older People that took place in 2016/17, identified a number of weaknesses in service planning and delivery and found some of our key processes to be 'unsatisfactory'. We have developed a robust action plan in response to the recommendations from the Inspection the implementation of which is being proactively managed.
- although we delivered a balanced budget in 2016/17 our financial position continues to be a challenge.

Whilst we do not wish to gloss over the performance and quality challenges, we have some positives to report. There has been significant progress in implementing the new structure that will support the delivery of services on a locality basis, and will

introduce more preventative and proactive services for the citizens of Edinburgh. We believe that this will allow us to provide more responsive and person-centred services focused on assessing, treating and supporting people as close to home as possible so they can live their lives in ways that suit them.

One of our great strengths is the dedication of our workforce all of whom are committed to providing the best services possible to keep the citizens of Edinburgh safe and healthy. Whilst the Joint Inspection report on Services for Older People was critical in several areas it did identify that services where they were received were good.

> *"When people received services, they were generally of good quality and made a positive difference."* *Joint Inspection of Services for Older People May 2017*

Our performance in respect of unscheduled care is amongst the best in Scotland.

Our teams are fully aware of the challenges that remain to be met in providing "the right care in the right place at the right time". With our restructure virtually complete and our staff teams motivated and keen to meet these challenges, we are in a much-improved position at the end of this reporting period.

The information contained in this report has been used to inform the programme of work we are taking forward to implement our strategic plan during 2017/18. The challenges are still great but the goal is within sight and I look forward to presenting next year's report.

Rob McCulloch-Graham

Chief Officer Edinburgh Integration Joint Board

Introduction and overview

The Edinburgh Integration Joint Board (IJB) was legally established in July 2015. Since April 2016, the Board has been responsible for the strategic planning and operational oversight of most community health and social care services for adults and some hospital based services.

In the main, the services for which the Board is responsible are managed, delivered and commissioned through the Edinburgh Health and Social Care Partnership. The Partnership brings together staff employed by the City of Edinburgh Council and NHS Lothian to provide integrated services under the leadership of a single Chief Officer. The Partnership also commissions services on behalf of the Integration Joint Board from a range of providers in the third, independent and housing sectors.

Whilst the provision of housing is not delegated to the Integration Joint Board, the Board recognises the importance of having somewhere warm, dry and safe to live for the health and wellbeing of citizens. The links between housing, health and social care are set out in the Housing Contribution Statement which accompanies the Strategic Plan.

The Edinburgh IJB is also responsible for some services that are managed directly by NHS Lothian or one of the other Health and Social Care Partnerships in Lothian.

Services for which the Edinburgh IJB is responsible include:

- Adult social work services
- Community dentistry, pharmacy and ophthalmology
- Community nursing
- Health and social care services for older people, adults with disabilities, adults with mental health issues and unpaid carers
- Health promotion and improvement
- Palliative and end of life care
- Primary care (GP)
- Services provided by Allied Health Professionals (e.g. Therapists)
- Sexual health
- Substance misuse
- Support for adults with long term conditions
- Unscheduled admissions to hospital

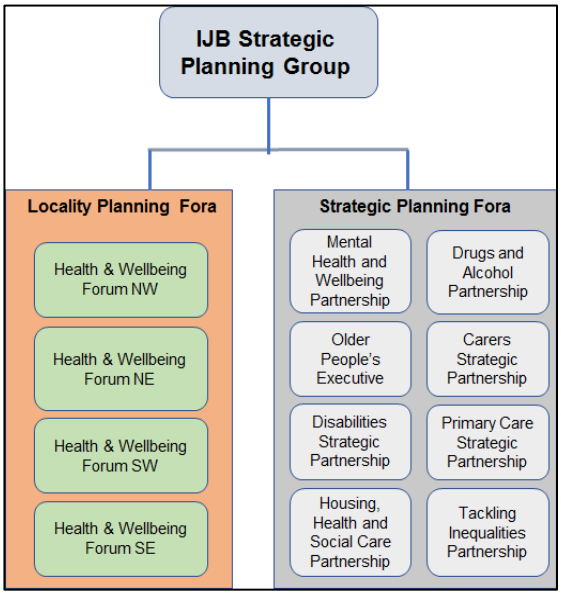
In March 2016, the IJB published its strategic plan setting out the strategic direction for health and social care services in Edinburgh from 2016 to 2019. The plan included our vision of 'People and organisations working together for a caring, healthier, safer Edinburgh'. To help us deliver this vision the plan identified the six linked key priorities in the diagram overleaf. The priorities reflect the dual role of the Integration Joint Board in planning services to meet current need and manage future demand.

Edinburgh Integration Joint Board Key Priorities

Strategic Planning

The Public Bodies (Joint Working) (Scotland) Act 2014 requires integration authorities to establish a strategic planning group for the purposes of consulting on their strategic plans. Our strategic plan published in March 2016 was produced in collaboration with our Strategic Planning Group, membership of which includes the Chair and Vice-chair of the Integration Joint Board; citizens with lived experience of using health and social care services or caring for someone who uses them; representatives of the City of Edinburgh Council and NHS Lothian; third and independent sector interface organisations and providers of health and social care services; providers of social housing and the Integration Joint Board's Professional Advisory Group that represents health and social care professionals.

We have established a strategic planning framework to support the Strategic Planning Group. This includes the locality health and wellbeing forums, strategic planning forums for mental health and wellbeing, older people, people with disabilities, and substance misuse. The framework also includes two cross-cutting forums focused on housing and tackling inequalities. Members of the locality and strategic planning forums include representatives of key stakeholder groups and act as a wider constituency for members of the Strategic Planning Group, providing them with access to a wide range of opinion.



Our strategic plan identifies the following twelve areas of focus which we believe will allow us to deliver our 6 key priorities:

- Achieving integration at a locality level
- Tackling inequalities
- Consolidating our approach to prevention and early intervention
- Ensuring a sustainable model of primary care
- Improving care and support for frail older people and those with dementia
- Transforming services for people with disabilities
- Supporting people living with long term conditions
- Redesigning Mental Health and Substance Misuse services
- Maximising the use of technology to support independent living and effective joint working
- Improving our understanding of the strengths and needs of the local population
- Integrated workforce planning and development
- Living within our means

We reviewed our strategic plan at the end of 2016/17 to identify the progress made in terms of what we set out to do and agree priorities for delivery in 2017/18. The outcome of this review has informed the content of our Annual Performance Report.

Our approach to reporting performance

In producing this annual report, we have used several sources of information:

i. National indicators
A core set of 23 national indicators has been developed to measure the performance of each health and social care partnership in achieving the Health and Wellbeing Outcomes. The indicators look at both the operational performance of partnerships and the experience of citizens who make use of health and social care services. Our performance against the 23 national indicators is detailed in Appendix 1. Comparative data for other areas across Scotland is not available for all indicators in respect of 2016/17, where this is the case and comparative data for 2015/16 is available, this has been used instead.

ii. The National Health and Care Experience Survey
A postal survey is undertaken every two years of a subset of people registered with a GP asking about their experience of accessing and using their GP practice, some social care services and support for unpaid carers. The survey is the source of nine of the core set of 23 national integration indicators. The survey was last carried out in 2015/16 which predates the establishment of the Integration Joint Board; however, the results of this survey identify issues that the Board needs to address and provide a baseline against which to measure future performance. The full results for Edinburgh can be accessed here.

iii. Local indicators
A set of indicators has been adopted locally to track progress against the strategic plan and towards the priority outcomes; some are used to measure performance within and between the four localities whilst others show performance at a citywide level. The local indicators can be found in Appendix 2.

iv. Feedback
We receive feedback from a number of sources including compliments and complaints and through formal inspections which may be themed or in respect of a specific service. We have also undertaken local satisfaction surveys.

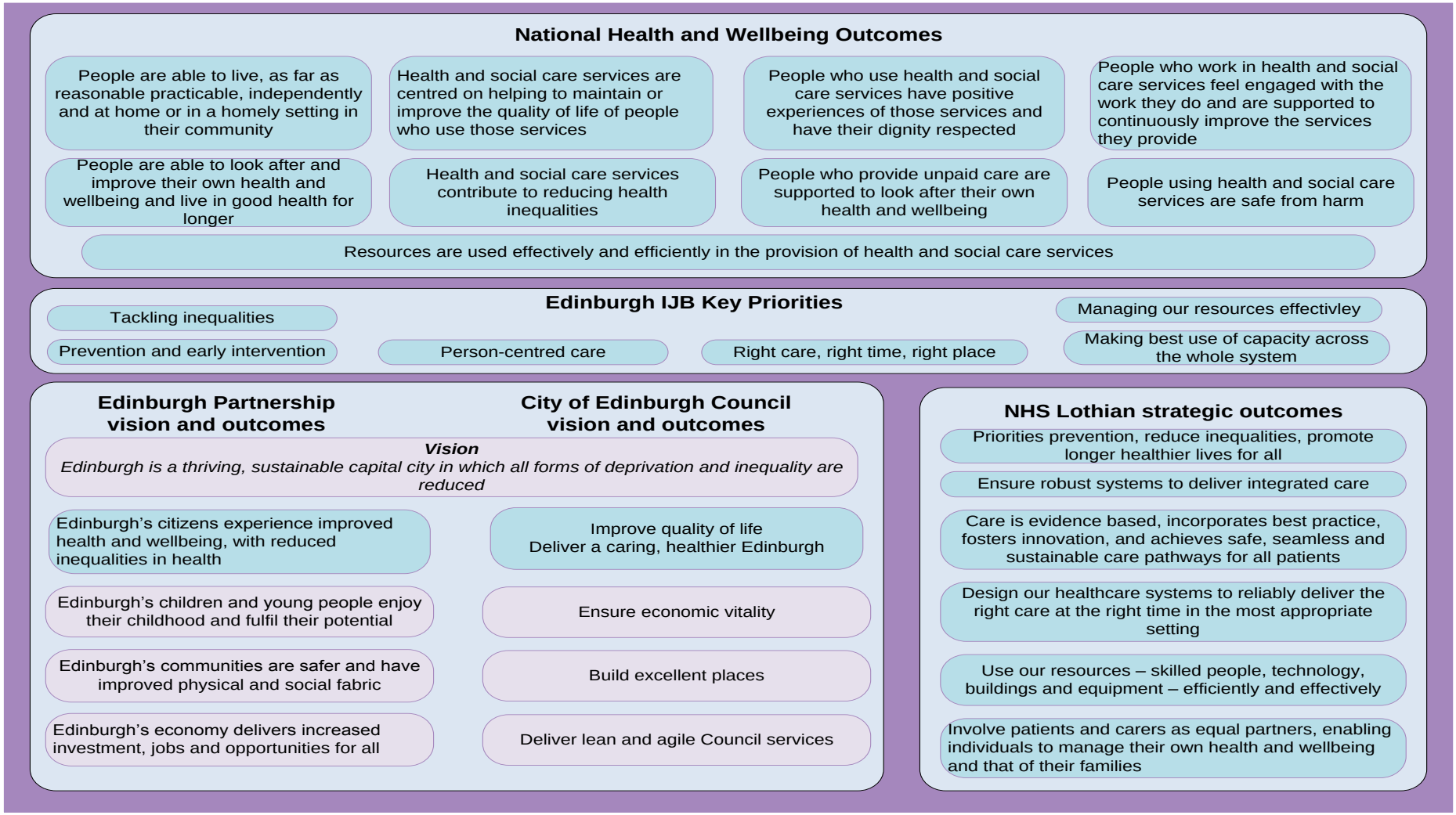
v. Case studies
We recognise the importance of stories in helping us to identify the impact of our strategic plan and the services provided and commissioned through the Health and Social Care Partnership. We have included some case studies in this report and will be developing ways of collecting these on a regular basis to help us improve future.

Delivering against the National Health and Wellbeing Outcomes

The nine National Health and Wellbeing indicators shown at the top of the diagram on the following page, are a set of high level statements produced by the Scottish Government. The outcomes describe what Health and Social Care Partnerships are working to achieve through the integration of services and the pursuit of quality improvement.

This section of the Annual Report details our performance against the nine outcomes from 1 April 2016 to March 2017. Information about our performance against each of the 23 national indicators is given throughout this section and in Appendix 1.

The 6 priorities within our strategic plan have strong links to the National Health and Wellbeing Outcomes and the strategic priorities of NHS Lothian, the City of Edinburgh Council and the Edinburgh Community Planning Partnership. These linkages are illustrated in the diagram below.



Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer

What we say in our strategic plan

Our strategic plan sets out a clear intention to develop a new relationship with and between citizens and communities, our services and staff and the many organisations who contribute to encouraging, supporting and maintaining the health and wellbeing of the people of Edinburgh.

Preventing poor health and wellbeing outcomes is a key priority within our strategic plan, we aim to do this by working with our partners to support and encourage people to:

- *achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing;*
- *make choices that increase their chances of staying healthy for as long as possible;*
- *utilise recovery and self-management approaches if they do experience ill health.*

How are we performing?

Access to responsive primary care services is central to supporting people to look after their own health and wellbeing. GP practices in Edinburgh are under considerable pressure from increased demand due to the growing population in the city and the national shortage of people wanting to enter the profession. Actions to help alleviate this situation have included making better use of the wider primary care workforce, improving GP premises and working collaboratively with partners to improve health and wellbeing in local communities. We also work with individuals affected by long term conditions to support them to manage their condition(s) themselves as far as possible.

Overall 96% of Edinburgh citizens who responded to the 2015/16 Health and Care Experience Survey said that they were able to look after their health very well or quite well. This compares with an average of 94% across Scotland.

Approximately 38 of the 74 GP practices in the city (51%) are operating restricted lists which means that they have introduced criteria to limit the number of new registrations. The number of people registered with GPs increased by 7,000 during 2016/17 and approximately 3.25 million patient consultations were undertaken by GP practices during this period.

Despite these pressures, patients' satisfaction with the services they receive from their GP practice measured through responses to the 2015/16 Health and Care Experience Survey was above the Scottish average:

- 89% of respondents rated the overall care provided by their practice as 'good' compared to a satisfaction level of 87% in Scotland as a whole;
- 85% of respondents in Edinburgh said that they 'could get to see a doctor or nurse within 2 working days' and agreed that the 'arrangements for getting to see a nurse were excellent or good' (compared to a Scottish average of 84% and 82% respectively).

However, only 76% of respondents agreed that the arrangements for getting to see a doctor were excellent or good. Whist this result is disappointing it is better than the national picture where only 71% of respondents agreed with the statement. Given the considerable pressures that GP practices are working under, it is perhaps not surprising that people feel that their GP is not as accessible as they would like.

Progress we have made

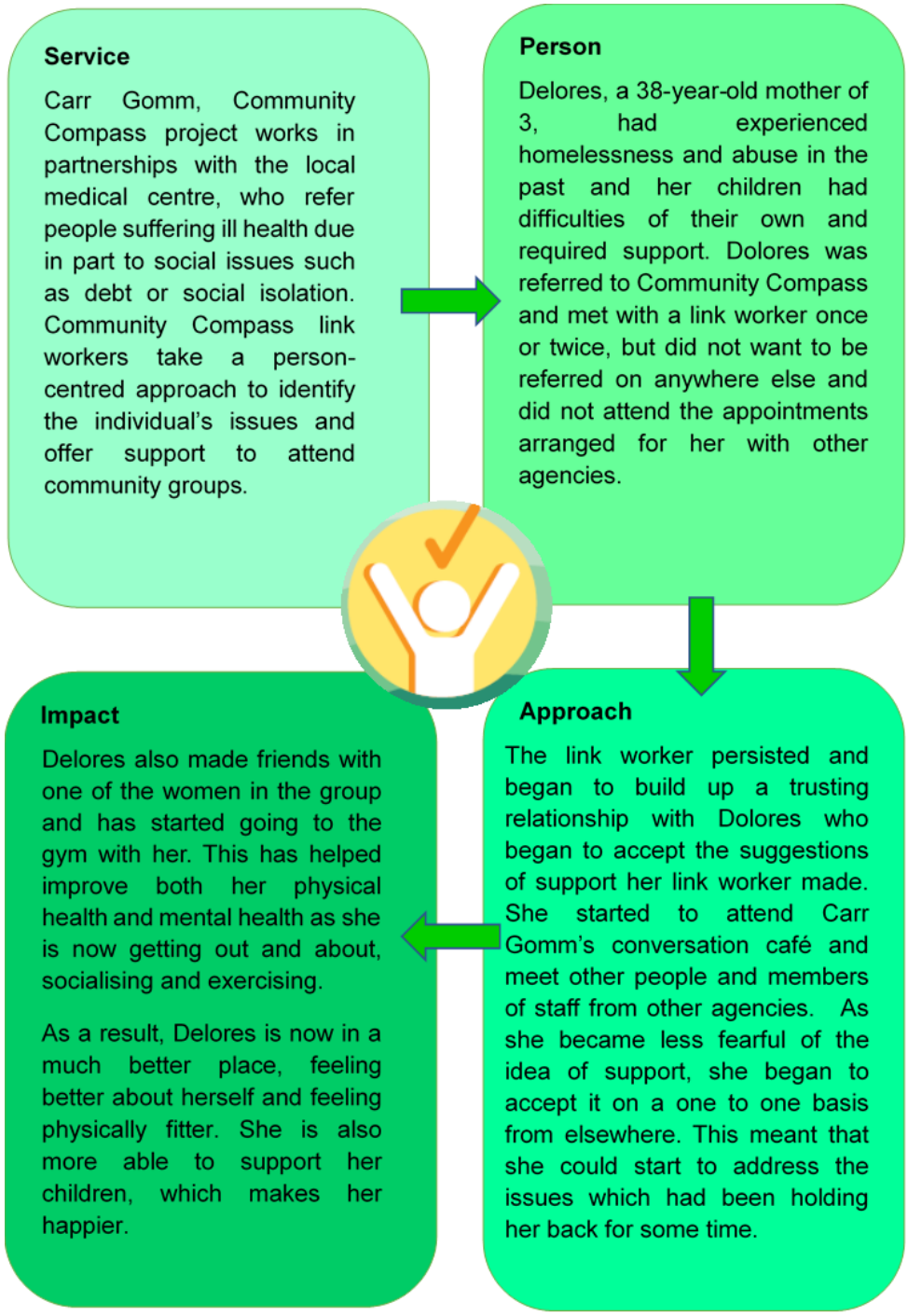
In 2016/17 we have:

- worked with 18 individual GP practices to ensure stability in the short to medium term including the use of pharmacists, advanced nurse practitioners, community psychiatric nurses, link workers and physiotherapists to supplement medical sessions;
- consulted with GPs across the city as to how funding should best be used to augment the workforce and stabilise Primary Care; this includes capacity to develop social prescribing and implement a network of link workers;
- worked with NHS Lothian to provide new or extended premises for eight practices and support population growth;
- developed plans that will see four new primary care premises open in 2017/18;
- consulted extensively with GPs to ensure that there is a premises plan that supports the City's Local Development Plan (2016–2026) which will see the population of Edinburgh increase by a further 50,000;
- developed the 'Fit for Health' physical activity programme in partnership with Edinburgh Leisure helping people with long term conditions to manage their own condition by improving their strength, mobility and cardiovascular function. 78% of participants reported greater wellbeing including weight loss and improved sleep – positively influencing both their physical and mental wellbeing;
- supported people whose health is affected by social issues such as debt or social isolation through Carr Gomm's Community Compass project, which works with local medical centres.

Priorities for 2017/18

- Continue the programme to enhance GP premises, including: relocation of Polworth practice; commissioning Ratho Medical Practice, North West Partnership Centre, Leith Walk Medical Practice and Allermuir Health Centre; co locate the Access Practice with a range of other services to support homeless people with complex needs.
- Implement the plan developed for the use of funding to augment the workforce and stabilise primary care.

Case Study – Carr Gomm Community Compass



Outcome 2:

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

What we say in our strategic plan

Delivering the right care in the right place at the right time for each person, is a key priority within our strategic plan. We aim to ensure that people:

- *are assessed, treated and supported at home and within the community wherever possible and are admitted to hospital only when clinically necessary;*
- *are discharged from hospital as soon as possible with support to recover and regain their independence at home and in the community;*
- *experience smooth transitions between services, including from children's to adult services;*
- *have their care and support reviewed regularly to ensure these remain appropriate;*
- *are safe and protected.*

How are we performing?

To provide the right care in the right place at the right time, we need to ensure that we have the right mix and capacity of services across all settings including preventative services in the community, proactive care and support at home, effective care at times of transition and intensive care and specialist support. Our performance in this regard has been mixed. Whilst we have been relatively successful at keeping people out of hospital and caring for them at home, too many people are waiting too long for the support they need either in hospital or in the community. This remains a significant challenge for the Edinburgh Health and Social Care Partnership.

Of those responding to the Health and Care Experience Survey in 2015/16, 82% agreed that they were supported to live as independently as possible.

Our performance in relation to emergency admissions to hospital in 2015/16, the last year for which comparative data is available, was the best in Scotland with 8,393 admissions per 100,000 of the population compared to the Scottish average of 12,138 admissions per 100,000 of the population. The rate of emergency bed days occupied, 112,147 per 100,000 of the population, also compared favourably to the national figure of 122,713. Whilst comparative data is not available for 2016/17 both the rate of emergency admissions and the rate of emergency bed days occupied have fallen in Edinburgh; admissions by 116 and bed days occupied by 3,542, which is positive. However, the

number of people who are readmitted to hospital within 28 days of being discharged is relatively high.

In 2015/16, 62.3% of adults with intensive care needs were supported to live at home which is better than the Scottish average of 61.6%. However, if we are to be successful in achieving our ambition of shifting the balance of care to the community, this is an area where performance needs to improve.

The Reablement Service provides intensive support for a short period to help people regain their confidence, skills and independence. The majority of people using this service have either needed no ongoing support or the level of support required has reduced.

Our biggest challenges in relation to providing people with the right care at the right time in the right place relate to providing a timely response to requests to assess people's needs and put packages of care in place within the community and supporting people to be discharged from hospital when they are fit to leave.

All urgent assessments are carried out within 24 hours; however, in March 2017, 1,428 people were waiting for social care assessments to take place in the community, the average waiting time was 101 days against a maximum target on 28 days. Although the number of people waiting was beginning to reduce by March 2017, the length of wait was growing. Our assessment processes have been reviewed and streamlined to address this significant challenge.

Our partner providers in the third and independent sectors continue to face difficulties in the recruitment and retention of staff. This impacts directly on our performance in respect of delayed discharges which is poor and has been for some time. There were 176 people whose discharge from hospital had been delayed in March 2017, although this is a reduction from 221 people in January 2017, the number remains unacceptably high. We have a target to reduce this number to 50 by the end of December 2017.

Progress we have made

During 2016/17, we have:

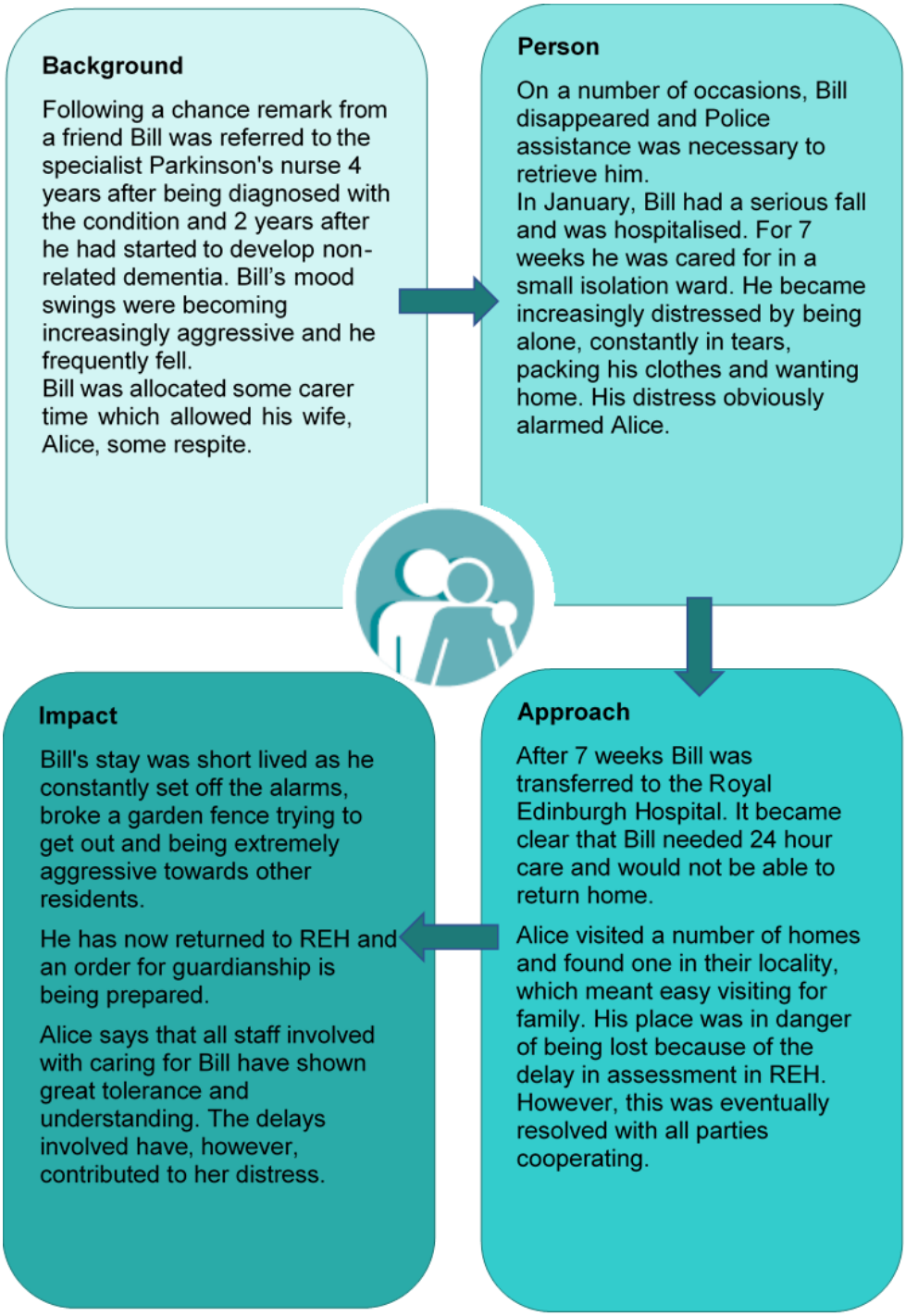
- established a locality based structure with integrated teams that will provide care and support closer to home to avoid hospital admission, facilitate timely discharge from hospital and help people maintain and regain their independence;
- established a new orthopaedic supported discharge team which facilitates safe, supported, early discharge by providing short term rehabilitation at home. 73% of the people supported did not need any further help;
- used dedicated Mental Health Officer time to speed up the granting of Guardianship Orders for people who lack capacity and are delayed in hospital. This resulted in the number of people waiting being reduced by almost 50%;

Priorities for 2017/18

- Reduce both the numbers of people waiting for support and the length of waiting times.

- Investigate reasons for hospital readmission rates and develop plans in response
- Work with the providers of care at home services to increase capacity.
- Simplify and streamline our assessment and review processes This will provide additional capacity to reduce the length of time people wait.
- Increase the provision within the community to allow people to move out of long stay hospitals, including Murray Park and the Royal Edinburgh Hospital.

Case Study – Impact of delays in assessment



Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.

What we say in our strategic plan

Practising person centred care is a key priority in our strategic plan and is key to delivering our vision for where we want to be by 2020 when:

- *people and communities work with local organisations to determine priorities and plan, design, deliver and evaluate services; and*
- *people, their families and carers are supported to decide how their care and support needs should be met and take control over their own health and wellbeing.*

We aim to do this by placing good conversations at the centre of our engagement with citizens.

How are we performing?

Evidence from the 2015/16 Health and Care Experience Survey shows that of those respondents who receive care and support with daily living activities, 89% felt that they were treated with respect and 86% agreed that they were treated with compassion and understanding, which is above the Scottish average of 85%. However, overall service user satisfaction levels are generally lower than we want them to be. The percentage of people who agreed that their health and social care services seem to be well co-ordinated fell from 75%, which is the Scottish average, to 71%. In the same survey, only 77% of people rated the care or support they received as good or excellent which is below the Scottish average of 81%. Whilst 80% of care services were graded as good or better in Care Inspectorate inspections in the same year.

Further work needs to be undertaken with our service users and other stakeholders to inform our improvement programme.

The percentage of people receiving care and support services in Edinburgh responding to the Health and Care Experience Survey in 2015/16 who agreed that they had a say in how their health care and support was provided reduced significantly from 83% in 2013/14 to 76% in 2015/16 which is below the Scottish average of 79%. The total number of people who made a choice as to how their care and support is arranged and managed through the four options of self-directed support increased from 3,989 in 2015/16 to 4,527 in 2016/17. However, the 2016/17 rate of 10 per 1,000 of the population aged 18+ is below the Scottish average of 11, which is the minimum we should aspire to achieve. Reinvigorating our approach to self-directed support to ensure that citizens in need of social care support can exercise greater choice over the way in which their care and support is provided will be a priority in 2017/18.

Progress we have made

During 2016/17, we have:

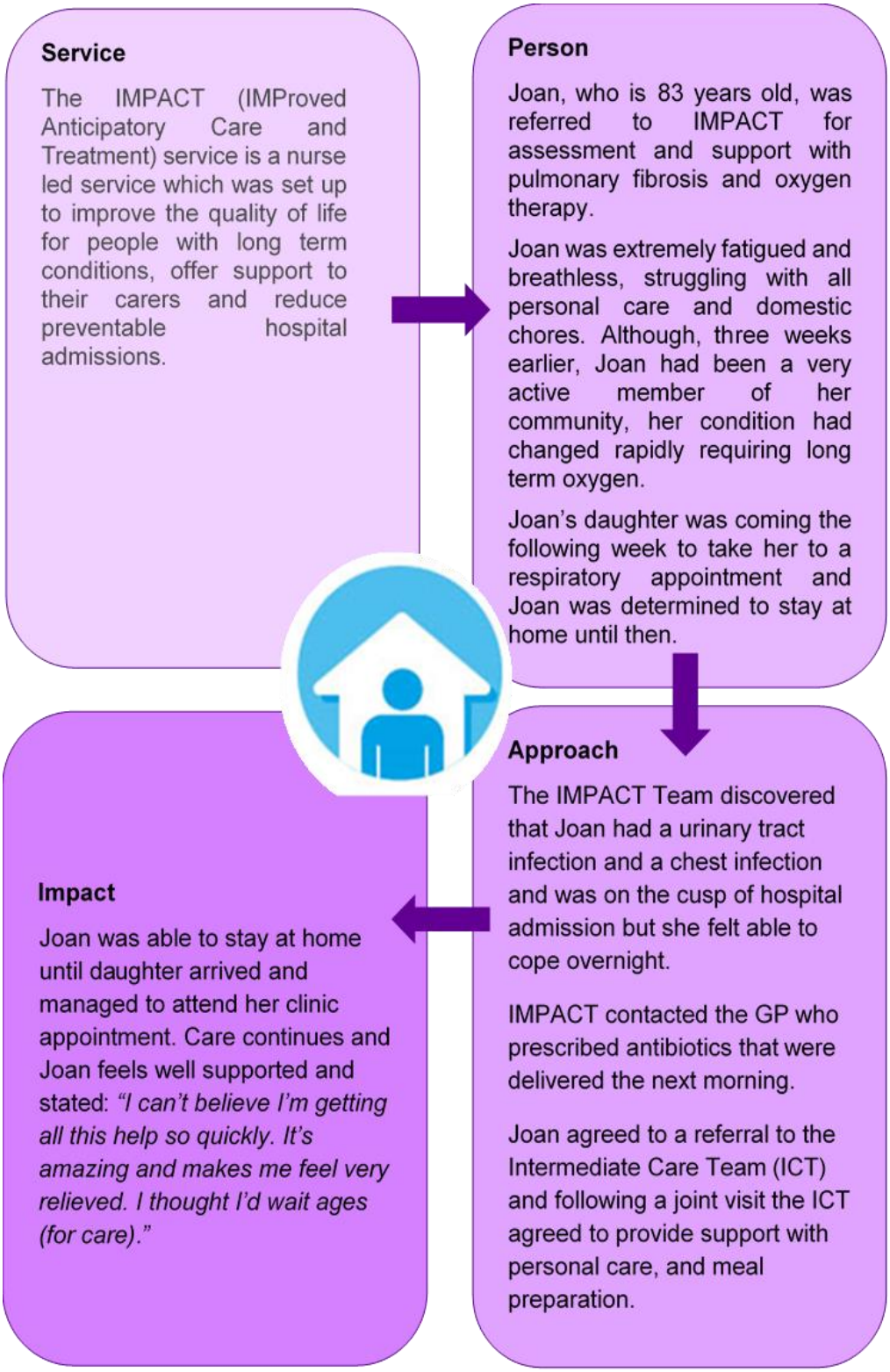
- increased the value of direct payments from £16.4m to £18.5m;
- rolled out a programme of training to GP practices on anticipatory care planning and the development of key information summaries, ensuring these contain information based on the person's wishes, including preferred place of care. To date training has been delivered in over 90% of practices in the city and four care homes in the North East Locality. 137,185 key information summaries were created in 2016/17. The next step is to implement this approach within the other localities and 6 further care homes;
- worked with people with learning disabilities moving from Murray Park and their families, to commission community based accommodation;
- established a network of autism champions and provided training to front line staff to improve understanding of autism and the local services available;
- funded a multi-agency approach to delivering Promoting Excellence in Dementia Care training across care homes, home care and supported housing services to improve awareness of the Promoting Excellence Programme and improve the quality of care for people living with dementia;
- tested the CleverCogs service through Blackwood Homes and Care, which provides night time support to people with disabilities and/or poor mental health using night time digital video calling service. Feedback from individuals was very positive, including increased feelings of control over how their support is provided and improved family and social relationships through the "Friends and Family" video link;
- engaged with citizens who use community mental health services and third sector and community organisations to take a Public Social Partnership approach to developing locality based preventative services that promote good health and wellbeing.

Priorities for 2017/18

- Reduce waiting times for assessment and review by streamlining existing processes whilst ensuring assessments and reviews are comprehensive and reflect the views of the person being assessed and the professionals involved.
- Co-design and deliver a person-centred support planning and brokerage service to provide better outcomes and deliver best value.
- Adopt the national anticipatory care plan, launched in July 2017; complete the anticipatory care planning training with GP practices and introduce this approach in all care homes across the city.
- Transfer 165 mental health patients from out-dated wards in the existing Royal Edinburgh Hospital to a new purpose built facility on the same campus.

- Reinvigorate our approach to the implementation of self-directed support for all citizens

Case Study – IMPACT (IMProved Anticipatory Care and Treatment) Team



Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

What we say in our strategic plan

Our linked priorities of tackling inequalities, investing in preventative approaches that help people retain their independence for as long as possible and involving people in decisions about how they can be best supported in the right place at the right time are key elements in improving the quality of life for citizens.

How are we performing?

82% of adults in Edinburgh who responded to the Health and Care Experience Survey in 2015/16 agreed that the services and support they received had an impact in improving or maintaining their quality of life. This is below the Scottish average of 84%.

Delays in accessing the care, support and treatment that people need is likely to have a negative impact on their quality of life. The challenges we face in putting non-urgent community based care in place and supporting people to be discharged from hospital has been detailed under Outcome 2 above. There are national targets for accessing some specific services. In March 2017, 89% of those referred for treatment related to drug and/or alcohol abuse started their treatment within three weeks compared to the national target of 90%. However, in the same month, only 54.5% of those referred for psychological therapies had their first appointment for treatment within 18 weeks compared to the national target of 90%. Average performance against this target in Scotland was 78%.

Most people want to live healthy and independent lives staying in their own home for as long as possible. In 2016/17, 53% of people who had been supported through the Reablement Service required no ongoing support and the overall reduction in the volume of support needed was 52.5%. During the same period, 220 people started to receive a Dementia Post Diagnostic Support Service, a rate of 6.3 per 1,000 of the population aged 75+. The service aims to equip people diagnosed with dementia and their families with the tools, connections and resources they need to live as well as possible with dementia.

Hospital is not a good place for people to be if they can be diagnosed, treated and supported in the community and most people would rather remain at home if at all possible. In 2016/17, 22% of people with acute chronic obstructive pulmonary disease (COPD) exacerbations which placed them at risk of being admitted to hospital, were referred to the Community Respiratory Team and treated at home or in the community rather than being admitted to hospital.

During 2016/17 the number of people waiting in hospital for Guardianship Orders to be issued was reduced by almost 42% from 24 to 14.

Most people also want to be able to die in the place of their choosing. In 2015/16, on average 13.3% of the last 6 months of life was spent in large hospital settings; the target for 2017/18 is to reduce this to 10% of the last 6 months of life.

Progress we have made

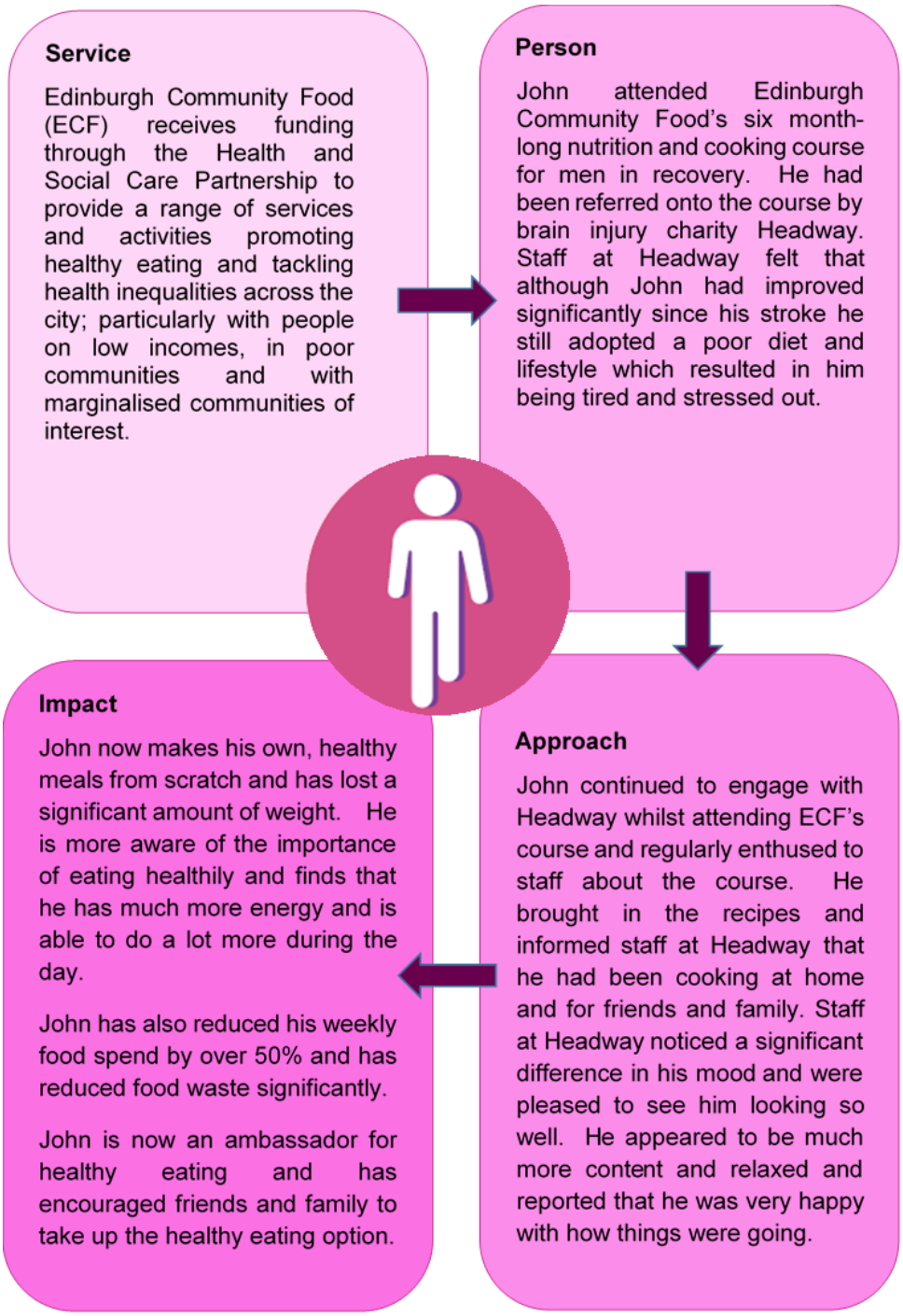
During 2016/17 we have:

- refocused our reablement service to target those most likely to benefit, this has led to an average reduction in the amount of ongoing care required of 52% as opposed to a reduction of 37% prior to the targeted approach being taken;
- developed a Public Social Partnership approach to expanding the capacity to provide community based mental health and wellbeing support at a locality level;
- established an integrated mental health and substance misuse team in each locality;
- commenced the process to retender the Dementia Post Diagnostic Support service with capacity to support more people;
- provided access to "dementia boxes" in local libraries as part of dementia awareness raising training so that people can learn more about how it feels to have dementia;
- set out "where we'd like to be" in supporting people with long term conditions through having good conversations with the person to find out what matters to them and work in partnership with them to manage their condition;
- supported residents of one care home to work with a filmmaker to create short films about their lives in a care homes under an initiative for the creative ageing festival, 'Luminate', providing new, creative experiences for those involved. This is available online;
- held a care home Olympics to tie in with the 2016 Olympics in Rio. Teams of residents from each of the care homes for older people operated by the Council competed in a number of events including indoor curling, javelin, 'funky moves' (memory game), 'Care Homes do Countdown' and a dancing competition.

Priorities for 2017/18

- Developing ways to demonstrate our effectiveness in helping people to identify and achieve their personal outcomes and manage their own conditions, in order to inform future improvement activity.
- Shifting the balance of care from hospital sites to communities for frail older people, people with disabilities and those with mental health problems so that people get the right care in the right place at the right time.
- Developing and implementing a palliative care and end of life strategy.

Case Study – Edinburgh Community Food



Outcome 5: Health and social care services contribute to reducing health inequalities.

What we say in our strategic plan

Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from current levels of inequality is a key priority within our strategic plan. We aim to do this by:

- *supporting individuals to maximise their capabilities and have control over their lives*
- *creating healthy and sustainable communities that can resist the effects of inequality on health and wellbeing*
- *ensuring that core health and social care services are delivered in such a way as to reduce and not exacerbate health inequality*
- *recognising that some sections of the population need targeted support to address the cause and effect of inequalities*

How are we performing?

Each of the four localities in Edinburgh has both areas of affluence and areas experiencing multiple deprivation as defined by the Scottish Index of Multiple Deprivation. Poorer health and earlier deaths affect those who face social and economic barriers such as poor housing, lack of employment, low pay or discrimination. People living in the least affluent areas are more likely to develop long term conditions and to develop them at least ten years earlier than their fellow citizens living in the most affluent parts of the city; they are also at greater risk of emergency admission to hospital.

The premature mortality rate for Edinburgh in 2015 was 406.3 per 100,000 of the population, this is below the Scottish average of 440.5 per thousand.

Whilst the delivery of health and social care services can have some impact on reducing health inequalities, many of the factors that can lead to health inequalities are outside the control of the Integration Joint Board. We are therefore, working with our partners in the Edinburgh Community Planning Partnership to develop and implement a coordinated approach to tackling inequalities across the city.

The Headroom Project was set up to improve outcomes for people in areas of the city with concentrated economic hardship building on the relationship between the patient and the health professional and the opportunities this creates to deliver patient centred care. The number of GP practices involved in the Project increased from 16 to 23 in 2016/17, covering around half of the city's areas of concentrated economic disadvantage. Different GP practices have taken different approaches whilst all involve some degree of social prescribing either through the use of Community Activity Mentors or by organising

activities themselves such as the respiratory choir, set up for people with breathing difficulties, through co-operation between Richmond Church and Niddrie Medical Practice. Although the choir was initially led by nurses from the Medical Practice the members now run it themselves.

Over 30,000 citizens have made use of third sector services funded through the Health Inequalities Grant Programme, total value £1.8 million. An evaluation based on self-reporting by grant recipients, shows the average customer satisfaction rate amongst those using the services was 91% and on average 77% of participants surveyed, agreed or strongly agreed that the service had the intended positive impact on them. The table below shows the number of individuals supported to achieve each priority outcome for the Programme.

Health Inequalities Grant Programme Priority Outcomes	People supported to achieve outcome
Increased income	13,189 people
Increased social capital	5,127 people
Increased number of people eating healthily	4,105 people
Increased community capacity	2,488 people
Reduced levels of anxiety and depression	1,812 people
More people live in and use green spaces	1,728 people
Increased participation in physical activity	1,572 people
Reduced stigma	173 people
Reduced damage to physical and mental health from all forms of abuse and violence	144 people
Reduced misuse of alcohol and drugs	75 people

Progress we have made

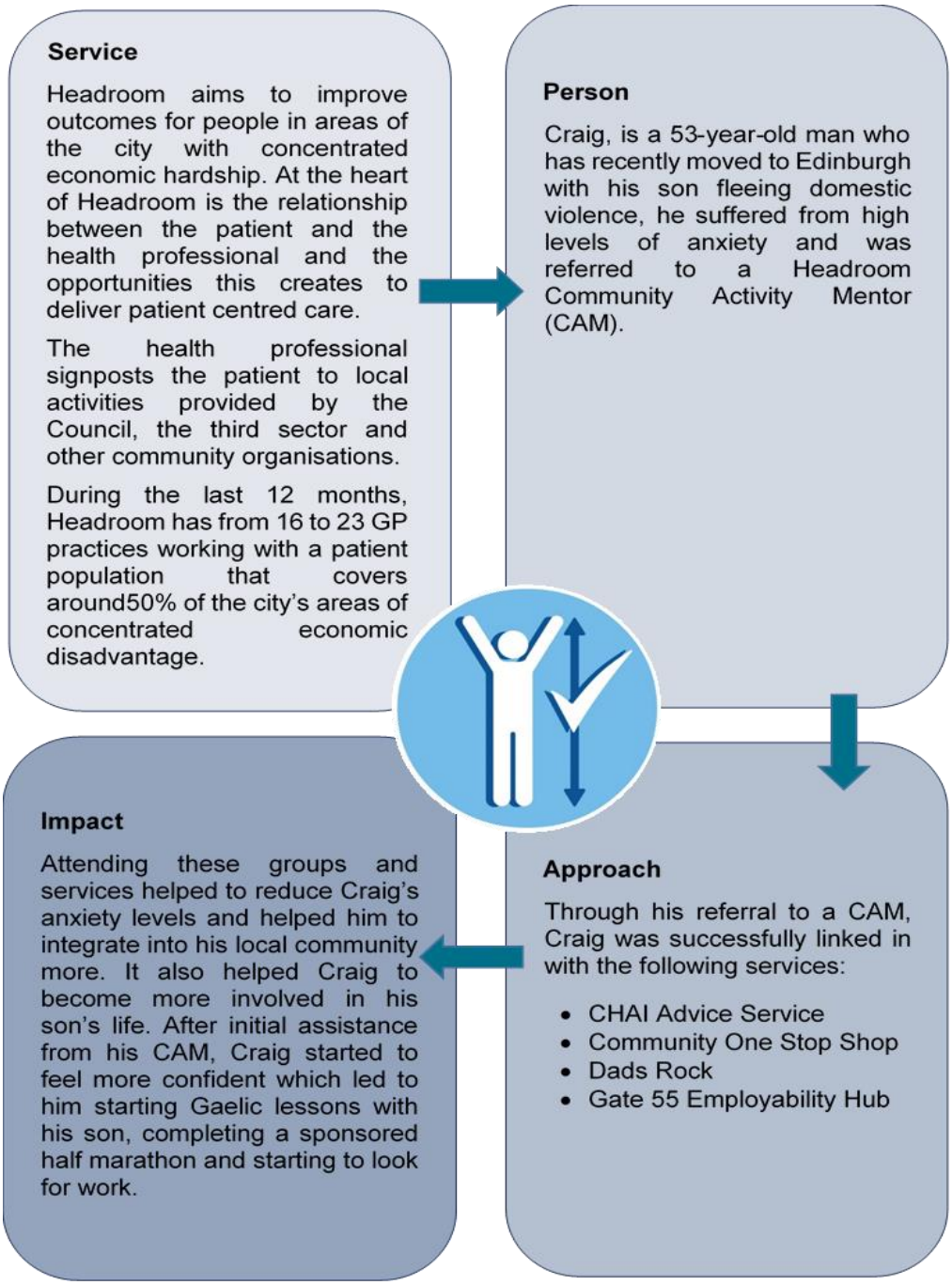
During 2016/17 we have:

- worked with fellow members of the Edinburgh Community Planning Partnership to consult with local communities to inform the evolving Locality Improvement Plans which will have a focus on tackling inequalities;
- provided a 'bridge' into more effective engagement with services for people who struggle to access service provision in traditional ways through the Inclusive Edinburgh project. We have introduced a "case coordinator" role with a focus on building effective relationships, leading to a higher quality of engagement with people with psycho-social issues;
- brought together people with lived experience, carers, and staff from a wide range of third sector agencies and statutory services to collaborate on the establishment of public social partnerships (PSPs) to improve outcomes for people's mental health and wellbeing.

Priorities for 2017/18

- Review the current grants programme to reflect the varying nature of the four localities in which we work and Locality Improvement Plans which will be published in October 2017.
- Introduce a network of link workers embedded in GP practices to help people access non-medical services to improve their overall wellbeing.
- Operationalise four locality wellbeing public social partnerships that will provide a range of social prescribing, meaningful activities and psychosocial and psychological support for people experiencing mental health problems.

Case Study – Headroom



Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

What we say in our strategic plan

Our strategic plan recognises the vital role that unpaid carers in Edinburgh play in supporting friends and family members with health and social care needs to live as independently as possible. Estimates for the number of unpaid carers range from 37,589 (2011 census) to 54,175 (Scottish Health Survey). We are also committed to delivering the vision set out in the Edinburgh Carers Strategy that "adult carers are able to live healthy, fulfilling lives and that they will be valued as equal partners in the provision of care and inform decisions about carer support. Carers will be able to sustain their caring role, if appropriate and if they choose it".

How are we performing?

We know from the Health and Care Experience Survey carried out in 2015/16 that the level of satisfaction amongst carers about the support available to them and the people they care for is low both in Edinburgh and across Scotland. 69% of unpaid carers from Edinburgh who responded to the survey said that they had a good balance between caring and other things in their life. This is slightly higher than the Scottish average of 68%; however, only 37% of those Edinburgh carers who responded said that they felt supported to continue caring, which is below the Scottish average of 41%.

A number of wider societal factors such as changes in the welfare benefits system will impact on unpaid carers and will influence the extent to which they feel supported, which makes it difficult to establish an absolute link to the performance of the Health and Care Partnership. However, in Edinburgh, we also know that the number of carers assessments undertaken in 2016/17 is very low; 5,079 people assessed for social care support indicated that they had an unpaid carer, but only 700 carers assessments were completed. Also, the length of time that people are waiting to receive support will inevitably have a detrimental impact on family and friends who are caring for them. The joint inspection of services for older people found that: "*there was insufficient recognition of the need to assess the needs of carers and provide timely support to them to help them maintain their caring role; and that carers often found it difficult to access support such as respite."*

The Edinburgh Strategic Carers Partnership has now been established as the joint planning forum for carers services linked to the Strategic Planning Group of the Integration Joint Board. The membership of this group includes carers and organisations that support both adult and young carers and will oversee the coproduction of the revised Carers Strategy and the work taking place in preparation for the implementation of the Carers Act (Scotland) 2016. We will also work with this group to establish local

performance indicators in respect of support for carers to drive forward improvement in this vital area.

Progress we have made

During 2016/17 we have:

- funded a new hospital discharge service which works alongside unpaid carers for adults, providing them with emotional support, information and advice; if required a carer support worker will also support carers in the vital first days at home;
- funded a carer support pharmacy technician, based in the Western General Hospital, to support people and their carers with pharmacy issues at the point of leaving hospital and provide ongoing support in the community if required;
- established a multi-agency project team, including representation from unpaid carers and Children's Services to implement the requirements of the Carers Act (Scotland) 2016;
- included content on carer support as part of the induction programme for new staff in Health and Social Care;
- provided dedicated one to one support, social opportunities, short breaks and residential breaks to people who have a caring responsibility, through 'Still caring', a collaboration between two third sector organisations, with reported benefits including improved resilience and being reconnected with their local communities.

Priorities for 2017/18

- To implement the requirements of the Carers Act (Scotland) 2016, including eligibility criteria, assessment and support planning.
- Work collaboratively with carers and carers organisations to review and update the joint carers strategy, taking account of current performance issues, feedback from carers and the legislation.
- Develop capacity plans that takes account of the requirement for respite.
- Train Carers Support Workers to undertake unpaid carer assessments.

Outcome 7: People who use health and social care services are safe from harm.

What we say in our strategic plan

The strategic plan sets out our twin objectives of ensuring that people are protected from abuse, neglect or harm at home, at work or in their community and protected from causing harm to others or themselves. We aim to achieve these by ensuring that people receive the right care in the right place at the right time. We also have a duty to ensure that the services we provide are high quality and safe.

How are we performing?

In 2015/16, 82% of people supported to live at home in Edinburgh who responded to the Health and Care Experience Survey said that they felt safe. This is below the Scottish average of 84%.

In 2016/17, we received 1,198 referrals where adult protection concerns were raised. 21% (425) of these referrals led to further work being undertaken under adult support and protection legislation, and 65% (1,292) led to further action being undertaken by social work teams. Longer term 'adult protection and support' plans were put in place in respect of 128 of the 425 (30%) referrals.

The report on the Joint Inspection of Services for Older People in Edinburgh highlighted that whilst systems and procedures were in place to ensure that adults are protected these were not adhered to consistently across the Partnership. Urgent action has taken place to address these deficiencies including the creation of two dedicated posts to provide additional training, development and support in respect of adult protection for the health and social care workforce.

The falls rate for people aged 65+ in Edinburgh is 21.5 per 100,000 of the population which is just above the Scottish average of 20.9 per 100,000 of the population. We are working to reduce this by investing in preventative approaches such as Steady Steps and supporting people at home rather than taking them to hospital when this is not necessary. 94% of the 5,200 calls to the Telecare Service in 2016/17 resulted in the person who had fallen being supported without the need for hospital admission.

We are integrating quality frameworks from health and social care so that they are overseen through a single Quality Assurance and Improvement Group that has oversight of:

- clinical standards and professional governance;
- health care acquired infection;
- inter-agency referral discussion (IRD) review system in relation to adult protection concerns;

- outcomes from multi-agency quality assurance meetings;
- significant adverse events;
- significant occurrence notifications.

Progress we have made

During 2016/17 we have:

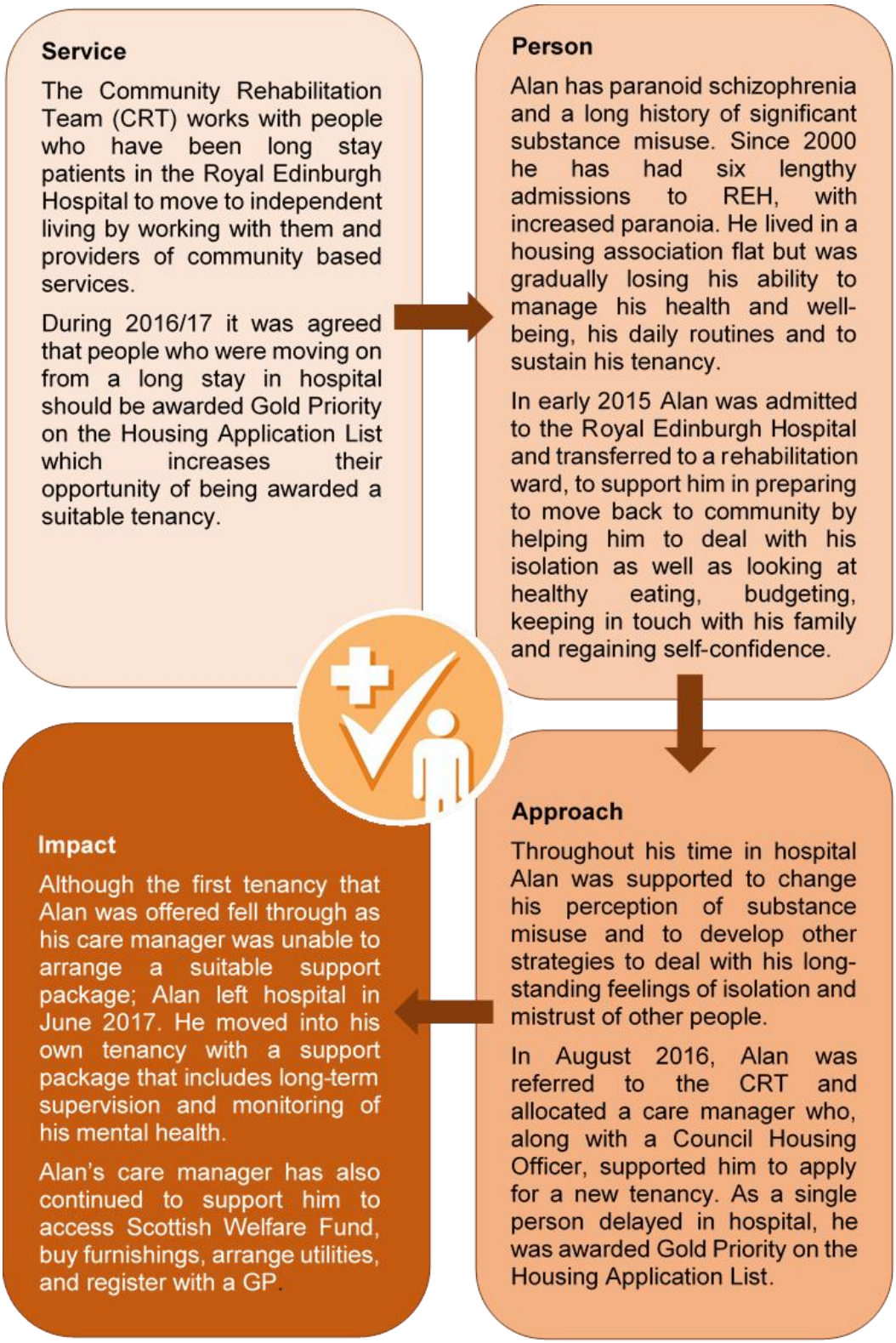
- undertaken a range of self-evaluation and quality assurance activities centred on Adult Protection, including;
    - practice evaluation and multi-agency case file audit found evidence that practitioners are skilled at engaging with service users often in very challenging circumstances
    - independent advocacy agencies have contributed to the adult support and protection training, which raises the awareness of the duty to consider independent advocacy for adults at harm
    - Easy read versions of adult protection leaflet have been produced
- implemented an Escalating Concerns Procedure that provides a framework enabling public partners to convene local multi-agency risk management case discussions (Getting It Right for Everyone) where the individual is not subject to adult protection, offender management or any other public protection process;
- responded to 5,200 calls from fallers to the Telecare service, 94% of whom were assisted by the support teams with no need for further assistance or admission to hospital;
- Edinburgh Leisure's 'Steady Steps' programme supported 302 older people in 2016/17 who have already had a fall, as part of the Falls and Fracture Prevention Pathway;
- provided approximately 700 places on a variety of evidenced-based suicide prevention courses (safeTALK; ASIST; STORM), these are delivered free of charge to professionals working with those at most risk;
- developed a crisis response service to prevent people with autism and learning disabilities being admitted to hospital from their family home or supported accommodation when there is a risk of the caring arrangement breaking down.

Priorities for 2017/18

- Strengthen adult protection processes and ensure staff compliance by increasing access to training and expert adult protection support for practitioners.
- Improve the falls pathway.
- Increase the use of technology enabled care and health by increasing the coverage of existing systems and exploring opportunities for innovation.

- Continue to collaborate with partners to co-produce a responsive, preventative service that will increase the resilience and independence for people with learning disabilities and their families and/or carers.

Case Study – Supporting people to move from hospital to independent living



Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

What we say in our strategic plan

Our strategic plan recognises the significant cultural change required to deliver efficient and effective integrated health and social care services. The skills, knowledge, experience and ideas of our workforce together with those of our partner agencies and unpaid carers are central to the delivery of that change. Taking a joined-up approach to developing this workforce will allow us to deliver on our priority of maximising capacity across the whole system.

How are we performing?

The national indicator on the percentage of staff who say that they would recommend their work place as a good place to work is under development so figures are not currently available. We are also working to develop a single system of obtaining feedback from our staff across both the City of Edinburgh Council and NHS Lothian using the iMatter system.

A survey of staff across the two employing agencies was undertaken by the Care Inspectorate and Health Improvement Scotland as part of the joint inspection of services for older people found that:

- 85% of respondents agreed that they enjoy their work;
- 79% of respondents agreed that they are well supported in situations where they may face personal risk;
- 78% of respondents agreed that they have access to effective line management;
- 76% of respondents agreed that they feel the service has excellent working relationships with other professionals;
- 76% of respondents agreed that they have good opportunities for training and professional development;
- 76% of respondents agreed that they feel valued by other practitioners and partners when working as part of a multi-disciplinary or joint team;
- 70% of respondents agreed that they feel valued by their managers;
- 64% of respondents agreed that their workload is managed to enable them to deliver effective outcomes to meet individual's needs;
- 47% of respondents agreed that their views are fully taken into account when services are being planned and provided;
- 36% of respondents agreed that there is sufficient capacity in the service to undertake preventative work.

Progress we have made

During 2016/17 we have:

- undertaken a major restructuring of services to support integration at a locality level. We have created teams of nurses, therapists and social care staff within a single management structure;
- introduced a blended approach to training, drawing from best practice in both NHS Lothian and the City of Edinburgh Council;
- ensured that all our contractual arrangements allow for payment of the Scottish Living Wage;
- continued to work with the Dementia Training Partnership to provide a sustainable and affordable model of training to deliver:
    - a confident and competent social care workforce, upskilled to meet current and future demands
    - consistency in service provision - raising standards across public and independent sector providers and
    - a forum for sharing good practice across traditional boundaries. Training was extended to care at home, supported housing and day care services;
- been successful in our application for Prospect Bank in Findlay House to become part of the Learning and Improvement Network for Specialist Dementia Units whose purpose is to bring together specialist dementia unit stakeholders to design a shared learning and improvement network.

Priorities for 2017/18

- Develop a workforce plan for the Health and Social Care Partnership which takes cognisance of the workforce strategy linked to the national Health and Social Care Delivery Plan.

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

What we say in our strategic plan

Making the best use of our shared resources to deliver high quality, integrated and personalised services, that improve the health and wellbeing of citizens whilst managing the financial challenge, is a key priority within our strategic plan. We use the term resources to include people, buildings, technology and information.

How are we performing?

In 2015/16, 23.4% of the total health and care budget was spent on hospital stays where the patient was admitted in an emergency, this is in line with the average figure for Scotland of 23.5%.

The indicator on expenditure on end of life care is being developed nationally and not yet available.

Progress we have made

As can be seen from our performance against some key indicators including delayed discharge and customer experience, we are not consistently using our limited resources to best effect. Improving flow through all stages of the pathway is an absolute priority.

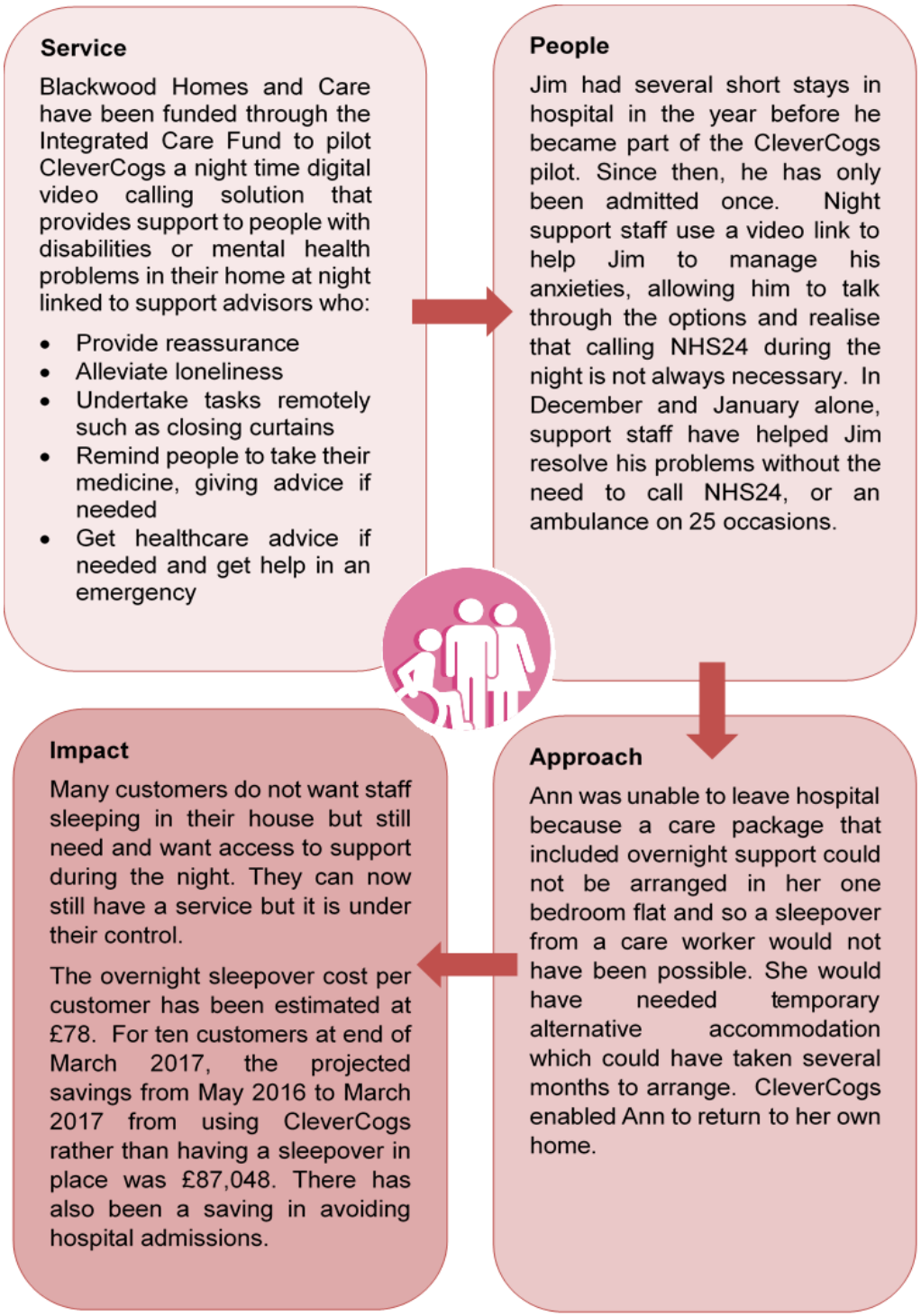
During 2016/17 we have:

- reconfigured hospital based complex continuing care beds and redirected staff to reduce the dependence on supplementary staffing
- brought together the Edinburgh Community Rehabilitation and Support Service as a single hub to provide support to people with physical disabilities across a range of activities from rehabilitation to lifestyle management.
- introduced a whole system approach to allow us to develop a shared understanding of flow across community and acute services to identify and implement targeted actions to address specific blockages
- developed MyConnect–a day support model for people with learning disabilities based on the principle of pooled personal budgets.
- The LOOPs Hospital Discharge Support Project is a partnership of three third sector organisations (Eric Liddell Centre, Health in Mind and Libertus), led by EVOC. The team is part of the new Locality Hub structure and participates in the daily Multi-Agency-Triage-Team (MATT) meetings in each locality to facilitate access to third sector and community based services. The Project aims to ensure that older people receive the support they need upon their return to the community.

Priorities for 2017/18

- Finalise our capacity plan for older people which will identify our future requirements and how these will be delivered.
- Collaborate with partners to produce a cross sector market facilitation strategy.
- Develop the financial frameworks that underpin the detailed delivery plans arising from the strategic plan. These will set out our intentions for investment and disinvestment.

Case study – CleverCogs

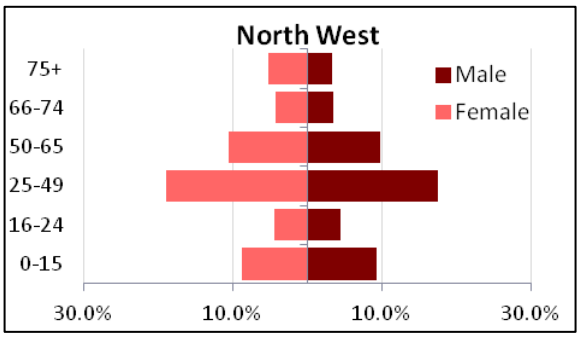


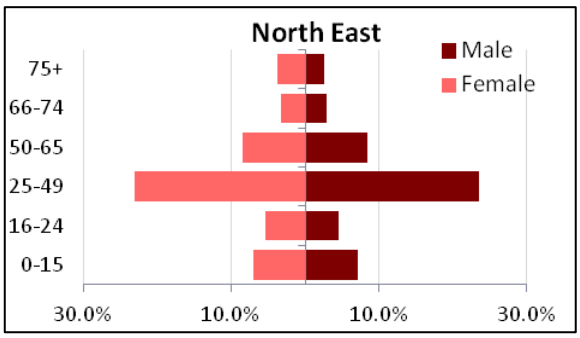
Locality working

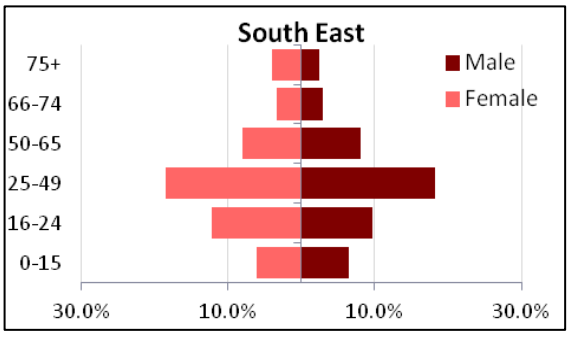
The population of Edinburgh is almost half a million people, accounting for 9% of the total population of Scotland and is predicted to grow faster than any other area of Scotland.

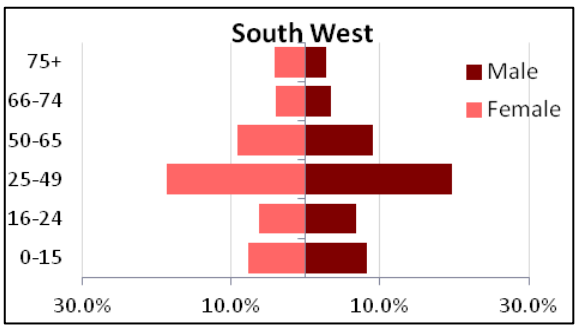
We have worked with the other members of the Edinburgh Community Planning Partnership to establish four geographic localities using neighbourhood partnership boundaries as the basis for service planning and delivery in the city. Whilst the city is often perceived as affluent each locality contains both areas of affluence and significant 'deprivation'. Profiles of the four localities can be found in our Joint Strategic Needs Assessment.

	North East	North West	South East	South West	Edinburgh	Lothian	Scotland
Total population	114,061	141,718	133,041	109,990	498,810	867,800	5,373,000
All Males	55,999	68,144	63,568	54,942	242,653	421,564	2,610,469
All Females	58,062	73,574	69,473	55,048	256,157	446,236	2,762,531







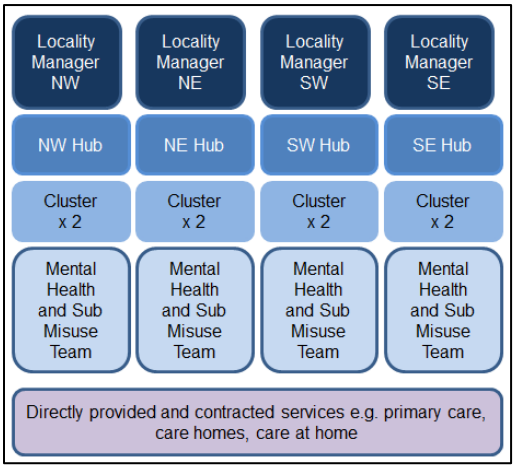


Our main priority in 2016/17 has been to implement a new locality structure to support the planning and delivery of services within the four localities. Each of the four Locality Managers oversees four integrated teams made up of nurses, social workers and allied health professionals (therapists):

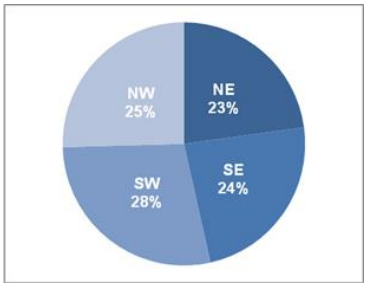
- the Locality Hub provides short-term support at a time of crisis to avoid the need for people to be admitted to hospital wherever possible, facilitate timely discharge from hospital and support people to maintain or regain their independence. A key function of the Hub is the Multi Agency Triage Team (MATT). The MATTs operate on a daily basis to work proactively with individuals in crisis and those ready for discharge from hospital to identify and put in place the most appropriate support to meet their needs. Third sector colleagues take part in the MATT function;
- the two Cluster Teams in each locality are linked to clusters of GP practices. The focus of these teams is to support those citizens who have longer term needs, again with a focus on supporting them to remain living as independently as possible within the community for as long as possible;
- each locality has a Mental Health and Substance Misuse Team that provides specialist support to citizens who have mental health issues and/or issues related to drugs and/or alcohol.

In addition to these teams each Locality Manager is responsible for a number of directly provided and contracted services, including:

- care homes;
- day centres and day services;
- home care and care at home;
- intermediate care and reablement;
- primary care services such as GPs, community nursing and community pharmacy.



A small number of specialist services will continue to be managed centrally and provide services on a citywide basis, examples of these are community equipment, telecare and emergency out of hours clinical and social care services.



The process to align resources to localities began in 2016/17, completing this is a priority for 2017/18. Each Locality Manager will have a clear budgetary framework to support them in developing and delivering services which best meet the needs of their individual populations. An estimate of the overall resource consumed within each locality in 2016/7 is shown in diagram opposite.

It is too early to establish the impact of the locality model, however, the following data from 2016/17 will be used as a baseline to allow us to assess impact in future years:

- Number of GP referrals to hospital
- Hospital admissions per 1,000 (by GP group)
- Sustainability of facilitated discharge (7-day readmission)

Our Locality Managers are members of the Locality Leadership Teams working with other community planning partners to co-ordinate the efforts of statutory, public, independent and third sector services within each locality to address common goals and concerns. During 2016/17 we have engaged with community planning partners at a locality level to engage the local community, including those in areas experiencing high levels of deprivation, in the development of Locality Improvement Plans. Forums have been established within each locality focused on health and wellbeing, bringing together representatives of public and third sector organisations and the local community to discuss and respond to local issues around health and social care.

Finance, Governance and Best Value

Finance and Governance

We have established a governance framework which covers the Integration Joint Board, its subgroups and sub committees as well as the Health and Social Care Partnership. The framework ensures that our structures and processes are transparent and responsive; provide appropriate accountability and scrutiny and encourage broad-based participation. Within these arrangements financial information is a key element of governance framework with financial performance for all delegated services reported at each meeting of the IJB.

Financial Plan 2016/17

Strong financial planning is required to ensure that our limited resources are targeted to maximise the contribution to our objectives. Like many other public sector bodies, we face significant financial challenges and will be required to operate within extremely tight financial constraints for the foreseeable future due to the difficult national economic outlook and increasing demand for services.

It was in this context that we undertook the financial assurance process on the 2016/17 funding contributions made available by NHS Lothian and the City of Edinburgh Council. Through this exercise a shortfall of £5.8 million was identified in the delegated NHS budget; with the council contribution assessed as representing a balanced plan, albeit incorporating a requirement to deliver savings of £15 million.

Based on this assessment, the IJB budgeted to deliver partnership services at a cost of £596 million. Funding adjustments during the year increased this budget to £676 million.

Financial performance 2016/17

Budget monitoring of IJB delegated functions is undertaken by finance teams within the City of Edinburgh Council and NHS Lothian, reflecting the IJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash resources. However, it is important that the IJB has oversight of the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

In 2016/17 we achieved a balanced budget position despite there being many pressures on the system.

During the year, we worked closely with NHS Lothian to identify measures to mitigate the funding shortfall described above which had reduced to £2.5 million by the end of the year. This which was funded by NHS Lothian through their achievement of an overall breakeven position. The cost of NHS delivered services therefore matched the income available. Similarly, following an additional contribution of £1.1 million from the City of Edinburgh Council, the health and social care services they provided also achieved a

break-even position. The combination of these one-off contributions allowed the IJB to achieve a balanced position for 2016/17.

In addition to this we carried forward £3.9 million of our £20.2 million allocation from the social care fund, established by the Scottish Government to support integration authorities. This money will be used in 2017/18 to support investments aligned to our strategic plan priorities.

Our financial performance for the year is summarised in the table on the following page:

Summary of financial performance 2016/17

	Budget £k	Actual £k	Variance £k
NHS delivered community services	26,636	27,300	(664)
General medical services	72,916	72,699	217
NHS delivered mental health services	35,098	34,148	950
Prescribing	77,974	80,167	(2,193)
Resource transfer	29,788	29,641	147
Other NHS partnership services	12,279	12,170	109
Reimbursement of independent contractors (dental, ophthalmology and pharmacy)	49,460	49,460	0
Learning disabilities	8,875	8,878	(3)
Other NHS hosted services	48,683	49,222	(539)
Set aside services	100,834	101,177	(343)
External purchasing	127,855	126,604	1,251
Care at home	14,336	14,422	(86)
Community equipment	1,518	1,542	(24)
Day services	14,748	14,829	(81)
Health improvement/health promotion	1,631	1,598	33
Information and advice	3,623	3,782	(159)
Intermediate care	1,611	1,619	(8)
Local area co-ordination	1,480	1,329	151
Reablement	7,810	8,669	(859)
Residential care	22,104	22,594	(490)
Social work assessment and care management	11,509	11,994	(485)
Telecare	700	717	(17)
Other	821	1,328	(507)
Net expenditure	**672,288**	**675,889**	**(3,601)**
Additional contributions			**3,601**
Net position			**(0)**

The current challenging financial climate reinforces the importance of managing expenditure within the financial resources available and this will require close partnership working between the IJB as service commissioner and NHS Lothian and the City of Edinburgh Council as providers of services.

Best Value

We have a duty to achieve best value, as do our partners, City of Edinburgh Council and NHS Lothian. As such we expect our partners to adhere to the principles of best value i.e. to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost in carrying out the directions of the board.

How others see us

This section of the report contains details of the feedback we have received from external sources either from individual citizens or through inspection by regulatory bodies.

Feedback from people who use our services

We recognise the importance of feedback from our service users as a way of checking that people are getting the support they need in ways that suit them and where we are not getting things right, feedback provides us with the opportunity to improve. Service user feedback is captured in three main ways: through compliments and complaints received through our formal feedback systems, by carrying out satisfaction surveys and by involving service users and carers in planning forums and reference groups.

In terms of formal feedback processes:

- NHS Lothian Patient Experience Team collect feedback in the form of concerns, complaints and compliments about health services. Outcomes and learning from patient feedback is shared with services and reported to the Health and Social Care Partnership Quality Assurance and Improvement Team. In 2015-16, 265 instances of service user feedback were recorded:
    - 91 formal complaints
    - 21 concerns
    - 6 enquiries / feedback
    - 147 compliments
- Social work related feedback is managed through a central team who support managers and staff to resolve and respond to complaints quickly and effectively. The table below summarises the complaints and compliments received in 2016/17.

Complaints	2015-16	2016/17	Commentary
Stage 1	173	67	• The figures show a reduction of 24% in stage 2 complaints • 71% of formal complaints were responded to within 20 working days or an agreed extension. • 18% of complaints were not completed within the targeted timescale. • 9% of complaints were withdrawn by the complainant.
Stage 2	114	87	
Complaints Review Committee (Stage 3)	5	14	
Cases escalated to SPSO	1	2	
Enquiries	219	155	
Care Service Feedback	37	36	
Positive Comments	21	8	

In the autumn of 2016 we carried out a user satisfaction survey in respect of our home care service. Of the 266 people who responded to this survey 94.7% said that they were very satisfied or quite satisfied with the service that they received.

Inspection by regulatory bodies

Our services are regulated through the Care Inspectorate, Health Improvement Scotland and the Healthcare Environment Inspectorate who carry out inspections of specific themes or services. The partnership responds to any areas of concern highlighted in inspection reports by developing and implementing improvement plans to address any areas of concern and respond to recommendations.

Themed inspections:

Between August and December 2016, the Care Inspectorate and Health Improvement Scotland undertook a joint inspection of services for older people in Edinburgh. The Partnership views the inspection as a helpful process and its findings confirm the need to continue to drive forward the improvements identified by the Integration Joint Board and the Health and Social Care Partnership following its inception in 2016.

The report from this inspection was published in May 2017. Services were evaluated against nine criteria as detailed in the table below:

Quality indicator	Evaluation	Evaluation criteria
Key Performance Outcomes	Weak	**Excellent** – outstanding, sector leading **Very good** – major strengths **Good** – important strengths with some areas for improvement **Adequate** – strengths just outweigh weaknesses **Weak** – important weaknesses **Unsatisfactory** – major weaknesses
Getting Help at the Right Time	Weak	
Impact on Staff	Adequate	
Impact on the community	Adequate	
Delivery of key processes	Unsatisfactory	
Strategic planning and plans to improve services	Weak	
Management and support of staff	Adequate	
Partnership working	Adequate	
Leadership and direction	Weak	

The inspection report also contained 17 recommendations detailed in the table below. A detailed improvement plan is in place to respond to these recommendations with a lead officer accountable for each of the actions. An Improvement Board meets regularly to oversee delivery of actions within the plan and the Performance and Quality Sub-group of the Integration Joint Board has a role in overseeing delivery of the Improvement plan on behalf of the Board.

Recommendations from the Joint Inspection of Services for Older People	
1	The partnership should improve its approach to engagement and consultation with stakeholders in relation to: • its vision • service redesign • key stages of its transformational programme • its objectives in respect of market facilitation.
2	The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.
3	The partnership should develop exit strategies and plans from existing interim care arrangements to help support the delivery of community based services that help older people and their carers to receive quality support within their own homes or a setting of their choice.
4	The partnership should engage with stakeholders to further develop intermediate care services, including bed-based provision, to help prevent hospital admission and to support timely discharge.
5	The partnership should work in collaboration with carers and carers' organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating its carers' strategy.
6	The partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.
7	The partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.
8	The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.
9	The partnership should work with the local community and other stakeholders to develop and implement a cross-sector market facilitation strategy. This should include a risk assessment and set out contingency plans. (A market facilitation strategy sets out in detail the partnership's priorities for the commissioning of services)
10	The partnership should produce a revised and updated joint strategic commissioning plan with detail on: • how priorities are to be resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • fully costed action plans including plans for investment and disinvestment

Recommendations from the Joint Inspection of Services for Older People	
	• based on identified future needs • expected measurable outcomes.
11	The partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.
12	The partnership should ensure that: • there are clear pathways to accessing services • eligibility criteria are developed and applied consistently • pathways and criteria are clearly communicated to all stakeholders • waiting lists are managed effectively to enable the timely allocation of services.
13	The partnership should ensure that: • people who use services have a comprehensive, up-to-date assessment and review of their needs which reflects their views and the views of the professionals involved • people who use services have a comprehensive care plan, which includes anticipatory planning where relevant • relevant records should contain a chronology • allocation of work following referral, assessment, care planning and review are all completed within agreed timescales.
14	The partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing is maintained.
15	The partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.
16	The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skill mix that delivers high-quality services for older people and their carers.
17	The partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model.

Service inspections:

The Care Inspectorate is the statutory regulator of care services and awards grades to services in respect of the following separate areas: quality of care and support, quality of environment, quality of staffing and quality of management and leadership. The gradings used are set out in the table below:

Grade	Description
6	Excellent
5	Very Good
4	Good
3	Adequate
2	Weak
1	Unsatisfactory

The Edinburgh Integration Joint Board (EIJB) and City of Edinburgh Council (the contracting authority) has indicated its minimum expectation of all service providers is the achievement of a Care Inspectorate Grade 4 (Good) in all relevant inspection areas. As at May 2017, 82% of providers were meeting or exceeding the EIJB's minimum service quality requirements.

Those who fail to meet the minimum quality requirements are referred to the relevant Multi Agency Quality Assurance Group whose remit is to ensure the immediate wellbeing of service users and co-ordinate the delivery of support and challenge to providers who need to improve service standards. In the event a provider proves unwilling or unable to achieve improvement the Quality Assurance Group will progress the application of sanctions and/or termination of contractual relations with them.

Details of individual service inspections undertaken by the Care Inspectorate and the related gradings are given in Appendix 3. Copies of the inspection reports are held on the Care Inspectorate website. The report on the joint inspection of services for older people concluded that:

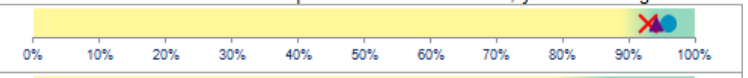
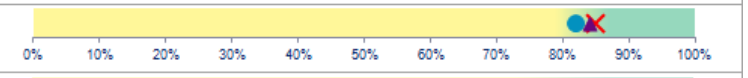
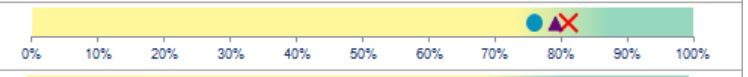
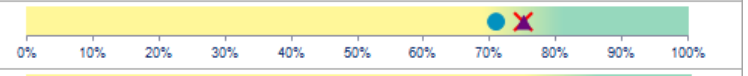
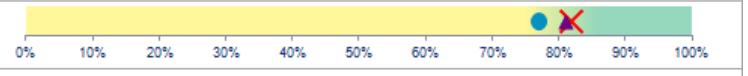
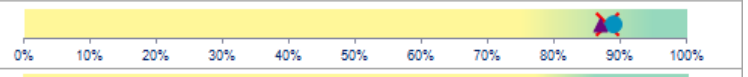
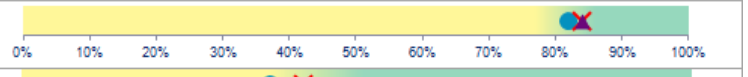
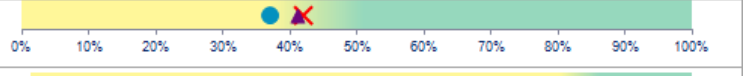
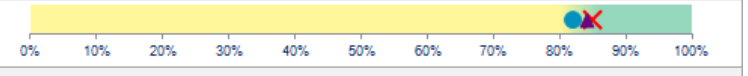
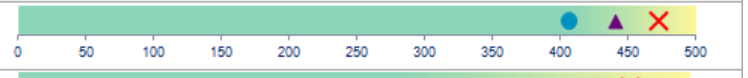
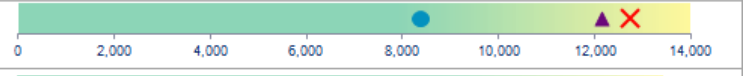
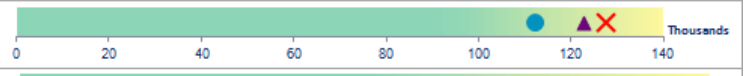
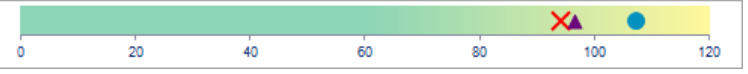
> "*In the main, at the time of inspection, regulated services were performing reasonably well across sectors and provision types and achieving positive grades.*"
>
> "*When people received services, they were generally of good quality and made a positive difference."*

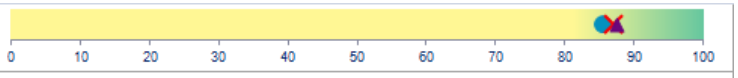
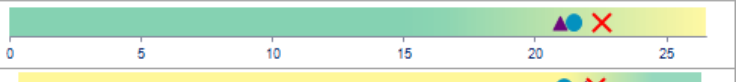
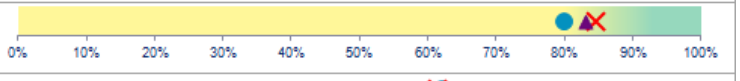
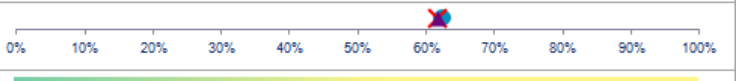
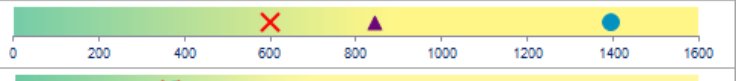
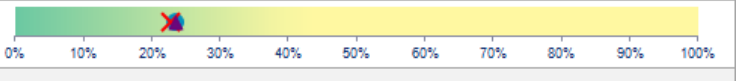
Health Improvement Scotland published a report on their inspection of Hospital Based Clinical Complex care in May 2016. The report includes six recommendations which are being addressed through an improvement action plan.

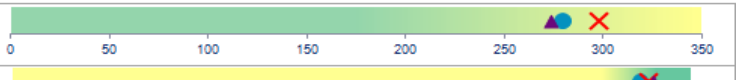
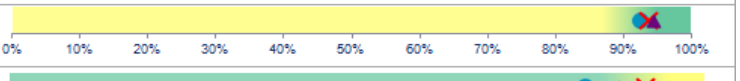
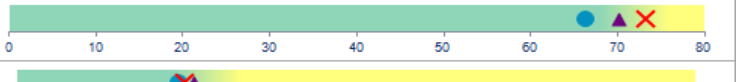
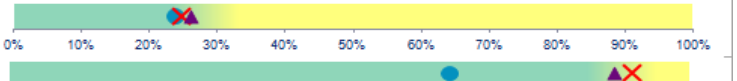
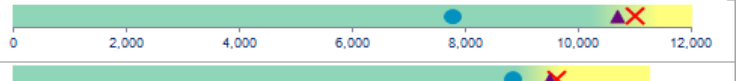
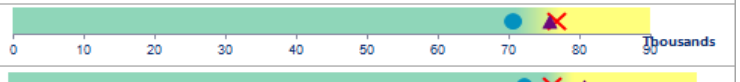
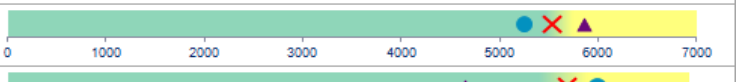
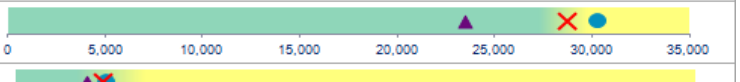
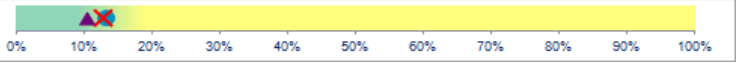
Appendix 1

National Indicators

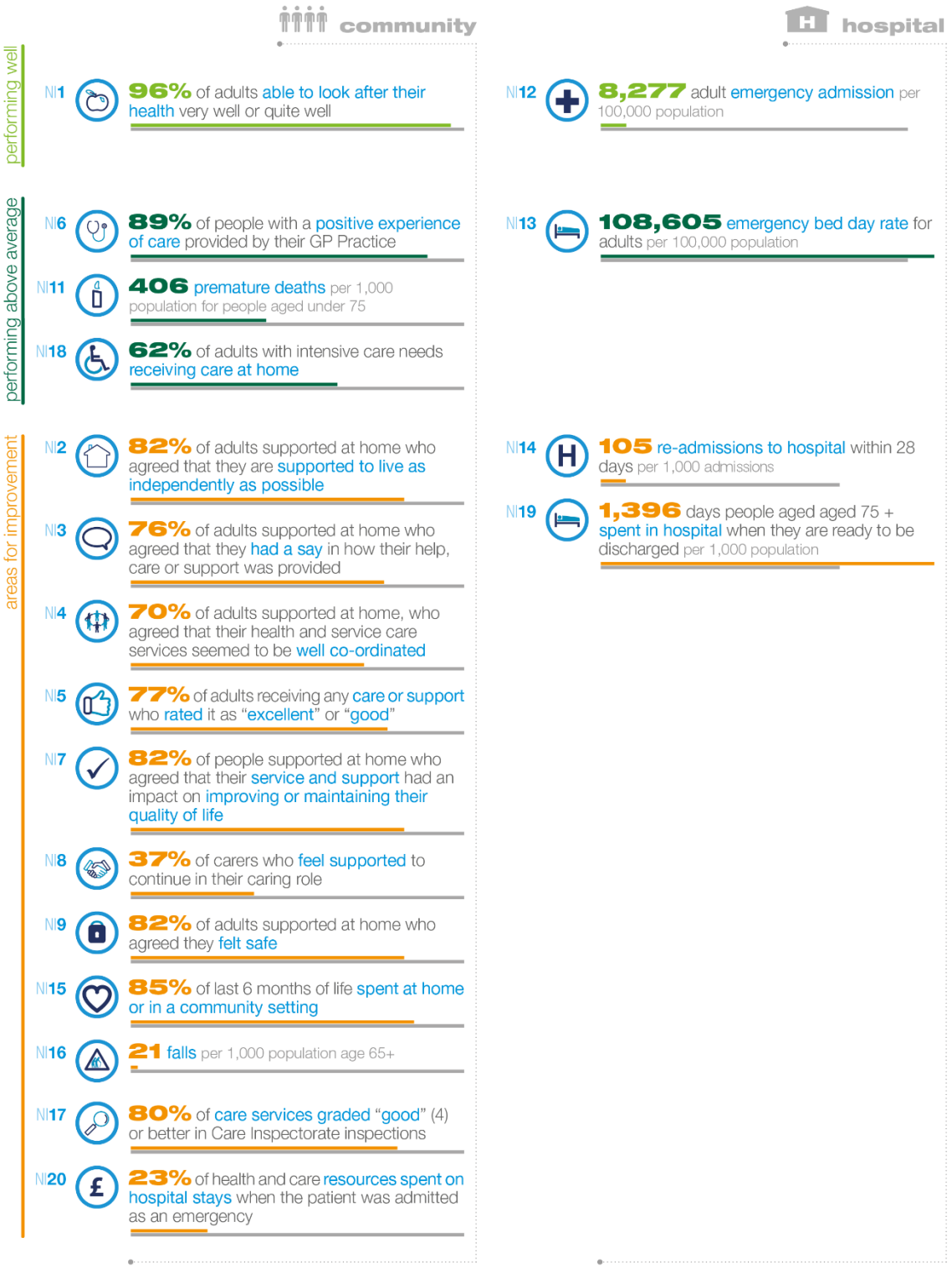
The scatter plots to the right of the table illustrate where Edinburgh City (the blue dot) lies in relation to both the Peer Group (red cross) average and the Scotland (purple triangle) values.

INDICATOR	Edinburgh City	Peer Group Average	Scotland	Green indicates the 'positive' side of the chart, yellow the 'negative'
1. Percentage of adults able to look after their health very well or quite well - 2015/16	96.0%	93.0%	94.0%	
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible. - 2015/16	82.0%	85.0%	84.0%	
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. - 2015/16	76.0%	81.0%	79.0%	
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.- 2015/16	71.0%	75.0%	75.0%	
5. Percentage of adults receiving any care or support who rate it as excellent or good - 2015/16	77.0%	82.0%	81.0%	
6. Percentage of people with positive experience of care at their GP practice. - 2015/16	89.0%	88.0%	87.0%	
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. - 2015/16	82.0%	84.0%	84.0%	
8. Percentage of carers who feel supported to continue in their caring role.- 2015/16	37.0%	42.0%	41.0%	
9. Percentage of adults supported at home who agree they felt safe.- 2015/16	82.0%	85.0%	84.0%	
*10. Percentage of staff who say they would recommend their workplace as a good place to work.**	*Not yet available.*			
11. Premature mortality rate (per 100,000 population) - 2015	406.3	472.5	440.5	
12. Rate of emergency admissions for adults (per 100,000) - 2015/16	8,393	12,728	12,138	
13. Rate of emergency bed days for adults (per 100,000) - 2015/16	112,147	127,683	122,713	
14. Readmissions to hospital within 28 days of discharge (per 1,000) - 2015/16	107.2	94.2	96.4	

15. Proportion of last 6 months of life spent at home or in community setting. -2016/17	85.5	87.0	87.5	
16. Falls rate per 1,000 population in over 65s. - 2016/17	21.5	22.5	20.9	
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. - 2015/16	80%	85%	83%	
18. Percentage of adults with intensive needs receiving care at home. - 2015/16	62.3%	61.6%	61.6%	
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged. (per 1,000) - 2016/17	1,396	600	842	
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. - 2015/16	23.4%	22.9%	23.5%	
*21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.**	*Not yet available.*			
*22. Percentage of people who are discharged from hospital within 72 hours of being ready.**	*Not yet available.*			
*23. Expenditure on end of life care.**	*Not yet available.*			

Ministerial Strategic Group Indicators	**Edinburgh City**	***Peer Group Average***	***Scotland***	
Rate of A&E Attendances per 1,000 population - 2016	279.4	297.5	273.3	
A&E performance against standard (seen within 4 hours) - 2016	92.5%	93.6%	94.4%	
Rate of emergency admissions from A&E per 1,000 - 2016	66.3	73.2	70.0	
Conversion rate from A&E to inpatient - 2016	23.8%	24.6%	26.0%	
Rate of emergency admissions per 100,000 - all ages - 2015	7,774.9	10,986.3	10,671.8	
Unscheduled bed days per 100,000 - acute specialties - 2015	70,618.1	76,668.2	75,653.8	
Unscheduled bed days per 100,000 - geriatric long stay - 2015	5,250.6	5,531.6	5,851.6	
Unscheduled bed days per 100,000 - mental health specialties - 2015	30,298.8	28,696.1	23,502.2	
% Last six months of life spent in a large hospital - 2015/16	13.3%	12.8%	10.6%	

Summary of the 23 National Indicators
for Edinburgh Health and Social Care Partnership



Appendix 2

Local Indicators

The tables below give an overview of the current key activity and performance indicators which are being used to track progress against the Edinburgh Integration Board's strategic plan and towards priority outcomes. The set of indicators is under development.

There are two sections:

1. Indicators which are available for Edinburgh's four localities, providing a snapshot, which, over time, will allow variation within and between areas to be identified and investigated.

2. Time series at city-wide level.

Important note
A person's locality can by defined in two main ways: a) where they live (this is the most commonly used) or b) where their GP practice is based.

A third way relates to the former boundaries, referred to as "sectors". These are being phased out, but still apply to some records.

In the tables below, the address of the person is used as the basis of the locality, unless stated.

SECTION 1 – Locality Measures

1. Core Integration Indicators by locality - Outcomes

About this data
A core suite of integration indicators has been developed by the Scottish Government in partnership with NHS Scotland, COSLA and the third and independent sectors. The indicators are in two categories, outcomes indicators, sourced from national survey data and other indicators derived from datasets and systems that are primarily used to support operational practice.

The table below shows the results from the Health and Care Experience Survey detailed in Appendix 1 broken down by locality. The survey was last carried out in 2015/16.

	Data Type	North East	North West	South East	South West	Edinburgh	Scotland
Percentage of adults able to look after their health very well or quite well	%	95%	96%	96%	95%	96%	94%
Percentage of adults supported at home who agree that they are supported to live as independently as possible	%	83%	80%	83%	82%	82%	84%
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	%	78%	73%	77%	78%	76%	79%
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	%	73%	66%	70%	73%	70%	75%
Percentage of adults receiving any care or support who rate it as excellent or good	%	76%	78%	77%	78%	77%	81%
Percentage of people with positive experience of care at their GP practice	%	86%	89%	91%	87%	89%	87%
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	%	85%	78%	84%	80%	82%	84%

	Data Type	North East	North West	South East	South West	Edinburgh	Scotland
Percentage of carers who feel supported to continue in their caring role	%	41%	42%	27%	40%	37%	41%
Percentage of adults supported at home who agree they felt safe	%	78%	83%	81%	87%	82%	84%

2. Pressures, unmet need, waiting lists

The indicators in this section relate to pressures on the health and social care system that present themselves both in the hospital and community. The indicators below focus on people waiting in hospital for discharge and people with learning disabilities who have an identified need for alternative accommodation. Additional information on people waiting for assessments is shown in section 2.

About this data
Delayed discharge data are collected monthly in line with national recording data definitions and guidance. The four indicators relating to delayed discharge are from the dataset that formed part of the census submission to ISD Scotland for patients delayed at 30 March 2017, the national census date, and for bed days lost to patients who were delayed throughout the whole month. Although data are not published at locality level, the locality of the patients delayed has been derived from their home address.

The number of people on the learning disability accommodation waiting list relates to those who are either in family home or hospital and require suitable long term accommodation. Of the 82 on the list, 60 require a place in 2017 and all but six are in the family home.

	Data Type	North East	North West	South East	South West	Edinburgh
Delayed Discharges: patients delayed March 2017	No.	29	39	47	59	176[1]
Delayed Discharges: patients delayed per 1,000 population aged 75+ March 2017	Rate	4.1	3.2	5.6	7.8	5.0
Delayed Discharges: bed days lost March 2017	No.	4,188	5,524	4,991	4,180	20,477[1]
Delayed Discharges: bed days lost rate per 1,000 population 75+ March 2017	Rate	595.6	457.0	596.8	548.9	583.5
Learning disability accommodation waiting list	No.	9	31	19	23	82

[1] Includes people who do not have a locality address e.g. of no fixed abode

3. Primary care

This section gives an overview of people's experience of primary care, GP practice capacity and pressures, and a high level indicator of hospital activity.

About this data
The source for the first group of indicators in this section is the Health and Care Experience Survey, a national, biennial survey which has sampling appropriate for the collation of data at locality level. The survey was last carried out in 2015/16.

Information relating to hospital admissions has been taken from TRAK (the NHS patient recording system). For this table, the localities are defined by where the person's GP practice is based.

	Data Type	North East	North West	South East	South West	Edinburgh	Scotland
Rate overall care provided by the GP Practice as excellent or good.	%	86%	89%	91%	87%	89%	87%
Can see or speak to a doctor or nurse within 2 working days	%	84%	84%	88%	85%	85%	84%
Can book a doctor's appointment 3 or more working days in advance	%	76%	82%	84%	80%	81%	76%
Overall arrangements for getting to see a doctor are excellent or good	%	70%	73%	81%	75%	76%	71%
Overall arrangements for getting to see a nurse are excellent or good	%	82%	85%	87%	84%	85%	82%
Strongly agree or agree patients are treated with respect	%	91%	92%	94%	92%	92%	92%
Strongly agree or agree patients are treated with compassion and understanding	%	84%	84%	88%	86%	86%	85%
Rate overall care provided by the GP Practice as excellent or good.	%	86%	89%	91%	87%	89%	87%
Hospital admissions per 1,000 (by GP group)	Rate	101.4	101.5	84.1	99.1	96.4	
Number of GP practices	No.	18	19	20	17	74	
Number of GP practices with restricted lists (31 March 2017)	No.	9	11	12	6	38	

4. Support in the community

Activity and performance on key supports for people with identified needs are summarised below.

Context
Reablement is a short term domiciliary care service that aims to support people to regain the skills needed to live as independently as possible.

The Social Care (Self-directed Support) (Scotland) Act 2013 places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their social care and support. The options are: a direct payment (option 1), an individual service fund (option 2) or for the council to arrange the support (option 3). Option 4 is a combination of two or more of the other options.

Post diagnostic support for people diagnosed with dementia forms part of the Scottish Government's dementia strategy. The indicator below relates to the service commissioned by the Partnership. Community mental health teams provide additional support.

About the data
Source: SWIFT (Health and Social Care's Client Information System).

	Data Type	North East	North West	South East	South West	Edinburgh
Reablement - impact (% reduction in hours of support needed)	%	46.2%	52.3%	49.0%	64.3%	52.5%
Reablement - impact (% of people who did not need a package of care)	%	42.9%	53.7%	53.5%	62.3%	52.6%
Carer assessments rate (per 1,000 population 16+)	Rate	1.25	2.21	1.37	1.41	1.68
Multidisciplinary falls assessments by Intermediate Care Teams as a rate per 1,000 pop 75+	Rate	11.1	9.5	11.5	12.6	10.9
Proportion of all services that are DP (Option 1) or ISF (Option 2) as at March 2016	%	13.7%	15.9%	14.9%	12.0%	14.0%
Proportion of all services that are DP (Option 1) or ISF (Option 2) as at March 2017	%	14.9%	19.2%	17.5%	14.4%	16.3%
Dementia post diagnostic support service starts	No.	38	84	55	39	220
Dementia post diagnostic support service starts as a rate per 1,000 population 75+	Rate	5.4	6.9	6.6	5.1	6.3

5. Staff

This section includes data on staffing in the new locality teams in the Edinburgh Health and Social Care Partnership

About this data
To allow the implementation of the integrated locality structure the staffing resource for each staff type in each locality was calculated. A comparison of those in post at the end of April 2017, compared with the allocation is given in this section.

This section is under development.

Proportion of locality social care staffing establishment which is in post	Data Type	North East	North West	South East	South West	Edinburgh
Senior OT	%	76%	106%	100%	111%	98%
Mental Health Officer	%	95%	93%	91%	93%	93%
Senior Social Worker	%	133%	93%	60%	83%	86%
OT	%	81%	91%	88%	93%	89%
Social Worker	%	90%	88%	89%	83%	90%
Community Care Assistant	%	110%	101%	100%	109%	101%

Mandatory training for NHS staff	Data Type	Compliance
Equality and diversity	%	89.3
Information governance	%	69.0
Health and safety	%	88.9
Health associated infections	%	70.7
Fire training	%	79.5
Manual handling	%	84.6
Public protection	%	81.8
Violence and aggression	%	88.5
Resuscitation	%	88.3

Section 2. Time Series

1. Pressure, unmet need, waiting lists

This section includes indicators on people waiting in hospital for discharge, for assessments and for support at home.

About this data
Delayed discharge data are collected monthly in line with national recording data definitions and guidance. Data are published at locality level to support operational and performance management.

The number of people waiting for a package of care includes people who are either waiting in hospital for a package of care or in the community where they have no package of care. The number of hours required includes those who require an increase to their existing package of care.

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Delayed Discharges: number NE	No.						32	42	46	45	41	40	29
Delayed Discharges: number NW	No.						52	58	57	57	61	64	39
Delayed Discharges: number SE	No.						39	48	40	42	69	51	47
Delayed Discharges: number SW	No.						48	48	37	41	50	51	59
Delayed Discharges: Total	No.	67	85	120	173	170	171	196	180	185	221	206	176[2]

[2] Includes people who do not have a locality address e.g. of no fixed abode

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Waiting list - social care assessments at month end	No.	1,348	1,409	1,635	1,421	1,629	1,606	1,547	1,444	1,522	1,430	1,495	1,428
Waiting list - social care assessment (average wait in days)	No.	69	70	69	78	97	76	80	84	92	89	92	101

2. Psychological treatment – 18 week target

This section focuses on response times for people who have been referred for psychological treatment. The national standard is for at least 90% of people referred for psychological therapies to start treatment within 18 weeks of referral.

About this data
The services included in this section relate to the former HEAT target 'Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological therapies from December 2014' as listed below:

Primary care mental health teams
Lothian Group service
Community mental health teams
Adult Psychology Teams
Older adult behavioural support service
Learning disabilities teams
Substance misuse psychology teams
Children & adolescent MH Services

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
People seen for 1st treatment appointment	No.	89	119	108	161	163	115	149	169	104	168	152	143
No. of people seen within 18 weeks	No.	50	58	61	84	82	57	60	80	57	70	80	78
No. of people seen over 18 weeks	No.	39	61	47	77	81	58	89	89	47	98	72	65
% seen within 18 weeks for 1st treatment appointment	%	56.2%	48.7%	56.5%	52.2%	50.3%	49.6%	40.3%	47.3%	54.8%	41.7%	52.6%	54.5%

3. Support in the community

This section focuses on activity in a range of supports intended to help people to remain living in the community, including: assessments of unpaid carers, fall assessments and telecare. It also shows GP list sizes in recent years and the balance of care – a key measure of the overall pattern of support.

About this data
Sources: SWIFT, ECO Stats.

The national balance of care figure reports the number of people receiving personal care at home via a direct payment or council-arranged service as a percentage of the total number of people requiring care. This local measure also includes those receiving personal care funded through an individual service fund.

The numbers included in the table around GP list size are recognised as being inflated by around 6% (this effect has been found in other areas of Scotland and investigated by NRS).

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Carer Assessments NE	No.	14	5	7	7	7	11	10	12	9	12	8	16
Carer Assessments NW	No.	22	23	23	14	18	28	23	20	17	15	23	26
Carer Assessments SE	No.	20	9	13	19	14	8	13	12	10	6	15	12
Carer Assessments SW	No.	12	10	16	16	9	12	9	18	6	7	9	9
Carer Assessments Total[3]	No.	69	50	60	57	53	60	61	65	47	42	61	69

[3] Note that the total includes people whose locality is not recorded or is outside of Edinburgh.

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Multidisciplinary falls assessments by Intermediate Care Teams	No.	29	49	39	36	40	15	27	30	39	27	24	30
Telecare: % of Hospital Admissions on response (65+)	%	1.7	2.5	1.1	0.5	0.4	0.6	0.5	0.8	1.6	1.2	0.6	1.2
Telecare: Response to Fallers (65+) – percent telecare staff response only (out of cases where action taken)	%	93.2	91.1	93.9	94.8	94.7	93.9	96.6	95.5	92.2	95	91	93.7
Balance of care	%	57.2	57.4	57.4	57.8	57.6	57.7	57	57.2	57.4	56.9	56.5	56.6

	Data Type	April 2013	April 2014	April 2015	April 2016	April 2017
GP list size	Number	519,434	525,755	530,699	536,016	543,249

4. Mental health and substance misuse

The indicators in this section relate to people who are subject to a mental health legal order or guardianship process, and to performance against the national standard for drug and alcohol treatment i.e. that 90 per cent of people will wait no longer than 3 weeks from referral received to appropriate treatment that supports their recovery. The guardianship process where they have been assessed as not having capacity and require legal process under the Adults with Incapacity (Scotland) Act 2000.

About this data
Sources: SWIFT, Trak, Drug and Alcohol Treatment Waiting Times Database, Edinburgh Leisure.

	Data Type	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
People on open MH legal orders (excluding guardianship)	No.	509	528	552	571	606	617	640	672	678	760	715	760
Percentage meeting 3-week target from referral to start of treatment for drugs and alcohol services	No.	85	71	79	83	86	79	80	81	85	83	89	
Delayed discharge guardianship delays	No.			24	23	20	20	22	16	17	11	12	14

5. Long Term Conditions

Data surrounding activity resulting from the Long Term Conditions Programme is shown below.

About this data
Sources: Trak, CATS service database, CRT database, Edinburgh Leisure

	Data Type	Apr – Jun 2016	Jul – Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Total
Number of A&E attendances due to falls for people aged 65+	No.	981	985	1013	930	3909
Referrals to fallen uninjured person pathway	No.	35	43	56	81	215
Bed days for people with a primary diagnosis of COPD	No.	1,860	1,757	1,774	1,899	7,290
Acute COPD exacerbations at risk of admission referred to Community Respiratory Team (CRT)	No.	263	237	286	267	1053
Acute COPD exacerbations assessed by CRT where admission avoided	No.	83	44	58	49	234
Number of Key Information summaries	No.	29,892	33,835	35,587	37,871	137,185

Fit for Health Programme	Data Type	2014-15	2015-16	2016-17
Fit for Health: no. referrals	No.	216	427	655
Fit for Health: no. engaged	No. (%)	185 (86%)	308 (72%)	523 (78%)
Fit for Health: Completion rate	No. (%)	22 (12%*)	100 (29%)	131 (33%)
Fit for Health: those completing who reported improved wellbeing	No. (%)	17 (77%)	80 (80%)	102 (77%)

*participants engaged through the referrals had not yet completed their 12 weeks at year end (first year)

Annual Performance Report Appendix 3

Inspection Gradings

Copies of the inspection reports are held on the Care Inspectorate website.

Care Home Services

Care homes provided by EHSCP	Type	Date of Inspection	Care & Support	Staffing	Management & Leadership
Firrhill	Learning Disabilities	29-Nov-16	5	NA	NA
Castle Crags	Learning Disabilities	03-Nov-16	5	4	NA
Clovenstone House	Older People	02-Aug-16	5	5	NA
Drumbrae	Older People	08-Sep-16	3	4	4
Ferrylee	Older People	30-Mar-17	4	4	4
Ferrylee	Older People	11-Apr-16	3	NA	NA
Fords Road	Older People	31-Oct-16	5	4	NA
Gylemuir	Older People	03-Apr-17	NA	NA	3
Gylemuir	Older People	22-Sep-16	3	3	2
Inch View	Older People	08-Nov-16	4	NA	NA
Jewel House	Older People	09-Jun-16	5	5	5
Marionville Court	Older People	13-Jan-17	4	4	4
Oaklands	Older People	26-Sep-16	4	4	4

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Four Seasons Health Care - Castlegreen	Not inspected in time period			
Abercorn Care Limited - Abercorn Care Home	08/02/2107	5	5	5
Abercorn Care Limited - Spring Gardens	01/02/2017	5	5	5
Abercorn Care Limited - Viewpark	15/02/2017	5	5	5
Antonine Care Limited - Forthland Lodge	24/06/2016	4	5	4
BUPA - Victoria Manor Nursing Home	15/07/2016	3	3	3
Claremont Park Nursing Home	31/10/2016	3	3	3
Crossreach - Queens Bay Lodge	25/10/2016	5	5	5
Renaissance Care (Scotland) Ltd - Letham Park Care Home	01/06/2016	3	3	3
Renaissance Care (Scotland) Ltd - Milford House	01/02/2017	5	4	4
South Park Retirement Home	21/04/2016	5	4	5
Barchester Healthcare Ltd - Strachan House	28/03/2017	6	NA	NA
Belgrave Lodge - Dixon Sangster Partnership	06/12/2016	4	4	4
Bield HA - Craighall Care Home	07/08/2016	4	4	3
Bield HA - Stockbridge Care Home	31/01/2017	4	4	5
Braeburn Home	14/12/2016	5	5	5
Eildon House	Not inspected in time period			
HC-One Limited - Murrayfield House Nursing Home	08/09/2016	5	5	5
Laverock House	23/02/2017	4	4	4
Manor Grange Care Home LLP	New service			
Salvation Army - Eagle Lodge	Not inspected in time period			
Sir James McKay Housing - Scottish Masonic Homes Limited	31/02/2017	4	5	5

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Struan Lodge Care Home	24/02/2016	5	5	5
BUPA - Braid Hills Nursing Home	26/11/2015	3	4	4
Cameron Park	25/08/2016	5	4	5
Cherryholme House	15/11/2016	4	4	4
Crossreach - Morlich Care Home	27/10/2016	6	NA	NA
Crossreach - The Elms	01/12/2016	2	2	2
Embrace (Kler) Ltd - Camilla House Nursing Home	13/09/2016	4	4	4
Erskine Hospital Ltd - Erskine Nursing Home	05/12/2016	5	5	5
Four Seasons Health Care - Colinton	09/06/2016	4	3	4
Four Seasons Health Care - Gilmerton Care Home	22/06/2016	4	4	4
Four Seasons Health Care - Guthrie House Nursing Home	23/06/2016	4	3	3
Four Seasons Health Care Group - St Margaret's Care home	29/09/2016	4	4	4
Jubilee House	07/07/2016	4	4	4
Little Sister of The Poor - St Joseph's Home for the Elderly	22/03/2017	5	2	NA
Mansfield Care Ltd - Belleville Lodge Nursing Home	14/12/2016	5	NA	NA
Randolph Hill Care Homes Ltd - Ashley Court Nursing Home	30/09/2016	4	4	4
Royal Blind - Braeside House	25/11/2016	5	4	4
Viewpoint HA - Lennox House Care Home	26/07/2016	5	5	5
Viewpoint HA - Marian House Care Home	13/10/2016	5	5	5
Viewpoint HA - St Raphael's Care Home	18/10/2016	5	5	5
Four Seasons Health Care - North Merchiston	12/11/2015	5	5	5
Lorimer House Nursing Home	25/01/2016	5	5	5

Care homes commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Randolph Hill Care Homes Ltd - Blenham House Nursing Home	09/03/2016	5	5	5
Salvation Army - Davidson House	12/09/2016	4	4	5
Thorburn Manor Nursing Home	21/03/2017	6	5	5

Home care and care at home services

Home care services provided by EHSCP	Type	Date of Inspection	Care & Support	Staffing	Management & Leadership
City of Edinburgh - Resource and Development Team	Support Service	20/02/2017	4	4	2
Intermediate Care - North	Home care	24/10/2016	4	NA	NA
Intermediate Care - South	Home care	24/10/2014	4	NA	NA
North East Edinburgh Home Care and Support Service	Home care	17/06/2016	5	4	NA
North West 1 Edinburgh Homecare and Support Service	Home care	18/01/2017	5	NA	4
North West 2 Edinburgh Home Care and Support Service	Home care	03/11/2016	4	4	NA
Overnight Home Care Service	Home care	27/05/2016	5	4	4
Positive Steps	Home care	20/02/2017	5	5	NA
South Central Edinburgh Home Care and Support Service	Home care	06/02/2017	5	NA	5
South East Edinburgh Home Care and Support Service	Home care	28/03/2017	4	4	4
South West Edinburgh Home Care and Support Service	Home care	22/08/2016	5	NA	4
SupportWorks	Home care	01/02/2017	5	4	NA

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
Hoseasons & Broomhouse (C&S) Quartermile (C&S)	Care at Home	12/12/2016	2	2	2
COMMUNITY INTEG CR SUPP LIV (CIC)	Care at Home	12/01/2017	3	4	4
DEAF ACTION	Care at Home	30/11/2016	5	NA	NA
LYNEDOCH CARE LTD	Care at Home	15/09/2016	5	NA	NA
MOCHRIDHE SUPPORT SERVICE	Care at Home	02/12/2016	5	NA	NA
PENUMBRA (VISITING SUPPORT)	Care at Home	30/11/2016	5	NA	5
Places for People St Leonards (Base C&S)	Care at Home	06/02/2017	5	5	NA
Places for People St Leonards (Base C@H)	Care at Home	06/02/2017	5	5	NA
Barony Housing Association Ardmillan Terrace, Mardale Crescent, Mayfield Rd, Upper Gray St (C&S) (C@H)	Care at Home	09/03/2017	5	NA	5
COMMUNITY HELP & ADV (CHAI)	Care at Home	Not inspected in time period			
CROSSREACH THRESHOLD EDINBURGH	Care at Home	07/03/2017	6	NA	5
ENABLE	Care at Home	26/08/2015	6	6	6
FREESPACE HOUSING	Care at Home	30/03/2017	2	2	2
FREESPACE HOUSING	Care at Home	08/09/2016	3	3	3
GARVALD EDINBURGH	Care at Home	26/10/2016	5	5	4
Leonard Cheshire Disability Stenhouse (Base C&S)	Care at Home	08/12/2016	6	5	NA
Link Living Edinburgh Mental Health Service	Care at Home	Not inspected in time period			
Places for People Edinburgh Mental Health Service	Care at Home	08/09/2016	4	4	4
REAL LIFE OPTIONS	Care at Home	24/11/2016	5	4	4

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
SUPPORT AND SOC CR NETWRK SSCN	Care at Home	04/01/2017	4	4	4
SUPPORT AND SOC CR NETWRK SSCN	Care at Home	03/05/2016	4	2	3
Bluebird Care	Care at Home	13-Oct-16	5	NA	NA
Care UK Homecare (Mears)	Care at Home	24-Aug-16	3	4	4
Carrick Home services	Care at Home	02-Jun-16	4	4	4
Everycare (Edinburgh)	Care at Home	02-Nov-16	5	4	NA
Family Circle Care	Care at Home	11-May-16	4	4	4
Home Instead Senior Care	Care at Home	16-Feb-17	6	NA	5
Independent Living Services	Care at Home	06-Feb-17	3	3	3
Highland Care Agency	Care at Home	25-Jan-17	2	1	2
Margaret Forrest Care Management	Care at Home	03-Oct-16	4	NA	NA
Prime Health Care	Care at Home	19-Sep-16	4	4	5
Professional Carers' Scotland	Care at Home	20-Jul-16	5	NA	4
Quality Care Resources	Care at Home	13-Feb-17	3	3	3
Bright care	Care at Home	10-Feb-17	5	NA	5
JB Nursing Employment Agency	Care at Home	07-Jul-16	4	3	4
Prestige Nursing PC Property	Care at Home	03-Mar-17	6	6	6
Blackwood Care	Care at Home	15-Mar-17	5	NA	5
Carewatch	Care at Home	17-May-16	4	5	4
Sutton Care Solutions	Care at Home	14-Jul-16	5	5	NA
Carr Gomm Morningside	Care at Home	02-Feb-17	5	4	NA
Carr Gomm Merchiston	Care at Home	28-Jun-16	4	3	3
Crossreach Eskmills	Care at Home	08-Nov-16	5	NA	NA
Harmony	Care at Home	17-Aug-16	5	NA	NA
L'Arche	Care at Home	29-Aug-16	5	5	4
Leonard Cheshire Bingham	Care at Home	15-Dec-16	5	5	NA
Leonard Cheshire Trafalgar Lane	Care at Home	29-Jul-16	5	5	5
Mears Care	Care at Home	15-Nov-16	5	NA	NA

Care at home services commissioned by EHSCP	Type of service	Date of Inspection	Care & Support	Staffing	Management & Leadership
Places for People Caltongate	Care at Home	20-Sep-16	5	5	NA
Richmond Fellowship	Care at Home	28-Mar-17	3	3	3
The Action Group A	Care at Home	08-Feb-17	5	NA	5
Thistle Foundation	Care at Home	07-Jun-16	5	NA	5
Autism Initiatives Bingham	Care at Home	04-May-16	5	4	4
Autism Initiatives Blackfriars	Care at Home	23-Nov-16	3	4	4
Places for People East Craigs	Care at Home	26-Jan-17	6	6	NA
Ark Housing	Care at Home	12-Aug-16	3	3	2
Avenue Care Services	Care at Home	10-Oct-16	4	NA	NA
Call In Homecare	Care at Home	29-Aug-16	4	NA	NA
Social Care Alba	Care at Home	24-Feb-17	4	4	NA
SCRT Careline	Care at Home	30-Jun-16	4	5	NA
Shaw Healthcare	Care at Home	02-Sep-16	4	5	NA
Aquaflo	Care at Home	24-Mar-17	2	2	2
MECOPP	Care at Home	Not inspected in time period			
Richmond Fellowship	Care at Home	Not inspected in time period			

Day services

Day Services commissioned by EHSCP	Date of Inspection	Care & Support	Staffing	Management & Leadership
Caring in Craigmillar	23/03/2017	5	4	NA
Lochend Neighbour Centre	New service			
North Edinburgh Dementia Care	16/03/2017	5	5	NA
Upward Mobility	01/12/2016	5	5	NA
Alzheimer Scotland	22/04/2016	5	NA	5
Corstorphine Dementia Project	Not inspected in time period			
Drylaw Rainbow Club	Not inspected in time period			
Lifecare	Not inspected in time period			
Queensferry Churches' Care in the Community	Not inspected in time period			
Eric Liddell Centre	15/06/2016	6	5	NA
Libertus	Not inspected in time period			
The Open Door	Not inspected in time period			
Places for People Pleasance Day Centre	Not inspected in time period			
Prestonfield and District NWP - Clearburn Club	Not inspected in time period			
Cornerstone Community Care Canalside	27/03/2017	5	4	4

NHS LOTHIAN

Board Meeting
4 October 2017

2.4

Director of Finance

FINANCIAL POSITION TO AUGUST 2017 AND YEAR END FORECAST

1 Purpose of the Report

1.1 This paper provides an update to the Board on NHS Lothian's year-end forecast position considered by the Finance and Resources (F&R) Committee at its meeting on the 20th September.

1.2 The paper sets out the following:

- Summary Information on the year to date financial position and the year end forecast;
- Assurance that processes are in place to oversee and take forward the achievement of financial balance in 2017/18;
- The next steps in supporting the achievement of a breakeven outturn in-year.

1.3 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 The Board is recommended to:

- **Accept** this report as a summary briefing on the current financial position and year end financial forecast;
- **Accept** this report as a source of significant assurance that the F&R Committee has received a report which sets out a current estimate of a £4.5m year end overspend with detail on the relevant issues and required actions to achieve a balanced outturn, and;
- **Accept** that a follow up process is in place which will include an update report on the year end position being brought to the Board at its meeting in December.

3 Discussion of Key Issues

3.1 The F&R committee received a paper on the Period 5 financial position and the year end outturn overspend projection for 2017/18 at its meeting of the 20th September. The paper highlighted an in year overspend of £6.6m and an anticipated year end overspend of £4.5m. Further detail on the financial position is provided in table 1 below.

Table 1 – NHS Lothian year-to-date overspend and year-end forecast

	Financial Plan 2017/18 £k	Q1 YE Forecast Variance with Mgt Actions £k	Movement from 17/18 Financial Plan £k	Month 5 YTD Position £k
University Hosp Support Services	(17,015)	(12,444)	4,571	(6,552)
REAS	(966)	(1,170)	(204)	(208)
Edinburgh Partnership	(4,206)	(5,339)	(1,133)	(2,512)
East Lothian Partnership	99	52	(47)	(24)
Midlothian Partnership	163	86	(77)	(454)
West Lothian Partnership	(565)	96	661	717
Facilities And Consort	1,036	951	(85)	(959)
Corporate Services	(1,758)	307	2,065	1,058
Inc + Assoc Hlthcare Purchases	111	374	263	496
Research & Teaching	(1,307)	(1,405)	(98)	(553)
Strategic Services	781	3,120	2,339	(789)
Operational Position	**(23,628)**	**(15,372)**	**8,256**	**(9,780)**
Reserves	1,252	3,834	2,582	1,598
Additional Flexibility	9,000	7,000	(2,000)	1,555
NHS Lothian Position	**(13,376)**	**(4,538)**	**8,838**	**(6,627)**

3.2 The F&R Committee considered the issues within the forecast and were able to acknowledge the actions being progressed to achieve breakeven in 2017/18. Actions being progressed to reduce the year-end deficit include:

- Accelerating property sales;
- One-off benefits generated as a result in delays in agreed developments;
- Non-recurrent cost reduction initiatives generated through business units.

3.3 The actions identified above will support the achievement of financial balance for 2017/18. However these do not address the issues of achieving recurrent financial sustainability in future years.

3.4 The Committee agreed that it had limited assurance at this point that the Board will achieve a breakeven outturn in 2017/18.

3.5 The Committee also discussed the impact of NHS Lothian's financial position on the IJBs' ability to achieve a breakeven outturn this year. NHS Lothian has commissioned work on the issue, which would be an agenda item considered at the next F&R meeting.

3.6 The next stages of supporting the achievement of financial balance include the following steps:

- Ongoing monthly monitoring and reporting of the financial position;

- Follow up meetings with business units as part of the Quarter 2 review to agree further actions to control and reduce spend;
- An update report to the F&R committee at its November meeting on the progress made to achieving in year financial balance, and a report on the five year financial outlook;
- A follow up report to the Board at its December meeting setting out the F&R committee's consideration of the financial position for 2017/18 and beyond.

4 Key Risks

4.1 The F&R Committee also considered the risks that may impact on financial performance throughout the year. Table 2 presents the risk schedule was shared with the Committee.

Table 2 – Risks to achieving year end financial balance

Key Assumptions / Risks	Risk rating	Impact
Recovery Actions	High	Delivery of planned recovery actions to the value required to cover the known pressures and developments within the individual Business Units.
Waiting Times	High	There requires to be continued management of the financial exposure on elective capacity pressures. The risk is that Current investment plans to deliver capacity will not deliver the required volume and meet the DFP Strategy.
Delayed Discharge	High	Need to manage the volume of delayed discharges and the cost of new initiatives that will be required to deliver the required reductions. At Q1 the level of delayed discharges had not reduced as anticipated.
Winter Costs	High	The risk remains whether sufficient additional resources are available to meet the pressures from anticipated winter demand, the Q1 forecast has not built in the costs of opening additional bed capacity, this will need to be managed with the delayed discharges
Integration	High	The financial plan assumed that the additional resource passed to the IJBs from the Social Care Fund would create additional capacity and reduce the total level of Delayed Discharges in the Health System, to date there is little evidence to support this assumption
Prescribing	Medium	A sustained level of ongoing growth and price increases were included in the 2017/18 financial plan, however there remains the risk that the increases are greater than projected. Short supply and increased use of new medicines are keeping the price per item higher than forecast
Pharmaceutical Price Regulation Scheme (PPRS)	High	The Pharmaceutical Price Regulation Scheme has provided a source of funding in previous year to offset the cost of approved IPTRs and New Medicines. A level of funding has been assumed for 2017/18, this funding as yet has not been received and there could be a risk that the level of funding is not at the level assumed in the plan.
Acute Prescribing	Medium	There is a risk that the level of growth exceeds the estaimte contained in the Quarter 1 ForecastFinancial Plan
Changes to pay T&Cs and backdated pay claims	Low	NHSL no longer has a provision for backdated pay claims, therefore any further claims will be an unplanned in year cost.
SGHD Allocations	Medium	The majority of SGHD funding for previously separately funded programmes and initiatives has now been receievd in year, however the level of funding has not increased since last year so expenditure will need to be mnanaged accordingly
Capital Programme	High	NHSiL has an ambitious capital programme which requires significant resources in addition to those available to deliver. The revenue consequences of the programme are a significant ongoing pressure to the organisation.
Outcomes Framework	Medium	The Financial Plan assumed that plans were in place to reduce expenditure in line with reductions in ADP and Bundles Funding, however this is proving difficult in some areas and is creating a financial pressure.

4.2 It was recognised by the Committee that those risks set out were consistent with those previously reported.

5 Risk Register

5.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

5.2 The contents of this report is aligned to the above risk. At this stage there is no further requirement to add to this risk.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 The implementation of the financial plan and the delivery of a breakeven outturn may require service changes. As this particular paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 There are no resource implications arising specifically from this report.

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