

BOARD MEETING

DATE: WEDNESDAY 5 APRIL 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

<u>Item</u>	<u>Lead</u>	
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 1 February 2017	SA	*
1.2. Running Action Note	SA	*
1.3. Corporate Risk Register	TG	*
1.4. Finance & Resources Committee - Minutes of 18 January 2017	MH	*
1.5. Healthcare Governance Committee - Minutes of 17 January	RW	*
1.6. Acute Hospitals Committee – Minutes 6 December 2016 & 22 February 2017	KB	*
1.7. Staff Governance Committee – Minutes 26 October 2016 & 25 January 2017	AM	*
1.8. Strategic Planning Committee – Minutes 8 December 2016 & 9 February 2017	BH	*
1.9. Audit & Risk Committee – Minutes of 5 December 2016 & 27 February 2017	JMc	*
1.10. West Lothian Integration Joint Board - Minutes of 31 January 2017	MH	*
1.11. East Lothian Integration Joint Board - Minutes 21 December 2016 & 26 January 2017	DG	*
1.12. Edinburgh Integration Joint Board - Minutes 20 January & 17 February 2017	AJ	*
1.13. Midlothian Integration Joint Board - Minutes 1 December 2016	CJ	*
2. Items for Discussion (subject to review of the items for approval)		
2.1. SG Health and Social Care Delivery Plan and the development of an East of Scotland Regional Health and Social Care Delivery Plan	AMcM	*
2.2. 2017/18 Draft Local Delivery Plan including 2017/18 Financial Plan	AMcM	*
2.3. Corporate Objectives 2017/18	AMcM	*
2.4. Quality and Performance Improvement	SW	*
2.5. Complaints and Feedback	AMcM	*
2.6. Drug and Alcohol Funding 2017/2018	AMcM	*

3. **Next Development Session:** 17 May 2017 at 9:30 a.m. at the Scottish Health Service Centre, Crewe Road South, Edinburgh EH4 2LF
4. **Next Board Meeting:** Wednesday 21 June 2017 **[Annual Accounts]** at 9:30 a.m. at the Scottish Health Service Centre, Crewe Road South, Edinburgh EH4 2LF
5. Matters Arising
6. Any Other Competent Business

Board Meetings in 2017

21 June 2017	SHSC [Annual Accounts]
2 August 2017	SHSC
4 October 2017	SHSC
6 December 2017	Chancellors Building, RIE

Development Sessions in 2017

17 May 2017	SHSC
19 July 2017	Chancellors Building, RIE
6 September 2017	SHSC
1 November 2017	SHSC

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 1 February 2017 Howden Park Centre, Howden, Livingston, West Lothian EH54 6AE.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mrs K Blair; Councillor H Cartmill; Councillor D Grant; Councillor R Henderson; Ms C Hirst; Ms F Ireland; Mr P Johnston; Councillor C Johnstone; Mr A Joyce; Mrs J McDowell; Mrs A Mitchell; Mr P Murray; Mr J Oates; Professor M Whyte; Mrs L Williams and Dr R Williams.

Executive and Corporate Directors: Mrs J Butler (Interim Director of HR & OD); Mrs J Campbell (Acting Chief Officer); Mr J Crombie (Deputy Chief Executive); Mr T Davison (Chief Executive); Dr D Farquharson (Medical Director); Dr T Gillies (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Director, Nursing, Midwifery & AHPS – Executive Lead REAS & Prison Healthcare) and Dr S Watson (Chief Quality Officer).

In Attendance: Mr G Curley (Director of Estates for item 63), Mrs C Harris (Head of Communications) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mr M Hill.

Welcome and Introduction

The Chairman welcomed members of the public and press to the Board meeting. He also welcomed Ms A Neilson, Director for Public Protection who was shadowing Professor McMahon. Mr Curley was also welcomed with it being explained that he was in the public gallery to support agenda item 2.6 'Sustainable Development Action Plan'.

The Chairman also welcomed the Chief Executive back from his period of sickness absence and advised that Mr J Crombie who had covered his duties in his absence had now been appointed as Deputy Chief Executive. Dr T Gillies was also welcomed to her first meeting as the newly appointed Medical Director replacing Dr D Farquharson who would retire later in the year. It was noted that a formal dinner event would be held to mark Dr Farquharson's service to NHS Lothian.

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.

57. Items for Approval

- 57.1 The Chairman reminded members that the agenda for the current meeting had been circulated previously to allow Board members to scrutinise the papers and advise whether any items should move from the approval to the discussion section of the agenda. There had been no such notifications.
- 57.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated“ For Approval” paper without further discussion: -
- 57.3 Minutes of the previous meeting held on 7 December 2016 - Approved.
- 57.4 Running Action Note – Approved.
- 57.5 Governance Committee and Integration Joint Board Membership – The Board confirmed the following Non Executive Board Member appointments to the NHS Lothian Governance Committees, and to the Integration Joint Boards: -
- Finance and Resources Committee: Martin Hill to replace George Walker as Chair and Peter Murray to join the committee both with effect from 1 February 2017.
 - Acute Hospitals Committee: Moira Whyte and Harry Cartmill to join the committee with effect from 1 February 2017.
 - Staff Governance: Alison Mitchell to replace Alex Joyce as Chair with effect from 1 February 2017.
 - East Lothian Integration Joint Board: Peter Murray to assume the role as Lead NHS Member, and Moira Whyte to join as member both with effect from 1 April 2017. Mike Ash to leave the IJB on 31 March 2017.
 - Edinburgh Integration Joint Board: Carolyn Hirst to join the IJB as Lead NHS Member and Mike Ash to join as member both with effect from 1 February 2017. Kay Blair to leave the IJB on 31 December 2016.
 - Edinburgh Integrated Children’s Services Board: Carolyn Hirst to join the group with effect from 1 February 2017. Kay Blair to leave the group from 31 December 2016.
- 57.6 Healthcare Governance Committee – Revised Terms of Reference – The Board agreed the recommendation from the Healthcare Governance Committee to amend its terms of reference. The changes were being proposed to support the integration agenda, and the ongoing project to ensure the right thing happens in practice every time with respect to clinical policies,
- 57.7 Finance and Resources Committee – Minutes of 30 November 2016 – Endorsed.
- 57.8 Healthcare Governance Committee – Minutes of 29 November 2016 – Endorsed.
- 57.9 East Lothian Integration Joint Board – Minutes of 22 September, 24 November 2016 – Endorsed.
- 57.10 Edinburgh Integration Joint Board – Minutes of 18 November 2016 – Endorsed.
- 57.11 Midlothian Integration Joint Board – Minutes of 27 October 2016 – Endorsed.

Items for Discussion

58. Person Centred Culture

- 58.1 The Board noted that the Person Centred Culture Working Group was chaired by Mrs C Hirst and as part of its membership included the Chairman, the Chief Quality Officer, the Executive Director for Nursing and the Head of Patient Experience Team. The working group had met the previous week and had discussed the implications of the introduction of new legislation for complaints handling from 1 April 2017 which would require clarity about policies and procedures. This would include dialogue with general practitioners as the new ways of working were significantly different.
- 58.2 The Board noted that work continued in respect of collecting patient information. It was noted that volunteers would be written to in respect of ongoing work around the Tell us Ten Things 'TTT' process in respect of undertaking a drive to increase the collection of information as currently there was not a consistent approach adopted to this. It was felt there was a need to embed this approach more into the system and to include this as a performance issue for clinicians and managers. The Corporate Management Team were discussing how best to build this into the 2017/18 objective setting process.
- 58.3 Consideration was currently being given to the infrastructure with visits having been carried out to other organisations at the suggestion of the Scottish Public Services Ombudsman (SPSO) following his meeting with the Chairman and other senior colleagues. Proposals around the infrastructure would be brought back to a future meeting of the Board.
- 58.4 The Board noted that there had been areas of success and improvement work undertaken in conjunction with the SPSO particularly in respect of the Royal Infirmary of Edinburgh approach to the management of complaints. It was noted that the Royal Edinburgh Hospital and prison complaints needed to be considered separately.
- 58.5 Mrs Hirst commented that there was a need to be clear about what the expectation was from the Patient Experience Team and to resource it properly commenting that there were different models of complaints handling in place throughout Scotland. She commented that the work of the working group would consider the short/medium and long term issues affecting the service. In the short term a key objective would be to ensure the smooth introduction of the new legislation and to make the best use of the current team to make these changes and improve the performance outcomes. In order to achieve this there would be a need to change culture with it being noted that there was already good examples in place within NHS Lothian and that real benefits could be obtained through good communication. The excellent work undertaken around the Serious Adverse Event process was shared with the Board with a comment being made that it was important to share learning across the organisation from areas of good practice. It was felt that improved communications and cultural change could help to develop the performance moving forward.

- 58.6 The Board noted in respect of monitoring that the Healthcare Governance Committee received a quarterly report with the Complaints and Feedback Quality Assurance Working Group receiving monthly data. It was noted that work was underway to consider how to present information better and more appropriately to specific audiences. In that regard it would be important to differentiate between the information presented to the Healthcare Governance Committee and the Board bearing in mind the new assurance remit of the Board Committee's. It was noted that the Healthcare Governance Committee had reported on its level of assurance at the previous Board meeting.
- 58.7 The Chair of the Healthcare Governance Committee confirmed that this was an issue that was considered in detail and was a standing item on the agenda. He reported that at the previous Board meeting the Healthcare Governance Committee had been unable to provide assurance to the Board and had asked for a detailed improvement plan to be produced which would be considered at its next meeting.
- 58.8 The Board noted that the nature of the work meant that there would always be increasing levels of complaints and that the pressures of working within this environment were enormous for the staff members concerned. The point was made however that a lot of the information was inconsistent and that for assurance purposes to the Board there was a need to receive confirmation that ongoing work was being delivered. It was noted that the current Board report commented that there were a number of 'no actions required' and it was suggested that this narrative without comment was a potential concern.
- 58.9 The Board were advised that every complaint was dealt with with a number moving forward to the SPSO office. It was noted that the volume of complaints was increasing with a significant number of people complaining about increases in waiting times and general practice access. The point was made that there was also a significant time commitment in dealing with telephone complaints. The new legalisation required a process to capture all complaints.
- 58.10 The Board received an explanation around the classification of no further action against a complaint. It was noted in such instances a significant amount of concerns were addressed through contact at ward level and this approach should be encouraged. The Nurse Director acknowledged that how this information was presented was important and he would reflect upon how this was undertaken for future reports.
- 58.11 The working group had agreed to change the format of the Board report to reflect the assurance requirements needed by the Board and that this would be a different report from the one considered by the Healthcare Governance Committee. In respect of the previous comments it was noted that no further action might be required if a complaint was not upheld and that there was an issue around managing expectations.
- 58.12 The Chairman of the Healthcare Governance Committee explained to the Board in detail the approach taken to obtain assurance. He commented that the committee were fully sighted on the patient experience workstream and recognised the work done by the team although they were not yet assured that all actions had been

taken. It was noted that to provide robust assurance there was a need for reliable data to be available.

- 58.13 The position in respect of the ability of IT systems to support the patient experience process was discussed as was the robustness of the current methodology.
- 58.14 The Board were supportive of the approach to further engage with primary care and noted that work was currently underway through the GP Subcommittee.
- 58.15 The Board noted that following patient feedback via 'wordle' that noise at night had featured as a strong area of feedback and work was being taken forward in wards about how best to manage that position better.
- 58.16 It was noted that to a lay person that the patient experience process represented a confused landscape with it being commented upon from a transformational perspective that there were opportunities regionally or on a Scotland wide basis to make information more meaningful. The question was raised about whether there was a more efficient model that sat out with the NHS family.
- 58.17 The Chief Executive commented that he and the Executive Nurse Director had discussed anxieties around the patient experience performance. In terms of exemplar practice the Nurse Director and Mrs Hirst had visited Greater Glasgow NHS Board where the infrastructure was better both in terms of the size of the team and the grade of staff employed. It was suggested that Lothian had possibly in the past been parsimonious around the resource provided to the patient experience department. It was felt that the transformation of the team would represent a cultural issue although it was felt that the time was probably correct to recognise that the service was under resourced.
- 58.18 The point was made that in cultural terms that face to face interaction was the best way to deal with patient concerns. There was a need to make this part of everybody's business and there was also a need to consider how to look at how complaints were investigated, and produce a standardised template in order to help people to formulate appropriate responses.
- 58.19 The Chairman questioned whether the Board through the Healthcare Governance Committee should work towards the development of an evaluation of quality and structure of information in order to widen the current dimension and also to learn from other experiences. Issues around IT support and input were important and would be taken forward through the Healthcare Governance Committee and the working group Chaired by Mrs Hirst.
- 58.20 The Board agreed the recommendations contained in the circulated paper.

59. 2016/17 Financial Performance

- 59.1 The Board noted that the Director of Finance was managing the position through to the end of the financial year where a breakeven position was anticipated. It was noted that positive good national work was being undertaken to identify increased resources and that this would be reflected in the 2017/18 financial position.

- 59.2 The Board noted that further work continued in respect of nursing agency and bank spend with the proposal being that NHS Lothian would support the creation of a regional bank which would help to address the current shortages in theatres and critical care. A similar exercise would be undertaken in respect of medical locums and agency spend. It was noted that the Nurse Director and the Chair of the Area Clinical Forum were driving national work.
- 59.3 Further work was underway in respect of facilities and property rationalisation and receipts. The work being progressed around climate change also had benefits.
- 59.4 It was reported that drugs expenditure both in the acute and primary sectors remained a huge and significant pressure. There were also pressures evident in respect of junior doctors although the reasons for this were now better understood. Supplies costs remained an area of pressure.
- 59.5 The Director of Finance commented in response to a question that she was more concerned about the prescribing position than junior doctors. She commented in respect of junior doctors that the issues were now known about and targeted efforts were expected to produce benefits. However primary care and hospital prescribing continued on an upward trajectory and despite a number of initiatives within the system these were not obtaining traction quickly enough. Details were provided of a West Lothian prescribing initiative which was adopting a quality approach in terms of the identification of GP levers to influence the prescribing budget. It was noted that GP were being incentivised to participate in the pilot project. An update was provided in respect of the national position and work around prescribing costs with a key issue being in respect of the trend around pricing. The 45 – 60 year age bracket needed further consideration as this cohort of patients were significant consumers of drugs. The Board noted that there was a need to elevate focus around the prescribing position up to and including national level.
- 59.6 The point was made that there might be a need to strengthen the influence of the national procurement team. It was noted however that it was felt that Scotland had enough purchasing power in the global market and that the key issue was to put more pressure on the national perspective through the Chairs, Chief Executives and Directors of Finance National Group. The Chairman commented on the need for upward accountability around some of these issues.
- 59.7 The point was made in respect of the cohort of efficiency savings that in some instances there was no improvement to the baseline. The question was raised whether this was because of lag-time or because some of the savings were now unachievable. The question was raised about whether there was any likelihood of an increased pace around the baseline. The Director of Finance commented that the system was having difficulty in producing more than 50% of savings on a recurrent basis with many of these being largely opportunistic and small scale schemes. The point was made that there was a need to move towards measuring productivity and a need to focus on patient level costing with almost 3 years of data being available already which was useful in measuring actual cost against activity.
- 59.8 The Board noted in respect of the budget allocation letters that there would be a need to reenergise the approach to productivity and efficiency. It was noted that

some measurement ability had been lost when the system had been asked to deliver to the bottom line. It was suggested that this would be a significant issue for 2017/18 and that there would be a need to undertake more effective measurement.

- 59.9 The Board noted from the circulated paper that there was significant variance by business units in the achievement of efficiency with the question being asked around what the next steps would be and how the system would be communicated with in respect of the requirement to meet savings. It was noted that this exercise was normally undertaken through performance meetings and holding each part of the system responsible for managing their own pressures. If pressures were not managed in-year then these rolled forward into the next year. The Board noted that the executive team were looking at efficiency and productivity with a desire to develop a longer term strategy which would need to emerge from finance and include a need for a broader holding to account in future.
- 59.10 The point was made that NHS Lothian was again using the independent sector to provide capacity with a question being raised about when the impact of this was show in the data. In response it was anticipated that the benefit would begin to become evident in the next month. The spend in this area would start to come through the financial reports over the next few months. The Chief Executive commented that this position would not influence the financial breakeven position as reported to the Board.
- 59.11 The Director of Finance in response to a question advised that NHS Lothian had always been transparent about the availability of resources and that all parts of the system were aware that reserves were held. This did however produce a position whereby people felt that the financial position would always be delivered at the end of the year despite how difficult it appeared in year. In terms of the national position it was reported that the Scottish Government were clear that the focus was around the non recurrent position. The Director of Finance commented that this was an issue for Lothian as the system was out of recurrent balance. The Board were advised that a key issue was how to tackle the next 3-5 years in a radically different way as the current financial position was not sustainable. The Chief Executive updated on the outcome of the midyear review process with the Scottish Government. He advised that through these sessions he was conscious that each year he stated that the delivery of financial targets was an impossible task but somehow NHS Lothian always managed to deliver a balanced budget and that this raised issues about the credibility of managing the message. He commented that NHS Lothian was on record as being honest about the scale of the financial challenge facing it. He advised that historically work around financial delivery had been undertaken at the margins. The Chief Executive commented that part of the quality management system was to look at the totality of resources and work with clinicians about how to reduce waste and unwarranted variation thereby suppressing cost.
- 59.12 The Board were advised in terms of the steps taken to close the financial gap in 2016/17 that this had been addressed through increased efficiency savings and a raft of non recurrent sources of funding including balance sheet opportunities. The Director of Finance stressed that the underlying position was deteriorating as reflected in the Auditor General's Annual Report on the NHS in Scotland which had flagged the increased reliance across the system on non recurrent savings. The

Board were advised that a single tangible consequence in the current year of delivering financial breakeven was a deterioration in the performance of the treatment time guarantees with significant spend being undertaken in the independent sector.

59.13 The Board noted that the Scottish Government had commended NHS Lothian on its good financial management.

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

60. 2017/18 Budget Allocation Principles and Process

60.1 The Chairman commented in terms of governance that this particular paper moved into the territory where Board members who served on Integration Joint Boards would have to look at the paper from the perspective of NHS Board members as reflected in their statutory responsibilities.

60.2 The Director of Finance advised that the budget allocation principles process had commenced in November with presentations having been given around the 2017/18 financial position. The position had been reported and discussed twice at the Finance and Resources Committee with a detailed paper having been submitted to the January meeting with the Board paper representing an overview of the discussion at that meeting.

60.3 The Director of Finance commented that at the current meeting she was keen to have agreement around the key principles set out in the circulated paper for distributing the uplift whilst commenting that it would not be possible to finally test the shift in the balance of resources to primary and community care until Scottish Government allocations had been finalised. The Board were advised that the four Local Authority Councils would be meeting in February 2017 to finalise their budgets.

60.4 The Director of Finance advised that the Scottish Government draft budget had been announced on 15 December 2016. This announcement had revised the baseline uplift to 1.5% for territorial Boards of which 1.1% would form a transfer to social care to support continued delivery of the living wage, leaving a net uplift of 0.4% within Boards. It was reported that in order to reflect this additional support provided through the NHS that Local Authorities had been given the flexibility to reduce their contribution to the IJB's by their relative share of £80m. It was noted that discussions were taking place with the local Lothian Authorities to understand their financial planning assumptions.

60.5 The Board were advised that the financial gap to date was c£50m with recurrent and non recurrent resources being identified to bring the savings target down from 6.6% to 5% as required by the Scottish Government. The Board were advised that there were currently 2 main bundles of cost pressures. The first was £33.8m in respect of Local Development Plan forecast costs without budgets that would require to be funded non recurrently. The need to obtain recurrent benefit against these pressures was stressed. In addition there were a number of new cost pressures in 2017 and not all of these would be capable of being funded.

- 60.6 The Director of Finance commented that section 3.10 in the paper set out the principles of the application of available resources with the intention being to try to ensure a reasonable level of efficiency challenge across the whole service and also to show evidence of a shift from acute to primary care funding. As previously reported it was not possible to finalise the allocation at this point as further resource allocations were expected from the Scottish Government although when these were received they would pass straight through to IJB's for health, primary care and health and social care use. It was noted there would be no ambiguity around the use of these funds in the current financial year unlike the position in the previous year.
- 60.7 The Director of Finance advised that she was trying to achieve a reasonable balance of risk to NHS Lothian given its statutory requirement to financially breakeven. The circulated paper detailed the available resources and proposals for utilisation as well as detailing issues around NRAC (National Resource Allocation Committee) and Reserve Funding. The proposal was to fund recurrently the baseline pressures that were funded non recurrently in the previous year.
- 60.8 The Board were advised that a further £10.4m of recurrent funding had been identified. This comprised the £5.4m of uplift at 0.4% and a further £5m from Odel (other departmental expenditure limit funding). It was proposed that this recurrent resource be utilised for pay awards.
- 60.9 The Director of Finance commented that through the generation of non recurring funding that she was reasonably confident that £10m could be generated. Another £4m was expected from Scottish Government allocations which would be used non recurrently.
- 60.10 The Board were advised that whichever option was decided upon that the balance of efficiency would remain within the acute sector.
- 60.11 The Director of Finance advised that the options described in the paper were not exhaustive but intended to illustrate the impact of the distribution of resource on business units and the challenge remaining to achieve balance. In particular it demonstrated that in all options the balance of risk remained within NHS Lothian across acute services, facilities and corporate departments. For this reason it was recommended that option 1 was implemented. The Board noted that appendices 1 and 2 of the circulated paper showed the impact of budget increases for each of the services across NHS Lothian including partnership and included adult social care. This information would work its way through into the model that set the IJB budget.
- 60.12 The Director of Finance advised that the next steps following the Board meeting and subject to its agreement to the principles and the recommended option would be to issue budget allocation letters by mid February. This would be inline with Council budget setting timescales. In parallel work would continue on the financial plan to support the Local Delivery Plan although it was important to recognise that the Board was not in financial balance at this point.
- 60.13 A question was raised in respect of the Local Authority flexibility to reduce their contribution to the IJBs by their relative share of £80m and what the impact of this would be on NHS Lothian. The Director of Finance advised that it was her

understanding that the four Local Authorities in Lothian were not proposing to use that opportunity although she would keep the Board updated if that position changed.

- 60.14 The point was made that under the recommendations and in terms of shifting the balance of resources to primary and community care that this should have an associated timeline as there was a feeling that progress to date had been slow and there was not any evidence that the pace would quicken in 2017/18. The point was made that pressures continued to grow in the acute sector and it would be important that appropriate messages were sent in to the system. The Board were advised that discussions were ongoing with Chief Officers of the IJBs and also with colleagues in the acute sector about the need for a 24/7 approach to future service provision.
- 60.15 The Board were advised that when any shift from the acute into primary care sectors happened there would be a need to evidence what the benefits were. It was suggested that the evolving performance framework would help to provide assurance in this area.
- 60.16 The point was made that the plan as detailed by the Director of Finance provided financial assurance. The question was raised however about whether there were any major issues or pressures that might come to the fore and cause concern. The Board were advised that a key issue was performance around access targets and the plan allowed for investment in this area. A significant area of ongoing concern was around outpatient numbers and how these translated into day cases and inpatients and the impact of this given the constraints on physical capacity. The point was made however that the NHS system was full and that this limited options. The Board were also advised that there was a limit to where additional money could be expended other than in the independent sector.
- 60.17 A point of clarity was sought in respect of the statement that the approach to be taken for 2017/18 financial plan was consistent with last years methodology and intended to strengthen the link between business unit plans and financial balance through the development of individual forecast and specific action plans at business unit level. The approach also recognised the Boards role in relation to the preparation of budgets for Integration Joint Boards. The Director of Finance advised that this approach was based on partnerships and current budgets and how they were approaching efficiency savings. The next stage would be to translate this to IJB budgets and to look for IJBs and NHS Lothian to understand the impact of the strategic plan. The Director of Finance advised that proposals would require to go to the IJBs and they would require to give Directions to the Board if they wanted to do something differently from that outlined in the strategic plan. The Board were advised that discussions were already happening and meetings with IJB Chief Officers were being held on a routine basis.
- 60.18 The point was made that table 3 in the circulated paper detailed additional costs around issues like insulin pumps which were delegated functions and would therefore require discussion with IJBs. The Board were advised that the detail in table 3 was unfunded and was an estimate of pressures which were not yet budgeted for and remained estimates of pressures in the system.
- 60.19 The question was raised in respect of the protection of the IJB budgets as per the Scottish Government direction particularly in relation to primary care and mental

health whether this included set a side elements of the IJB budget. The Director of Finance would clarify.

- 60.20 The point was made in terms of process that the letter to IJBs would be the beginning of discussions and that the direction of travel could change. The Director of Finance advised that the letter to IJBs would be about the allocation of budgets. The point was made that the process needed to be about Directions that IJBs needed to give NHS Lothian to reflect their allocation. The timeframe for work moving forward would be linked to the Local Delivery Plan the first draft of which would be required by the end of March 2017. It was noted that dialogue had been held with Chief Officers and Council colleagues.
- 60.21 The Director of Finance in response to a question advised that she would like each IJB to have a three year financial perspective as there was a need to do things differently in future to move towards a sustainable financial position. She advised that attempts were being made through informed discussions to look ahead and consider how the current year's position supported the collective view.
- 60.22 Dr Williams commented in respect of the third recommendation that as a Board member he felt that the strategy should be to shift care to the community and that all aspects of service should be about achieving that position. He commented that historically the prescribing budget was less than spend and that the current proposals were not closing the gap and he felt there was a need to increase budgets to a level of known spend. He felt as a Board there was a need to close the prescribing gap at the same time as sustaining primary care to recognise the previous points made about the acute sector. Dr Williams felt that option 2 demonstrated a process of resource shift and not option 1. Councillor Henderson advised that he supported Dr Williams and that option 2 would make more sense given previous Board discussion. He advised that the Edinburgh IJB would suffer disparity under option 1.
- 60.23 The point was made that the Scottish Government was expecting 5% efficiency from NHS Boards and that NHS Lothian would need to mitigate this position. The point was made that previously NHS Lothian had achieved 2% efficiency and that there had been several years of anticipated saving without changing the service. The point was made that the achievement of a 5% efficiency saving was an extremely challenging target and that the Board would be looking for assurance that a plan was in place to achieve that in a way which avoided past problems of recycling current efficiency savings. The Director of Finance reiterated her previous point that the NHS Lothian financial position was not a sustainable one and that the Executive Team were working on a 3-5 year plan to create sustainable solutions and this debate would include IJB Chief Officers. The Board were advised that across Scotland all NHS Boards were in a similar position. NHS Lothian were working with partnerships across the region. The point was made that there was a need to revert back to the Board to provide assurance around future financial performance with the point being made that on a UK wide basis that public sector investment programmes would worsen.
- 60.24 The Vice Chair commented in respect of table 3 what the position was in respect of Information Technology as she had heard many people raising this as a priority area for investment. In response the Board were advised that this was an area where

there was a significant gap and that the issue was being addressed through the capital plan and that this represented another financial gap. The Director of Finance advised that there was an aspiration to identify resource although the system was not yet in a position to have a strategy in place.

- 60.25 The question was raised if acute pressures continued for example around hip replacements whether it would be reasonable for the Board to consider not undertaking acute interventions if acceptable community care was available. It was noted that issues like this would be part of the ongoing realistic medicine debate.
- 60.26 The Chief Executive commented that at one level the debate was about semantics as all of the financial risk lay with NHS Lothian. He reminded the Board that currently there was not sufficient resource to pay for drugs and that debate between the Board and IJBs related to the same group of patients. He commented that option 2 did not prevent the Board from having to bear the cost of acute drugs approved by The Scottish Medicines Consortium. The Board were advised that the desire was still to shift a balance of care and that this would form part of the Board Development Session in March and that this might be about stopping doing procedures in the acute care where these could be provided in the community although it was important to recognise that people would still want to receive the drugs approved by the Scottish Medicines Consortium. The Chief Executive advised that the forecast of cost growth represented a gap that was not yet bridgeable. He commented that the Board had a duty to distribute resource in an equitable and fair way that did not demoralise the system by setting unachievable targets. He reminded the Board that NHS Lothian would only receive 0.5% as an uplift with more than double that going into IJBs. He commented that the intention of the circulated paper was to try and agree principles and through that process develop a bigger picture that would ensure that resource was shifted. The Board were reminded that NHS Lothian remained responsible for covering financial gaps. The Chief Executive reminded the Board that the Executive Team were in direct dialogue with IJB Chief Officers and Council and through these discussions the IJB and Council would set budgets as would NHS Lothian. The Chief Executive reminded colleagues that there would be an opportunity at the Board Development Session in March to discuss views further although this should not be regarded as a negotiation opportunity or vehicle. The Board were reminded that there was a need to submit the Local Delivery Plan in April after the Board meeting and that the total income available to the Board was unlikely to change except for receipt of allocations around the primary care and the mental health fund.
- 60.27 The Chairman commented that although the debate had been interesting there was a need to establish a basis on which to progress.
- 60.28 The Board were advised that the paper had been discussed with IJB Chief Officers and Section 95 Finance Officers who were comfortable with the paper and understood the principles contained within it. All Chief Officers had been concerned about prescribing although it was noted that NHS Lothian was covering the overspend. Councillor Henderson commented that he was inclined to support option 2. The Chief Executive commented that he would propose supporting option 1 with IJBs having further ability to reflect on this not least at the Board Development Session in March 2017. He pointed out that IJBs were part of the process and would need to discuss the proposals and be comfortable with them on the basis of ongoing

dialogue round the propositions set out in option 1. The Board noted that further dialogue was needed around prescribing.

60.29 Dr Williams commented that the issue was not about GP prescribing but about primary care prescribing. He commented as the GP stakeholder he did not support option 1 although he heard what the Chief Executive stated in respect of further dialogue. He reiterated as GP advisor he could not support option 1.

60.30 The point was made that it would be helpful to have more information around the impact of each of the options on the delivery of service as well as an explanation of the differences under each of the available options.

60.31 The question was raised about whether the discussion was around issues that would affect patient care. The Chief Executive advised that this was not the case and that if general practitioners and other professionals prescribed drugs then NHS Lothian would require to bear the cost. He commented that there was a need to set targets which would drive and squeeze efficiency around issues like prescribing although it would be important not to set targets which were too difficult and would result in demoralising engagement. He commented that a reasonable balance of risk was the key principle. The Chief Executive commented that the fundamental problem was that the 0.5% uplift did not even cover pay award costs and would not even start to address the prescribing position. He commented that there was a need to set budgets that incentivised real management of prescribing even although it was recognised that the NHS in general was a good prescriber. He felt however that there would still be some waste within in the system and that some work was being done to move to a point of dialogue around what was going to be done to address waste and inefficiencies.

60.32 The Chairman commented that he felt from the debate that recommendation 3 in the paper was too firm and should be changed to reflect that the Board agreed to take forward proposals as described in option 1 with stakeholder engagement with outputs coming back to a future Board meeting.

60.33 The Chief Executive commented that the key issue was around how best to use available resource to meet the prescribing pressures in primary care and the acute sector.

60.34 The Chief Executive commented that it was important that the principles were agreed in order to ensure that budget letters were issued based on option 1 subject to further dialogue about how to use the available resource around prescribing pressures. The Board agreed this approach.

60.35 The Board agreed the recommendations contained in the circulated paper subject to the amendments suggested around recommendation 3.

61. Quality and Performance Improvement

61.1 The Board were advised that the draft Local Delivery Plan required to be submitted to the Scottish Government by the end of March 2017 and would need to include IJB Directions as well as reflecting regional input. The final version of the LDP would require to be submitted by the end of September.

- 61.2 It was noted that the outcome of the recent review undertaken by Professor Sir Harry Burns was not yet known and would not be available until the end of March and would need to be reflected in any submission. The Board noted that if NHS Lothian was not meeting its target then the new Committee assurance process would consider the work needed to ensure that targets were met.
- 61.3 The Board noted that at the midyear review with the Scottish Government that outpatients and the treatment time guarantee had been discussed as well as work around the 2017/18 trajectory. Work was being undertaken by the Acting Chief Operating Officer around the management of risk. It was noted that it was intended to provide the Board with future assurance around this process and to demonstrate no diminution to patient care. It was noted that diagnostics and gastrointestinal medicine would be looked at in the first instance as these were the area of largest value and least capacity.
- 61.4 The Board noted that the Healthcare Governance Committee continued to seek assurance around the Child and Adolescent Mental Health (CAMHS) performance where there had been a reduction in the number of 18 week waits.
- 61.5 Delayed discharges remained an area of significant focus particularly in respect of patient flows and patient care and safety. The action plan around delayed discharges would require to be part of the LDP submission agreed by the Board.
- 61.6 The point was made that the report in respect of CAMHS provided the Board with limited assurance given the position in relation to the rest of Scotland. The point was made that the Healthcare Governance Committee were maintaining a key focus around CAMHS with a view to reducing the backlog and looking at referrals. Positive work had been undertaken around reducing the number of longest waits. The Board were assured that any child that required to be seen urgently would be seen.
- 61.7 The Board noted in respect of outpatients that a combination of issues were at play particularly in respect of the rates of urgent patients. There was also an issue about chronic disease with there being a need to increase return capacity. Significant staff absences had also meant there had been a reduction in available capacity. The Board were reminded that the LDP for 2016/17 was characterised by the decision to step away from the independent sector which had had a significant impact. The Board were advised that essentially what was happening was that the predicted trend from ceasing independent sector engagement was now coming to fruition. The Board were advised however that this did not take away from the clinical governance aspects of people having to wait longer than desirable.
- 61.8 Work was underway within specialties to set processes to allow tests to be reviewed to identify people needing urgent treatment although it was important to recognise that this impacted on the next in line point on the list.
- 61.9 The Board noted that the narrative around cardiac arrests did not provide any assurance with it being noted that the system was moving to the end of year 3 of a 4 year programme. The Board were advised that a detailed paper would be submitted to the next meeting of the Healthcare Governance Committee around the lower level of 10% and assurance would be provided when available. Following the discussions

at the next meeting of the Healthcare Governance Committee a level of assurance would be applied.

- 61.10 The point was made in respect of Board assurance that for future meetings it would be useful to have more detail about what was discussed at Board Committee meetings through summary reports as there was a need for more assurance around the issues that were being considered.
- 61.11 It was reported that although assurance reporting was welcome and useful it would be beneficial to obtain the views of other Board members.
- 61.12 Dr Williams as Chair of the Healthcare Governance Committee commented that following discussions it had been agreed that papers to governance committees were expected to demonstrate evidence around assurance levels. If this was not demonstrated then an escalation paper would be submitted to the Board.
- 61.13 The Chief Executive commented that at the midyear review the approach had been to prioritise those on the waiting list to determine the relative need of patients on the list. A process was underway to look at the very long waiters and to consider a prioritisation process for these patients. He commented that there was a need to report to the Board on a nuance standard around what was a reasonable and sensible approach even although it would not ever be possible to meet the HEAT standard in full.
- 61.14 The Chairman advised that Board Chairs would be meeting with Sir Harry Burns to receive detail of the outcome of his review although it was not expected that this would produce immediate relief in terms of the requirement to meet targets.
- 61.15 The recommendations contained in the circulated report were agreed.

62. Healthcare Associated Infection

- 62.1 The Board were advised that this was the last time that a separate paper would be discussed at the Board as the issue was covered in detail at the Healthcare Governance Committee. Performance would be recorded as part of the quality improvement report in future.
- 62.2 The Board noted that NHS Lothian had exceeded its targets around clostridium difficile which had been achieved through strong acute sector leadership particularly in respect of changes to the antibiotic prescribing policy. Although the staphylococcus aureus bacteraemia targets were not being met NHS Lothian was no longer an outlier and the position had improved significantly from 12 months previously.
- 62.3 The Board noted that work was underway in respect of skin ulcers and diabetic foot ulcers where it was felt that a better treatment model would improve the position in respect of staphylococcus aureus bacteraemia rates.

63. Sustainable Development Action Plan

- 63.1 The Board noted that the paper on the Climate Change Act which had been introduced in November 2015 which required public sector bodies to submit a climate change report and action plan. The Board noted that NHS Lothian through their facilities team were already at the forefront of work in this area within Scotland.
- 63.2 The Board noted that the prioritisation given in the circulated paper referred to the sustainable action plan submitted to the Scottish Government. The Director of Facilities provided the Board with a detailed explanation of technical aspects of the paper.
- 63.3 The question was raised whether the use of renewable energy sources was an ambition that the Board was signed up to in respect of new and current estate. Examples were provided of many forms of renewable energy used within NHS Lothian with it being pointed out that the reduction of the use of fossil fuels had been an area of significant focus. There had also been an increase in the use of solar UV panels which now generated up to 25% of energy use. In addition when the Board was buying energy it ensured that 25% of this was obtained through a renewable energy source. It was noted that NHS Lothian was at the top end of performers in this area within Scotland. Attempts should be made to ensure new projects should become cost neutral over time and that this requirement would be build into new buildings.
- 63.4 The Board were advised in respect of new developments that currently there was a requirement to ensure a 20% renewable energy quota. It was reported however that it would not be possible to achieve a carbon neutral base because of issues around procurement including drugs etc.
- 63.5 The action plan would be amended to reflect transport fleet and energy source issues. In terms of assurance it was noted that progress was reported internally and that 2 of the HEAT targets related directly to this issue.
- 63.6 The point was made there was a 2030 target to mitigate the impact of climate change and this would link to financial sustainability. It was suggested that either annual or bi-annual reports to the Board should be considered to demonstrate sustainability.
- 63.7 The Bike Club Scheme for staff was welcomed with the point being made that a similar emphasis should be made for visitors to use bikes particularly at St John's Hospital. It was agreed that the Acting Chief Operating Officer would look to improve this position through the already established group looking at healthy working lives.
- 63.8 The point was made that there was huge potential for staff and patient and relative engagement with there being opportunities for people to come forward with ideas for transformation. This would link to the need for better internal communications.
- 63.9 The Board agreed the action plan and the recommendations contained in the circulated paper.

64. Redesign of Eye Services in Lothian Including the Reprovision of the Princess Alexandra Eye Pavilion

- 64.1 The Board noted that the revised Initial Agreement for the redesign of ophthalmology services including the reprovision of the Princess Alexandra Eye Pavilion had been submitted to the Scottish Government Capital Investment Team in December 2016 for consideration at the Capital Investment Group meeting on 10 January 2017 the outcome of which was awaited. This submission had been made following the oversight of the Finance and Resources Committee which had ensured that the development was future proofed.
- 64.2 The Board were advised of the input of the Scottish Government Access Team in respect of elective centre developments and further noted the work being undertaken around redesigning the workforce in order to optimise the input of staff groups to deal with people with the highest need.
- 64.3 Community Optometry Partners were being engaged to maximise community care. The Board were advised that the Initial Agreement would allow improved productivity and efficiency through eye care and the provision of the new building.
- 64.4 The Board noted that the proposal assumed ongoing continuation of the current service level agreement with the NHS Golden Jubilee Hospital and that the national group overseeing elective centres and terms and conditions would be consulted at the appropriate time.
- 64.5 The Board were advised that revenue consequences would start to be firmed up through the development of the Outline Business Case and would be built into a financial strategy with there being an expectation that a contribution would come from the regional aspect. It was pointed out however that there would be an ongoing revenue issue as the replacement building was larger than the existing facility.
- 64.6 The Board noted the need for a new eye pavilion although the comment was made that there was little mention of community service redesign and the increased use of community facilities. The Board were advised in response that there had been significant work undertaken with community ophthalmology including a detailed audit of glaucoma and how to risk manage this in the community through self help opportunities. The redesign proposals were about reducing demand into the acute sector and increasing community engagement to help self help opportunities. This would be made more explicit in the Outline Business Case.
- 64.7 The point was made that the use of the survey detailed in the paper was welcomed and that the response rate of 54% had been excellent. It would be important however through the redevelopment of services not to lose the benefits of good work already evident within the system especially in terms of the outcomes of the patient survey from which it would be important to learn lessons. The Board were advised that the 'Tell Us Ten Things' exercise had not been undertaken in the Princess Alexandra Eye Pavilion previously and that leadership were now using this as a tool to receive information and feedback. The Chairman commented that the point raised mirrored debate at the Healthcare Governance Committee about mutual benefit.

- 64.8 The Deputy Chief Executive assured the Board that the new process sat within the acute hospitals plan and represented part of the wider modern acute service. The Board were reminded that currently a significant amount of ophthalmology provision was provided at St Johns Hospital and that this would continue with an area being refurbished to increase the available capacity. The new building would allow changes in IT infrastructure to deliver a transformational agenda.
- 64.9 The Board were advised that part of the redesign work included detailed engagement with ehealth to allow different ways of managing outpatients. The Outline Business Case would enhance and build on the relationship for further redesign opportunities.
- 64.10 The point was made that there was a need for clarity of function between hospital doctor requirement and opticians in the community in order to minimise the risk of wasted hospital appointments. The Board were advised that in future the first point of contact would be through community facilities and that there was a need to look at pathways in the community to ensure education and awareness in future.
- 64.11 The Board agreed the recommendations contained in the circulated paper.

65. Date and Time of Next Meeting

- 65.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 5 April 2017 in the Scottish Health Services Centre, Crewe Road, Edinburgh.

66. Invoking of Standing Order 4.8

- 66.1 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.

RUNNING ACTION NOTE

Action Required	Lead	Due Date	Action Taken / Outcome	Outcome
<u>Delayed Discharges</u>				
<ul style="list-style-type: none"> 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	<i>For IJB Chief Officers to address</i>	
<u>Quality and Performance Improvement</u>				
<ul style="list-style-type: none"> The Chairman advised that Board Chairs would be meeting with Sir Harry Burns to receive detail of the outcome of his review although it was not expected that this would produce immediate relief in terms of the requirement to meet targets. 	BH	<i>June 2017</i>		
<u>Person Centred Culture</u>				
<ul style="list-style-type: none"> 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	<i>Action Plan being progressed</i>	
<u>NHS Lothian Quarterly Directorate Progress and Next Steps 2016/17</u>				
<ul style="list-style-type: none"> To develop a specific information session for Board Members. 	SW	5 April 2017		
<u>2017/18 Budget Allocation Principles and Process</u>				
<ul style="list-style-type: none"> Board agreed to take forward proposals as described in option 1 with stakeholder engagement with outputs coming back to a future Board meeting. 	SG			

SUMMARY PAPER – NHS Lothian Corporate Risk Register

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

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

<ul style="list-style-type: none">• Use the risks in the Corporate Risk Register to inform assurance requirements and provide context for papers and issues discussed on the Board agenda.	2.1
<ul style="list-style-type: none">• Note the actions being undertaken in response to the February 2017 Audit & Risk Committee requests.	3.2.10
<ul style="list-style-type: none">• The reporting (Table 2) 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.	3.3.1

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15 March 2017
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NHS Lothian

Board
5 April 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 Accept this paper as 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, and to inform assurance requirements
- 2.2 Acknowledge that as a system of control, the Governance committees of the Board have been asked to assess the level of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

3 Discussion of Key Issues

- 3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risks are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.
- 3.2 This report sets out the Quarter 3 position. Table 1 below provides a summary of the corporate risks and movement in risk grading over last 4 quarters. Appendix 1 provides additional details of each individual risk on the Corporate Risk Register. When a risk's adequacy of control is inadequate or uncertain, the rationale is stated on the individual risk.

3.2.1 There are 13 risks in total, with one risk: Patient Experience – Management of Complaints & Feedback, being increased from High to Very High (20) in Quarter 2; the top 5 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. **Achieving the Delayed Discharge targets at 2 and 4 weeks ***
4. **General Practice Sustainability**
5. Patient Experience – Management of Complaints & Feedback

* Outwith risk appetite as illustrated in Table 2 on page 5.

3.2.2 The Risk Management Steering Group (RMSG), through the executive lead for each risk, examined very high risks in detail to assess risk both individually and across risks. The review concluded that the four very high risks set out above in bold remained very high and the rationale was reported to the September Healthcare Governance Committee, September Audit & Risk Committee and October Board. The Corporate Risk Register continues to be examined on a monthly basis through the RMSG, chaired by the Chief Executive.

3.2.3 The Board needs to assure itself 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.

3.2.4 The Patient Experience risk – Management of Complaints & Feedback was increased to Very High 20 in Quarter 2, following a meeting with the Scottish Public Services Ombudsman (SPSO). The SPSO highlighted a number of areas that required improvement with respect to the management of complaints. A programme of improvement in response to the SPSO recommendations has been drawn up. The HCG Committee in January 2017 reviewed this risk and agreed it will continue to be a key item on its agenda to inform assurance requirements, as at present there are assurance gaps. A paper at the March 2017 HCG Committee set out the improvement plan for the management and learning from complaints. The Committee concluded that moderate assurance could be drawn with respect to there being an improvement plan in place. At present, however, it was unclear if the newly established plan would lead to an improvement, and as such members agreed to review every second meeting to allow time for progress to be made between updates.

3.2.5 The General Practice Sustainability risk was discussed at the November 2016 HCG Committee and December 2016 Board. When discussed at the November 2016 HCG, it was agreed that there was limited assurance that controls were in place to address this risk and there would be a further update at the meeting in January 2017, including impact on service provision supported by data if possible. A paper was presented at the March 2017 HCG and limited assurance was provided as there was no plan in place to mitigate this risk. The committee requested the plan for the next meeting in May 2017.

- 3.2.6 Delayed Discharges have been identified by the HCG committee as a complex area that requires further discussion, acknowledging there is an assurance gap at present. The Chief Operating Officer was asked to bring back a paper to the January HCG Committee to inform assurance needs. The paper was well received and members agreed that they received significant assurance that controls were in place to monitor delayed discharges. However, there is limited assurance that at present actions in place would mitigate the risk to the Board.
- 3.2.7 Financial Sustainability risk is overseen by the Finance & Resources Committee (F&R), Audit & Risk Committee and Board. Recovery plans have been submitted to both the F&R Committee and the Board, along with Board Development days. This risk remains very high in response to issues of financial sustainability. The rationale for this is set out in the detailed risk in Appendix 1.
- 3.2.8 Achieving the 4-hour Emergency Target risk. Should the current target continue to be met in a sustained manner, there will be a recommendation to reduce its risk score when reviewed in Quarter 3. The present data has not shown sustained improvement and as such it remains Very High.
- 3.2.9 Nursing Workforce – Safe Staffing Levels risk was reduced in Quarter 2 from High 16 to Medium 9. The rationale for this is that the risk associated with safe staffing levels is reducing, with the exception of district nursing due to a range of interventions including the recruitment plan. This grading, however, is under review. The HCG Committee in March 2017 considered this risk and received Moderate assurance that measures were in place to mitigate this risk.
- 3.2.10 The February 2017 Audit & Risk Committee recommended a number of actions to enhance the Risk Register report which are being progressed and are summarised below:-
- To confirm that the governance committees of the Board were using the Risk Register to inform agenda planning and are seeking assurance that the actions described will reduce the Board's exposure to the identified risks to an acceptable level within accepted timescales.
Action: Committee Chairs have been asked to confirm the above and if required, further discussions to take place through the Chairs Group.
 - The Committee asked that risks such as Delayed Discharges and GP Sustainability be reviewed in light of Integration Joint Boards.
Action: This was discussed at the March 2017 RMSG. It was agreed that these risks needed to be rewritten to set out the impact from both the perspective of NHS Lothian Board which is responsible for delivery through the H&SCP and the impact on achieving IJB strategic plans. It was suggested that these risks need to be visible on Board, H&SCP and IJB risk registers. This will be initially discussed with the Joint Officers.
- 3.2.11 If you have an electronic version of this report, links to each risk in Appendix 1 have been embedded in the below table (please click on individual Datix risk number in the table).

Table 1

Datix ID	Risk Title	Initial Risk Level	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Oct-Dec 2016
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)	High 12	Very High 20	Very High 20	Very High 20	Very High 20
3203	Achieving the 4 hour emergency target (Acute Services Committee) (Set out in Quality & Performance Improvement Report)	High 10	Very High 20	Very High 20	Very High 20	Very High 20
3726	Achieving the Delayed Discharge targets at 2 weeks (New areas for HCG Committee) (Set out in Quality & Performance Improvement Report)	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	General Practice Sustainability (new risk – October 2015) (HCG Committee)	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3454	Patient Experience – Management of Complaints and Feedback (HCG Committee) (Set out in Quality & Performance Improvement Report)	High 12	High 16	High 16	Very High 20	Very High 20
1076	Healthcare Associated Infection (HCG Committee) (Set out in Quality & Performance Improvement Report)	High 12	High 16	High 16	High 16	High 16
3480	Patient Safety - Delivery of four SPSP Work streams. (HCG Committee & Acute Services Committee) (Set out in Quality & Performance Improvement Report)	High 16	High 16	High 16	High 16	High 16
3211	Achievement of National Waiting Times Targets (Acute Services Committee) (Set out in Quality & Performance Improvement Report)	High 12	High 16	High 16	High 16	High 16
3527	Medical Workforce Sustainability (Workforce assessment reported to Board) (HCG Committee)	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)	High 15	High 16	High 16	High 16	High 16

Datix ID	Risk Title	Initial Risk Level	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Oct-Dec 2016
3455	Health & Safety – Management of Violence & Aggression. (Reported at H&S Committee, via Staff Governance Committee)	Medium 9	High 15	High 15	High 15	High 15
3828	Nursing Workforce – Safe Staffing Levels (HCG Committee)	High 12	High 12	High 16	Medium 9	Medium 9
3328	Roadway / Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee, via Staff Governance Committee)	High 12	High 12	High 12	High 12	High 12

3.3 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 2 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 2

	Current Status	Current Position	Data Report
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.2 Deliver Safe Care) Low Risk Appetite			
<ul style="list-style-type: none"> 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)
<ul style="list-style-type: none"> 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)
<ul style="list-style-type: none"> Achieve 184 or fewer SAB by March 2016 with a tolerance of 95% against target. n=193 to 184 	Red	220	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> Achieve 262 or fewer C.Diff by March 2016 with a tolerance of 95% against target. n=275 to 262 	Green	201	Quality & Performance Improvement Report (HCG Committee)

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

	Current Status	Current Position	Data Report
<ul style="list-style-type: none"> Reduce falls with harm by 20% with a tolerance of 15-20% by March 2017 	Green	53%	Quality & Performance Improvement Report (HCG Committee)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.1 Deliver Person-centred Care) Low Risk Appetite			
<ul style="list-style-type: none"> Patients would rate out of 10 their care experience as 9, with a tolerance of 8.5 	Amber	8.64	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> 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)
<ul style="list-style-type: none"> Staff absence below 4% with a 5% tolerance (4.2%) 	Red	5.45%	Quality & Performance Improvement Report Staff Governance Committee)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.4 Scheduled Care & Waiting Times) Low Risk Appetite			
<ul style="list-style-type: none"> 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90% 	Red	79.3%	Quality & Performance Improvement Report (Acute Hospitals Committee)
<ul style="list-style-type: none"> 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95% 	Red	88.7%	Quality & Performance Improvement Report (Acute Hospitals Committee)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.3 Appropriate Unscheduled Care) Low Risk Appetite			
<ul style="list-style-type: none"> 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98% 	Green	93.2%	Quality & Performance Improvement Report (Acute Hospitals Committee)
<ul style="list-style-type: none"> No patients will wait no more than 14 days to be discharged by April 2015 with an appetite of 14 days, and a tolerance of 15 days * 	Red	230	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> 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%. 	Amber	72.8%	Quality & Performance Improvement Report for management actions (Acute Hospitals Committee)
Corporate Objective 1 – Protect & Improve the Health of the Population. Medium Risk Appetite			
<ul style="list-style-type: none"> Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas, with a 10% tolerance (36-40%). (Target = 293 	Red	235	Quality & Performance Improvement Report (HCG Committee)

	Current Status	Current Position	Data Report
minimum per quarter).			
<ul style="list-style-type: none"> 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 – 88.8%	Quality & Performance Improvement Report (HCG Committee)
Corporate Objective 3 – Secure Value & Financial Sustainability (LDP 2015-16 – 3.1 Financial Planning)			
Medium Risk Appetite			
<ul style="list-style-type: none"> In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5% 	Green	£892k underspend at period 11 equating to 0.7%	Period 11 Finance Report (Finance & Resources Committee)
<ul style="list-style-type: none"> For the year to date, the overspend against the total core budget for the year to date is not more than 0.1% 	Red	£1,423k overspent for the year-to-date, equating to 0.1%	Period 11 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.

3.3.1 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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15 March 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.	<p>NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target.</p> <p>On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years.</p> <p>If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.</p>	<p>The Board has already established a financial governance framework and systems of financial control.</p> <p>NHS Lothian is currently reliant on non-recurring efficiency savings. A detailed Action Plan, attached to this risk, is in place and is regularly reviewed by the Senior Finance Team.</p> <p>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.</p>	<p>Risk reviewed December 2016: Following the Q2 review, there is no revision to the September 2016 update.</p> <p>The Q1 review reports that, if the identified efficiency schemes are achieved and non-recurring funding is utilised, then the Board expects to achieve financial balance in 2016/17.</p> <p>However, current plans show that financial balance will not be achieved in 2017/18, Service managers are being encouraged to think long term and the Finance Director plans many sessions across all the main NHS Lothian sites to present the financial position to service managers and clinicians.</p> <p>The key focus for 2017/18 will be to support the Board to deliver a medium term Financial Plan that identifies how NHS Lothian achieves recurring financial balance.</p> <p>Risk grading/rating remains Very High/20.</p>	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Craig Marriott	Finance & Resource Committee

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
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	<p>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.</p>	<p>A range of governance controls are in place for Unscheduled Care notably:</p> <ul style="list-style-type: none"> - 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 <p>NHS Lothian's Winter Planning Project Board is now established as NHS Lothian Unscheduled Care Committee in collaboration with the Integrated Joint Boards to promote sustainability of good performance all year round</p> <p>A number of performance metrics are considered and reviewed, including:</p> <ul style="list-style-type: none"> - 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 <p>Adherence to national guidance/ recommendations</p> <p>Plethora of work now focussed around the Scottish Government's <i>6 Essential Actions</i> initiative to support achievement of 95% target (stretch target of 98%) for 4 hour performance.</p>	<p>Risk Reviewed: January 2017 Risk Grade/Rating remains Very High/20</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>The above has been absorbed as part of approach to winter planning, led by NHSL UCC Committee. The approved Winter Plan outlines the approach to supporting performance over the winter period and beyond. This reflects a number of actions namely:</p> <ul style="list-style-type: none"> • Winter Readiness plans in place for each site • Plans will have a focus 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 <p>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.</p> <p>The Winter Planning Board was established 2016/17 as NHS Lothian Unscheduled Care Committee to enhance performance as a collaborative response all year round.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jacquie Campbell	Angela Tuohy	Acute Services Committee

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
3726	2: Improve the quality and safety of health care	Unscheduled Care: Delayed Discharge	<p>There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.</p>	<p>A range of governance controls are in place for Unscheduled Care notably:</p> <p>NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area.</p> <p>The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a fortnightly basis</p> <p>The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings.</p> <p>Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON</p> <p>NHS Lothian's Winter Planning Project Board is now established as the NHSL Unscheduled Care Committee in collaboration with the Integrated Joint Boards</p> <p>NHS Lothian strategy to improve unscheduled care performance and delayed discharge is being delivered under the umbrella of the Scottish Government's 6 Essential Actions initiative.</p>	<p>Risk Reviewed: January 2017: Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include:</p> <ul style="list-style-type: none"> • 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, chaired by WLH&SCP • 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 <p>The Winter Planning Board/ NHS Lothian Unscheduled Care Committee are overseeing the necessary actions in support of sustained performance during the winter period and beyond. Lothian's approved Winter Plan sets out the key requirements in supporting service delivery and access performance during winter and beyond. Actions include:</p> <ul style="list-style-type: none"> • 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	Low 1	Jacque Campbell	Angela Tuohy	Acute Services Committee in partnership with IJBs

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3829	2: Improve the quality and safety of health care	GP Workforce Sustainability	<p>There is a risk that the Board will be unable to meet its duty to provide access to primary medical services for its population due to increasing population combined with difficulties in recruiting and retaining general practitioners, staffing and premises difficulties. This may affect:</p> <ul style="list-style-type: none"> - ability of practices to accept new patients (restricted lists); - patients not being able to register with the practice of their choice; - ability to successfully fill practice vacancies; - ability to cover planned or unplanned absence from practice; - ability to safely cover care homes; and <p>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;</p> <ul style="list-style-type: none"> - other parts of the health and social care system eg secondary care, referrals, costs <p>As a result of these pressures practices may choose to return their GMS contracts to the NHS Board.</p>	<ol style="list-style-type: none"> 1. PCCO maintain a list of restrictions to identify potential and actual pressures on the system – this is shared with HSCPs and taken to PCJMG monthly. 2. Closure position set out in regulatory framework. 3. Ability to assign patients through PSD. 4. HSCP development of risk register for general practice. 5. "Buddy practices" through business continuity arrangements. 6. PCJMG review the position monthly with practices experiencing most difficulties. 7. Primary Care propositions in strategic plan – updates reported to Board and Strategic Planning Committee. 8. Risk reflected on IJBs and PCCO Risk Registers. 9. Primary Care Summit on 29 September 2016 to agree a joint set of priorities for primary care (NHS Lothian and the IJBs). 10. NHS Lothian proposed investment of £5m over three years from 2017/18 to address the key pressures. <p>Rational for Adequacy of Controls In development</p>	<p>Risk Reviewed: November 2016</p> <p>Description & Controls in place updated.</p> <p>Risk Grade/Rating remains Very High/20</p>	Inadequate; control is not designed to properly manage the risk and further controls and measures are required.	Very High 20	High 16	Tracey Gillies	David Small	Healthcare Governance Committee

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
3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care. 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 and waiting times. This includes the management of and learning from complaints.	<ul style="list-style-type: none"> NHS Lothian Board approved in full the Listening and Learning form Feedback and Complaints report (Jan 2015) that agreed to a devolved approach to complaints and feedback. The Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical adverse event reporting and response. The National Person Centred Health & Care Collaborative has been concluded and work is being undertaken nationally to embed patient experience into the existing quality improvement programmes with a particular focus on real time patient feedback. Tell us Ten Things questionnaire was reviewed in November 2014 and aligned to the "5 Must dos". Patient experience data feedback to the service on a monthly basis at service and site level to inform improvement planning. TTT is live on 3 acute hospitals and will be reviewed on the 13 April with the Lothian Professional Nurses Committee. Regular reports on Complaints management through Datix Dashboards and reports. Monthly meetings of the Complaints & Improvement Committee. 	<p>Risk Reviewed January 2017</p> <ul style="list-style-type: none"> Regular reports to the Healthcare Governance Committee that brings together complaints performance and patient experience reports. Additional reports have been submitted to the Audit & Risk Committee and the Board. Both complaints and patient experience are part of the monthly quality and performance reporting arrangements. Devolved complaints process now in place: WGH, DATCC, Women's services, RIE, REAS, East Lothian HSCP, Midlothian HSCP & Edinburgh HSCP/ Meetings with the clinical teams planned to discuss local arrangements and performance Weekly performance reports shared with clinical teams Agreement to have the PE Team contact details on all correspondence Telephone lines now open from 9am – 4pm Work ongoing to support the complaints and feedback systems within the 2 prisons encouraging early resolution and the devolved complaints function. Met with the Director of Patient Opinion. Feedback & Improvement Quality Assurance Working Group ToR agreed and monthly meetings arranged chaired by Non Executive. Complaints improvement work commissioned directly by the RIE & WGH sites. Programme of improvement work to support the Scottish Public Services Ombudsman activity following August meeting with SPSO. SPSO Improvement Framework completed by all sites / IJBs. Letter sent to SPSO to update on progress. Letter sent to Scot Gov re new policy Specialist in complaints management is contributing to the Daring to be Great Nov programme Recruiting to current vacancies <p>Risk Grade/Rating remains Very High/20</p>	Inadequate: control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Alex McMahan	Jeannette Morrison	Healthcare Governance Committee

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
1076	2: Improve the quality and safety of health care	Healthcare Associated Infection	<p>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. Support to the clinical teams and service deliverables is currently being impacted due to staffing within the service. This is a combination of staff moves, sickness and absence and ratio of trainees. 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.</p> <p>Finance restrictions have also meant for 2017 the IPC Budget will be unable to continue to provide funding to support the AMT Nurses</p>	<p>The NHS Lothian Infection Service, encompasses all specialist clinical/medical, nursing and pharmaceutical aspects of infection. The aim is to offer a coherent, clinically excellent and efficient approach to improve the quality of NHS Lothian 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. Work will progress in 2017 to develop the roles and responsibilities and deliverables of the integrated service. The service reflects the move to Geographical Structure as currently is the standard for the Infection Prevention and Control Team and the wider NHS Lothian services and departments.</p> <p>NHS Lothian Infection Committee is supported by the regional acute services committees and the CHP Infection Prevention and Control Committee. The CHP Committee will require a review in future as Integrated Joint Boards become more established. 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. It has been suggested that LICAC's role should be reviewed in 2016/17 to reflect the changes and assess the future role and responsibilities. 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.</p> <p>Within the NHS Lothian Infection Prevention & Control team, there are 4 geographical regions (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established with responsibility for both acute and community settings within their remits. This will be reviewed at a later date with the move of RHSC to RIE site.</p> <p>A review of the current workload across the regions has been undertaken to provide temporary changes to work streams to accommodate the current staffing position within the service. Sickness rate within the team is 6.77%. 2 staff have above 20% and are being managed and supported in accordance with Promoting attendance policy. 1 member of staff remains on long term absence and of the remaining 15.2 WTE Band 6 IPCNs in post 7 are trainees. There are also 2 staff anticipated maternity leave commencing in February 2017.</p> <p>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.</p> <p>Education:</p> <ul style="list-style-type: none"> 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. HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro. IPCT provide support for NES Cleanliness Champions Programme accessible to all staff to increase an understanding of Infection Prevention and Control Precautions. In addition local and ad hoc sessions are provided at each of the sites as and when required. 	<p>Risk Reviewed December 2016:</p> <p>The risk factors have been updated.</p> <p>Actions to recruit staff have been completed.</p> <p>Action has been added for the upgrade of server to improve data quality.</p> <p>Risk Grade/Rating remains High/16</p>	Adequate but partially effective: control is properly designed but not being implemented properly	High 16	Medium 4	Tracey Gillies	Fiona Cameron	Healthcare Governance Committee

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
				<p>Controls Continued:</p> <p>Incidents/Outbreaks:</p> <ul style="list-style-type: none"> • IPCNs work collaboratively with clinical and non clinical services to communicate risk, support improvement and escalate concerns as appropriate. 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 <p>Surveillance:</p> <ul style="list-style-type: none"> • 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 and CDI incidences. From April 2016 enhanced surveillance on ECB became mandatory. 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 Arthroplasties. High risk organisms are also monitored through electronic surveillance e.g. MDR and XDRs. • Incidences where patients have CDI and SAB noted on their death certificate are reviewed in conjunction with clinical teams. The reviews are published on DATIX and are available to site management teams. • As part of the work stream review a proposal was submitted to discontinue voluntary facture neck of femur surgical site infection surveillance. The infection rates have been below 1% for over 3 years. This was supported and the surveillance was discontinued in Oct 2016 <p>Antimicrobial Stewardship:</p> <ul style="list-style-type: none"> • 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. <p>Policies and Guideline:</p> <ul style="list-style-type: none"> • 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. 							

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
3480	: Improve the quality and safety of health care	Delivery of SPSP Work Programme	There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm	<ul style="list-style-type: none"> The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety. Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical 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 which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. 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. Programme Managers have been given access to national outcome data by Board which enables boards to see whether they are outliers and escalate concern and risk as appropriate Access to Adverse Event Improvement Plan in place monitored via HCG Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly. Single System medicines reconciliation group. 	<p>Risk Reviewed January 2017:</p> <ul style="list-style-type: none"> 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 17% with the 3 major sites having a lower rate than the Scottish rate. Work is ongoing within current resources to improve cardiac arrest rate. However, given our rate is lower than Scotland, it is not expected to be able to meet the 50% target NHS Lothian is on the HIS risk register for MCOIC Paeds and Neonatal. 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 NHS Lothian was on the HIS Suicide Risk Register with respect to timely reviewing of suicides and has been removed since last reporting. A recovery plan was agreed at the May and update reported in September Healthcare Governance Committee and current performance is improving. The Annual Report submitted to HCG provided significant assurance of patient safety measures (Essentials) however moderate assurance with respect to point of care priorities such as pressure ulcers, medicine reconciliation, MCOIC and Paeds etc and as such there remains a patient safety risk to NHS Lothian. <p>January 2017-Risk grade/rating remains High/16 based on unmet actions for key safety priorities</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Tracey Gillies	Jo Bennett	Healthcare Governance Committee

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
3211	2: Improve the quality and safety of health care	Achievement of National Waiting Times Targets	<p>There is a risk of:</p> <p>Inability to meet national waiting times targets for a number of reasons due to lack of core capacity, demand exceeds capacity or resources are not optimally utilised</p> <p>Withdrawal from independent sector April 2016 sees a deteriorating performance for some specialties</p> <p>Financial overspend due to reliance on ad hoc additional capacity – i.e waiting list initiatives/ locums; and risk of not achieving Value for Money.</p> <p>Lack of robust management process and staff capability to deliver consistent management of waiting lists.</p> <p>Adverse publicity relating to failure to meet waiting times targets.</p>	<p>Delivering for Patients II- a detailed Demand, Capacity, Activity and Queue (DCAQ) process undertaken providing a consistent approach across all acute services, giving detailed understand of capacity gaps and has efficiency opportunities identified and monitored.</p> <p>Weekly scheduled reviews between this Director and Chief Officer and further underpinned by a weekly operational and Pan Lothian Access group, with performance reported to CMT and Acute Hospitals Committee.</p> <p>These reviews consider:</p> <ul style="list-style-type: none"> • Performance against trajectory across a range of measures (including waiting time standards) • Finance • Governance position, in terms of adherence to national guidance and local access policy/SOPs <p>Monthly Access and Governance Meeting to review adherence to National Guidance and local access policy/SOPs. Underpinned by regular staff training and updates easily accessible on intranet relating to SOPs</p> <p>Use of Non Recurring Scottish Government funding to target services at highest risk of excluding, diagnosing, treating cancers and services with the longest waiting times.</p>	<p>Risk Reviewed December 2016:</p> <p>Controls in place updated.</p> <p>Risk Grade/Rating remains High/16</p>	Satisfactory: controls adequately designed to manage risk and working as intended	High 16	Low 1	Jim Crombie	Jacquie Campbell	Acute Services Committee

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
3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	<p>There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff.</p> <p>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.</p>	<ul style="list-style-type: none"> •In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. •For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG. •A report is taken to each Board meeting updating the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. The main challenges have been in Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Radiology and Medicine for the Elderly. •For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. •A Medical Workforce Group has been established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model. 	<p>Risk Reviewed January 2017</p> <p>No update since last review – awaiting outcomes of the recruitment processes within paediatrics and GP</p> <p>A recent review of trained doctor establishments show significant improvements in recruitment from 2 years ago with an overall establishment gap of 5%. There remain challenges in particular at the St Johns Site within Ophthalmology, Respiratory and General Medicine. Within Paediatrics there are 13wte posts under recruitment to provide additional capacity at both RHSC and St John's sites in line with the recommendations of RCPCH review. Recruitment to GP posts within independent practices continues to be very challenging, recruitment to permanent salaried Board employed GP posts has been relatively successful however recruitment to fixed term posts has thus far been unsuccessful.</p> <p>Risk Grade/Rating remains High/16</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Tracey Gillies	Nick McAlister	Staff Governance Committee

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
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.	<ul style="list-style-type: none"> •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 2015/16. 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 re-provision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years. 	<p>Risk Reviewed December 2016</p> <p>The 2016/17 Programme of works for has been progressing, The allocation for the works is £2.5m for the current financial year . The programme of works concentrates on high and significant risk areas including fire precaution works at all sites, mechanical and electrical plant replacement, legionella, HEI, building fabric.</p> <p>Programme of works will be prepared for future years.</p> <p>A review of the current risks and re-categorisation of the risks dependent on use of property is currently ongoing and reviewed regularly.</p> <p>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.</p> <p>Surveys have recently been carried out on WG, Edington, Belhaven and a few community properties – this information will be update the BLM for these sites. Further surveys will be undertaken this financial year.</p> <p>The disposal programme, capital investment projects will contribute in reducing the overall backlog maintenance liability for the Board.</p> <p>The disposal programme for 16/17 also includes the disposal of 15 Craiglea Place, 162 & 163 Craiglea Drive, 151 Morningside Drive and 63 Morningside Drive.</p> <p>Risk Grade/Rating remains High 16</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 4	Jim Crombie	George Curley	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3455	2: Improve the quality and safety of health care	Management of Violence & Aggression	There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations If the risk from violence and aggression adverse events are not adequately controlled. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being.	<ul style="list-style-type: none"> •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. <p>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.</p>	<p>Risk Reviewed: January 2017: The exec responsibility for Occupational Health and Safety transferred from Alan Boyter to the Medical Director on 1st August. The Centre for Managing Aggression (The violence and aggression management team) will remain within HR+OD after 1st August, through Mary Parkhouse to the HR Director.</p> <p>Feedback from the majority of the 12 local Health and Safety Committees into the main NHSL H+S Committee at the end of August, by way of the quarterly reporting system, clearly evidences current significant risk control failings, including and in particular, provision of V+A training. It is therefore suggested that the risk level still remains as "High".</p> <p>A review has been commissioned by the Executive Lead.</p> <p>Risk Grade/Rating remains High/15.</p>	Adequate but partially effective: control is properly designed but not being implemented properly	High 15	Medium 6	Tracey Gillies	Alastair Leckie	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3828	2.2 Deliver Safe Care	Nurse Workforce – Safe Staffing Levels	<p>There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and / or inability to recruit.</p> <p>Risks occur across the nursing and midwifery workforce where additional capacity is opened to facilitate delivery of other corporate targets (e.g HEAT target 4 hour wait) or where patients have a greater level of acuity than the funded establishment is based upon.</p> <p>Service sustainability risks are high within theatres and anaesthetics, critical care and in health visiting owing to lower levels of workforce supply.</p> <p>Risks arise from the high use of supplementary staffing to counteract shortfalls.</p> <p>The impact of any of these situations potentially compromise the safety of the patient care delivered with consequent impact on length of stay, patient experience and long term</p>	<p>Two Nursing and Midwifery Workforce meetings are being convened (one for in patient areas and one for community nursing). The remit of these groups will include the performance monitoring previously led by the Nurse Director and Deputy Finance Director and will consider the wider agenda around the staffing levels. Work is also being taken forward around Safe Staffing Levels in line with the national agenda to generate Safe Staffing Legislation.</p> <p>The agency embargo remains. In addition to the Theatres and Anaesthetics, Critical Care and complex care packages for adults in the community exemption pending work to establish a national critical care / theatres bank the PICU has had a 3/12 block booking with agency to manage significantly increased activity. NHS Lothian is implementing the national arrangements for bank for critical care and theatres.</p> <p>A collaborative to consider management of patients that are at risk of falls is being established to support the investment in technological solutions and continued use of 1:1 care for falls / wandering.</p> <p>A recruitment plan, including open days and external recruitment events has been established with success in reducing the establishment gap.</p> <p>A calendar to ensure the annual use of the nationally accredited workforce tools has been developed.</p> <p>eRostering and SafeCare Live tools are being rolled out to all nursing and midwifery wards, community teams and departments to provide real time information for local decision making around the deployment of the available staffing. The roll out is 50% complete with 194 rosters (over 5000 nursing staff) actively using eRostering.</p> <p>Datix reports are escalated on a weekly basis for all adverse events with staffing issues identified as a major or contributory factor and these are reviewed by the senior management team at the PSEAG. The supplementary staffing and rostering detail is annotated to provide context and enable risk to be understood.</p>	<p>Risk Reviewed January 2017:</p> <p>Controls updated.</p> <p>The risk with the exception of District Nursing the likelihood is reducing to possible from likely although the impact would remain moderate (until the improvements can be sustained)</p> <p>Risk Grade/Rating remains: Medium/9</p>	Satisfactory: controls adequately designed to manage risk and working as intended	Medium 9	Low 2	Alex McMahon	Fiona Ireland	Healthcare Governance Committee

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
3328	1: Improving the Quality and Safety of Healthcare	Roadways / Traffic Management	There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> segregation of vehicle and pedestrian traffic where possible; risk assessing and controlling reversing manoeuvres for drivers and vehicles under NHS control creation of protected walk ways where possible; development and use of one way systems where possible use of barriers and entry systems to control traffic where possible drop-off areas and disabled spaces; 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 <p>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</p> <p>Local TM Groups will continue to apply simple and low cost actions and repairs/improvements where approvals and budgets allow.</p>	<p>Risk Reviewed December 2016:</p> <p>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.</p> <p>Applications have been submitted to extend the TRO at the REH and introduce a TRO at the AAH. Funding has been approved and works have been completed on the REH site and nearing completion on the AAH site.</p> <p>The resurfacing of car park P at St John's Hospital (main visitors car park) is now complete and operational. This will now provide additional traffic management controls due to the relining of spaces etc. .</p> <p>Funding has now been approved to undertake high risk items at the WGH - works will be to alter the road layout at Turner House which will reduce the speed of traffic. This is understood to be the highest risk on the WGH site. Cycle path works are nearing the end of completion.</p> <p>Traffic Management works are due to commence at Whitburn, Health Centre, Liberton Hospital, PAEP and Midlothian Community Hospital. .</p> <p>Risk grade/rating remains unchanged - High/12</p>	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 8	Jim Crombie	George Curley	Staff Governance Committee

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9:30 on Wednesday 18 January 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr G. Walker, Non-Executive Board Member (chair); Dr D. Farquharson, Medical Director; Ms S. Goldsmith, Director of Finance; Mr R. Henderson, Non-Executive Board Member; Mr M. Hill, Non-Executive Board Member; Mr B. Houston, Board Chairman; Mr P. Murray, Non-Executive Board Member; Ms L. Williams, Non-Executive Board Member.

In Attendance: Mr C. Briggs, Associate Director of Strategic Planning; Mr M. Cambridge, Associate Director of Procurement (item 55.4); Ms J. Campbell, Acting Chief Officer, Acute Services; Mr J. Crombie, Chief Officer, Acute Services; Ms L. Cullen, Communications Manager (observing); Mr G. Curley, Director of Facilities; Mr I. Graham, Director of Capital Planning and Projects; Ms C. Harris, Head of Communications; Mr C. Marriott, Deputy Director of Finance; Ms B. Pillath, Committee Administrator (minutes); Mr C. Stirling, Site Director, Western General Hospital (item 56.4); Ms L. Seville, Efficiency and Productivity Programme Manager.

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.

52. Minutes from Previous Meeting (30 November 2016)

48.1 The minutes from the meeting held on 30 November 2016 were approved as a correct record.

53. Running Action Note

53.1 The updated cumulative action note had been previously circulated.

54. Matters Arising

54.1 Members' Development Session Update

54.1.1 A date would be set for this Workshop in the next couple of weeks.

55. Financial Performance

55.1 Month 9 2016-17 Financial Position

55.1.1 Mr Marriott spoke to the previously circulated paper. He advised that the 70 whole time equivalent junior doctors over budget was due to historical vacancies in junior doctor posts which had led to a reliance on use of bank and agency locums.

Vacancies had now been recruited into but bank and agency locum use had continued. The financial support for locums had been central but would now be distributed to directorates to discourage over use. A piece of work was in progress with clinical teams considering how the reduction in locum use would affect rotas. The problem was specifically centred at the Royal Infirmary.

55.1.2 Members accepted the recommendations laid out in the paper.

55.2 Scottish Budget and 2017-18 Financial Plan

55.2.1 A paper had been previously circulated, and Ms Goldsmith gave a presentation on the budget and financial plan for 2017-18. There would be a reduction in funding from the Scottish Government compared to the previous year. The figures presented did not take into account regionalisation or NHS inflation, which was higher than general inflation. £74 million had been kept back from the NHS Lothian budget to go towards the Integration Joint Boards in Lothian.

55.2.2 As demographic change compared to other Boards had not been taken into account in NHS Lothian's NRAC allocation there would be a gap of £12 million. It was necessary to continue bringing this issue to the attention of the Scottish Government as failure to take demographic change into account in the budget would lead to compromise of patient care.

55.2.3 Each local authority would give £180 million of their budget to the Integration Joint Board. They did have an option to reduce their contribution by £80 million, but this was not expected.

55.2.4 It was agreed in principle that as funding did not allow any scope for transformational change and improvement there should be a local reprioritisation of funding within Lothian to create a pot of money for strategic change, and that if money was received or saved in a particular area it should be saved into this pot and not distributed in amounts which would have little impact. It was agreed that the services could not continue to be provided with reduction in funding and therefore transformational change was needed. The Quality Improvement strategy would provide a basis for this.

55.2.5 Members accepted the recommendations laid out in the paper.

55.3 Overview of GP Prescribing

55.3.1 Mr Marriott spoke to the previously circulated paper. It was noted that GPs have said that taking on prescription recommendations for patients who have been in secondary care had caused a rise in spend; work was in progress to find out how much of an affect this had.

55.3.2 It was noted that primary prescribing costs were increasing in all Scottish Health Boards due to factors such as aging populations and increased risk of obesity and cardiac arrest.

55.3.3 The ScriptSwitch software made it easier for GPs to change prescribing habits and become compliant with the Formulary and 90% of GP practices were now using this.

55.3.4 It was agreed that priorities for early intervention in local populations to improve population health should be considered as a way of reducing costs.

55.4 Procurement Non Pay Expenditure Review

55.4.1 The chair welcomed Mr Cambridge to the meeting and he spoke to the previously circulated paper.

55.4.2 Members that this was a positive report and that assessment by Deloitte had shown that Procurement was in a strong position. Mr Cambridge was also optimistic that further improvements could be made.

55.4.3 Members congratulated Mr Cambridge and his team for their hard work and asked that their thanks be passed on to the team.

55.4.4 The recommendations laid out in the paper were accepted.

56. Property and Asset Management

56.1 Property and Asset Management Investment Programme

56.1.1 Mr Graham spoke to the previously circulated paper. Ms Goldsmith noted the importance of having all capital cases on the plan. Mr Crombie noted that there would be some work on getting a plan of accommodation re-provision required and assets expected from sale of property over the next ten years to allow planning.

56.1.2 It was noted that the backlog of maintenance work was in a considerably better position than in previous years.

56.1.3 Members accepted the recommendations laid out in the paper.

56.2 GP Premises

56.2.1 Mr Graham spoke to the previously circulated paper. A key issue was that because of the urgency of the situations NHS Lothian was entering into leases and taking on liabilities which did not fit into a strategic solution for sustainable improvement; there needed to be more forward planning with Integration Joint Boards and this work was urgently required. This could be an opportunity for investment in premises and grouping of professionals which would meet strategic aims. Planning ahead was challenging as GP practices may own premises and NHS Lothian would have no influence on decisions made; when GPs sell their practice NHS Lothian would have no other premises for patients and would have to buy the practice from them.

56.2.2 Previously there was a Lothian GP practice prioritisation process whereby there would be a list of practices in order of prioritisation for assistance. There was now one list for each Integration Joint Board using different criteria, which made overall prioritisation challenging. The CFO had been approached to consider whether there

should be an overall NHS Lothian list. It was suggested that a group be set up lead by NHS Lothian with representatives from each of the Integration Joint Boards to consider shared criteria for prioritisation and this should be based on the model of multi-disciplinary practices rather than the current model.

56.2.3 Members accepted the recommendations laid out in the paper.

56.3 Corporate Office Rationalisation – Full Business Case

56.3.1 Mr Curley spoke to the previously circulated paper. It was noted that plans had been changed to ensure provision for meeting space for 30-45 people; this would meet requirements for all Committee meetings except the Board, which would be held off site. There would be offices for Executive Directors and further small meeting rooms.

56.3.2 There had been extensive consultation with staff regarding the new arrangements both through department leads and at workshops open to all and staff appeared supportive. Concerns had been raised regarding personal issues including travel expenses; the Board policy on this would be followed.

56.3.3 The cost of the project would be £1.73 million in revenue and £1.31 in capital, with an expected recurring saving of £1 million per annum.

56.3.4 Members accepted the recommendations laid out in the paper.

56.4 Edinburgh Cancer Centre – Update

56.4.1 The chair welcomed Mr Stirling to the meeting and he spoke to the previously circulated paper. The paper gave an update on progress and sought support from the Committee on project management arrangements to take work forward to the next stage.

56.4.2 It was known that the clinical environment was inadequate but there had not yet been agreement on a strategic plan. The project was currently on a list of requests for funding from the Scottish Government but awaiting decision. This could be prioritised in the capital programme to find funding within NHS Lothian or start the bridging programme outlined in the paper.

56.4.3 A substantial donation had been offered for a haematology project by an anonymous donor. The Haematology project could be completed separately to the larger cancer centre project, but it would be more efficient in terms of funding, project management and tender to carry out all the work together.

56.4.4 Mr Hill felt that affordability of the project should be discussed as part of the strategic assessment in the context of the financial situation, but it was noted that the current status of the cancer centre was not acceptable and ways to afford improvement needed to be considered. Mr Briggs noted that the process laid out by the Scottish Government was to carry out a strategic assessment without reference to cost, and that priorities and affordability would then be considered as part of the wider hospitals plan. It was agreed that this project would be of a high priority in comparison to other current capital priorities.

56.4.5 The total costing for this capital project was £25.4 million. Any project over £5 million had to be signed off by the Scottish Government. It was agreed that Ms Goldsmith and Mr Crombie would write to the Director of Finance at the Scottish Government stating that NHS Lothian was unable to wait for the decision on funding for this project and that it proposed to fund the project itself following prioritisation. **SG / JC**

56.4.6 Once the project could move to the next stage there would be communication with other Boards about funding support as this was a regional centre. There was a national move towards strengthening regional approaches which could be to advantage in this project.

56.4.6 Members supported the need for project support for a project of this complexity and the recommendations in the paper were accepted.

56.5 Edinburgh Bioquarter – Collaboration Agreement

56.5.1 Mr Graham spoke to the previously circulated paper. Members were please to see this work progressing and accepted the recommendations laid out in the paper.

57. Property and Asset Management Investment Programme 2016-17 Business Case Monitor

57.1 The paper had been previously circulated. Ms Goldsmith noted that challenges going forward would be how to best develop assets belonging to NHS Lothian but which were within Integration Joint Boards, for instance the Royal Victoria Hospital integrated healthcare facility.

57.2 Mr Graham noted that post project evaluation was important to show whether savings identified at the start of the project had been delivered. A model had been developed and the evaluations would be submitted to the Scottish Government and could also be submitted to this Committee.

57.3 It was noted that the carbon energy programme at St John's Hospital had been on hold for some time but that the Scottish Government had now accepted an energy efficiency grant which the project would meet the requirements for and so would now progress.

58. Any Other Competent Business

58.1 Thanks to George Walker

58.1.1 This was Mr Walker's last meeting as chair of the Committee as his term as a Board Member had come to an end. Ms Goldsmith thanked Mr Walker for his hard work and his contributions to the Committee both as Member and as Chair over the last seven years, and he was presented with a gift. Mr Hill would take on the Chair of the Committee from the next meeting.

57. Date of Next Meeting

57.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 15 March 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

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

- Wednesday 10 May 2017;
- Wednesday 12 July 2017;
- Wednesday 20 September 2017;
- Wednesday 15 November 2017.

1.5

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9:00 on Tuesday 17 January 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr R. Williams, Non-Executive Board Member (chair); Ms P. Eccles, Partnership Representative; Ms C. Hirst, Non-Executive Board Member; Ms Fiona Ireland, Non-Executive Board Member and Chair of the Area Clinical Forum; Mr J. Oates, Non-Executive Board Member; Mr A. Sharp, Patient and Public Representative.

In Attendance: Ms S. Ballard-Smith, Nurse Director, Acute Services; Ms J. Campbell, Acting Chief Officer, Acute Services; Dr B. Cook, Medical Director, Acute Services; Ms K. Dimmock, Information Analyst (observing); Dr D. Farquharson, Medical Director; Mr J. Forrest, Chief Officer, West Lothian Health and Social Care Partnership; Ms S. Gibbs, Quality and Safety Assurance Lead (on behalf of Ms Bennett); Ms C. Harris, Head of Communications; Mr B. Houston, NHS Board Chairman; Mr A. Jackson, Assistant Director of Healthcare Planning; Mr R. Mackie, Senior Information Analyst (observing); Dr N. Maran, Clinical Lead, Scottish Patient Safety Programme (items 53.1, 53.2 and 54.2); Professor A. McCallum, Director of Public Health and Health Policy; Mr T. Montgomery, Director of Operations, Royal Edinburgh Hospital (item 54.1); Ms J. Morrison, Head of Patient Experience; Ms B. Pillath, Committee Administrator; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership (item 53.7); Ms C. Swift, Scottish Patient Safety Programme Manager (item 53.2); Professor A. Timoney, Director of Pharmacy; Mr S. Watson, Chief Quality Officer.

Apologies: Ms S. Allan, Non-Executive Board Member; Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr H. Cartmill, Non-Executive Board Member; Mr J. Crombie, Chief Officer, Acute Services; Mr T. Davison, Chief Executive; Ms W. Fairgrieve, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Professor A. McMahon, Director of Strategic Planning; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership.

Chair's Welcome and Introductions

Dr Williams welcomed members to the meeting and members introduced themselves.

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

47. Patient Story

47.1 Ms Ballard-Smith read out a letter from the relative of a patient with dementia who was cared for in Ward 14 at the Royal Edinburgh Hospital. Although the relative had read negative reports of the ward online, they were very impressed with the high level of care showed to the patient and the relatives by all the staff, and by the activities arranged for patients over the Christmas period. The meeting with the named nurse once per month and the Charge Nurse weekly drop in surgery were particularly

valued. Overall the relative felt that the clinical team provided holistic and committed care to patients.

48. Minutes from Previous Meeting (29 November 2016)

- 48.1 The minutes from the meeting held on 29 November 2016 were approved as a correct record.
- 48.2 The updated cumulative Committee action note had been previously circulated.

49. Matters Arising

49.1 Child and Adolescent Mental Health Service

- 49.1.1 Ms Ballard-Smith noted that the manager post had now been recruited to and it was expected that this leadership would improve reduction of the waiting list. A further update would be given at the meeting in March 2017. **AMcM**

49.2 Reports and Assurance Levels

- 49.2.1 It was agreed that it would be requested that reports submitted to the Committee would offer a level of assurance in the recommendations, which the Committee would agree with or otherwise. The chair would discuss with Mr Payne the change required to the paper template and the instructions for writing reports. **RW**

50. Emerging Issues

50.1 Community Nursing

- 50.1.1 Ms Ballard-Smith gave a verbal update on the current situation in community nursing. There was a 20% vacancy rate in the community nursing teams in Edinburgh, and 57% of band 5 and 6 nurses were eligible to retire in the next five years. There had been difficulties recruiting to the vacant posts. This could be partly due to the ability to move up to band 6 level in acute services without having as high a qualification as was required for community nursing at this level, and because of the requirement to complete a full time training programme to become qualified.
- 50.1.2 Nine nurses were currently undergoing the 9 month full time training programme for community nursing. At least 15 trainees per year would be required for the next three years to maintain adequate staffing levels. The possibility of making the course modular or part time so that it could be completed while working was being considered.
- 50.1.3 An upgrade of technology used by community nursing teams could lead to time being better spent as currently staff had to return to their base to write up patient notes.
- 50.1.4 All new staff would be recruited to an integrated night and day team with staff rotating shifts, as this would mean workload could be spread more efficiently. Current staff were being asked to change to this system, but this would be their choice.

50.1.5 A formal update paper would be provided at the meeting in March 2017. **AMcM**

51. Committee Effectiveness

51.1 Corporate Risk Register

51.1.1 A paper had been previously circulated. Dr Farquharson noted that the Patient Experience – Management of Complaints and Feedback risk had been changed from 'high' to 'very high'. Otherwise there was little change from the previous report.

51.1.2 Members accepted the recommendations in the paper.

51.2 Quality and Performance Improvement Report

51.2.1 Dr Farquharson introduced the previously circulated paper.

51.2.2 Mr Jackson noted that guidance had been received from the Scottish Government stating that the 48 hour access to GP target had been reinstated, although this was subject to the review of targets expected in May 2017.

51.2.3 Mr Jackson suggested that a timetable showing at which meetings assurance areas were covered by the Committee be created. This would be in addition to the Committee work programme, but it was agreed that a more formal assurance programme would be helpful.

51.2.4 It was agreed that there had been no significant change in any levels of assurance since the previous meeting, and all areas of high risk were on the agenda for discussion.

52. Person Centred Culture

52.1 Person Centred Culture Update

52.1.1 Ms Morrison spoke to the previously circulated paper. Due to the low returns of the Tell us Ten Things patient questionnaire, consideration was being given to other options for receiving patient feedback. It was noted that all Health Boards in Scotland were taking a different approach, but none were yet further ahead than Lothian. Dr Watson noted that as part of scoping there would be consideration of how other public organisations got customer feedback, consultation with staff on ideas, and then an action plan would be developed. It was expected that a range of methods would be used.

52.1.2 Ms Ballard-Smith noted that the Care Assurance Standards (CAS) was being implemented and was now in fifteen wards at the Royal Infirmary, St John's Hospital, the Western General Hospital and Liberton Hospital. This included taking patient feedback as part of a qualitative response. It was noted that many clinical areas also had their own methods of receiving patient feedback.

52.1.3 It was noted that the solution needed to be sustainable and that staff needed to understand the benefit of taking patient feedback otherwise it would not be a priority,

this included there being a clear use for the information received to benefit patient care. If used properly, data could be very important for evaluation of transformational change and quality improvement. Mr Sharp noted that a patient story could have a very high impact, and that from a patient's point of view a questionnaire asked what the Board wanted to know rather than what the patient wanted to say.

- 52.1.4 Members agreed that the paper did not provide assurance that patient experience data was being collected and used. Further discussion would take place at the Feedback Review Group and an action plan would be brought back to the Committee. **AMcM**

53. Safe Care

53.1 Human Factors Update Report

- 53.1.1 The chair welcomed Dr Maran to the meeting and she spoke to the previously circulated paper. Shelly Jeffcott had presented here team intervention work at the meeting in November 2015. This had followed a number of serious adverse events occurring in theatres, the occurrence of which had reduced significantly following the intervention. Safety huddles now took place on all theatre sites and communication had been improved.

- 53.1.2 It was agreed that a plan for promoting successes to the public and encouraging this sort should be included as part of complaints management and suggested that learning could be shared in other areas of the organisation.

- 53.1.3 Dr Maran noted that the intervention should be sustainable as multi-professional 'human factors advocates' had been trained in all theatre areas and would continue to make improvements in the groups set up. There was a need to continue to support this, and to provide training for new staff.

- 53.1.4 The Committee supported the approach, recognising the significant efforts that had been made to improve patient safety, but requested a formal evaluation of the project including patient impact and sustainability plan. This would be submitted at the meeting in July 2017. **DF**

53.2 Scottish Patient Safety Programme Annual Report

- 53.2.1 The chair welcomed Ms Swift to the meeting and she spoke to the previously circulated paper. This report gave high level data covering a wide range of areas. The Committee noted that the report was positive. Data showing improvement in individual departments was feedback to clinical teams making the improvements, but a wider appreciation was needed for their excellent work. Ms Harris agreed to use this document to promote these achievements both internally and to the wider public.

- 53.2.2 It was agreed that Non Executive Board Members could receive a briefing on initiatives and improvement projects in a particular clinical area before visiting on walkrounds so that these could be discussed.

53.2.3 The chair asked for more information before a decision could be made on the recommendation in the paper to reduce the target for reduction for cardiac arrests from a reduction of 50% to a reduction of 10%. Ms Swift explained that this was because of the very low current numbers, but agreed to bring a paper with data and a more detailed explanation to the next meeting in March 2017. **DF**

53.2.4 With this exception, Members accepted the recommendations in the paper and agreed that they had received significant assurance in this area.

53.3 Management of Adverse Events

53.3.1 Ms Gibbs spoke to the previously circulated paper. It was noted that the 'being open' process was currently only in use in one area due to the large amount of training required. A lower level version of the training including processes for involving the family in significant adverse event reviews may be available to introduce to all areas. It was very important to be more open, including writing reports in a style which could be shared with the patient and family, feedback being requested from patients and clinicians meeting with patients. The Acute Services group chaired by the Medical Director for Acute Services and the Nurse Director for Acute Services always asked about patient involvement when reviewing significant adverse events.

53.3.2 The requirements of the Duty of Candour legislation were to be implemented by April 2018, but more direction was required from the Scottish Government. There was already a professional requirement for duty of candour.

53.3.3 Members agreed that the paper provided significant assurance that actions were in place to ensure significant adverse events were reviewed and lessons learned.

53.4 Public Protection Update Report

53.4.1 Ms Ballard-Smith introduced the previously circulated paper. It was noted that the electronic Interagency Referral Discussion (eIRD) allowing professionals from different authorities to share information electronically was not yet in place but significant progress had been made. In the meantime there was a robust system in place for information sharing without this facility.

53.5 Capacity Analysis

53.5.1 Ms Campbell gave a presentation on work in progress to better understand, monitor and improve bed capacity, and reduce waiting times using data analysis and improvement focus groups in key clinical areas.

53.5.2 An Outpatient Programme Board had been established with representation from each Integration Joint Board, Acute Services and General Practice, and would be chaired by the new Medical Director. This group would oversee workstreams to improve performance and reduce the number of patients waiting over 12 weeks for an outpatient appointment. The Scottish Government had produced a piece of work called 'The Modern Outpatient' which included recommendations for reducing the number of outpatient appointments in Scotland by delivering care to patients in

different ways. The terms of reference for the Outpatient Programme Board would be reviewed to take into account this new guidance.

53.5.3 Work would start on keeping in touch with patients on the waiting list, and breaking down classification of waits for 'routine' appointments to ensure correct prioritisation. All referrals were triaged currently but the status was not reviewed during the wait; methods of doing this would be considered by the Outpatient Programme Board.

53.5.4 Members agreed that there was significant assurance that a process was in place for improvement, but asked for more information on patient impact and on actual capacity improvement progress. An update paper would be submitted at the meeting in July 2017. JC

53.6 Delayed Discharge

53.6.1 Ms Campbell spoke to the previously circulated paper. It was noted that the figures in the paper did not include Royal Edinburgh Hospital and Associated Services (REAS) delayed discharge figures, so the situation for some Integration Joint Boards could be worse than shown.

53.6.3 A piece of work on maintaining packages of care when a patient was admitted to hospital was in progress. Currently the package of care would be cancelled after 7 days. There was a need to change the process of reassessment of the package of care on discharge with this being done by community teams after rather than acute teams to reduce delay and possibility of cancellation of the package already in place. It was recognised that prioritisation of patients in hospital waiting for a package of care or a care home would have an impact on those waiting at home for these services.

53.6.4 Funding for Integration Joint Boards to improve capacity and reduce delayed discharge had been increased, but the extra capacity has not yet been utilised due to problems with recruitment into new posts. All Integration Joint Boards were working on this.

53.6.5 It was noted that although improvement was still required on performance, there had been some improvement over winter 2016/17 compared with the previous year, collaboration between acute services and Integration Joint Boards was working well and this would be built on.

53.6.5 Members agreed that they was significant assurance that controls were in place for review of delayed discharge and that there was a detailed level of focus on this, but noted that there was an ongoing risk associated with performance level. This would be discussed at the Integration Joint Board item on the next Committee agenda.

53.7 GP Sustainability

53.7.1 The chair welcomed Mr Small to the meeting. Mr Small advised that problems with GP practices in difficulty were continuing and that the number of practices with restricted lists in Edinburgh was increasing. A Primary Care Investment and Redesign Board would be set up to direct the substantial investment in primary care

over the next few years, and to oversee the co-ordination of the four Integration Joint Boards in this area.

- 53.7.2 National funding was expected but there was not yet any detail as to where this would be directed. Funding for additional pharmacists and link workers was expected with the possibility of transfer of immunisation duties to the Health Board. More clarity on national programmes of investment was expected after March 2017. The new quality framework for GP practice would start in April 2017.
- 53.7.3 A formal paper giving an update on this high risk area would be submitted at the next meeting. **DS**
- 53.7.4 Mr Houston noted that he had discussed with Moira Whyte the importance of the university and medical training for a sustainable future and the need for NHS input on medical school strategy.

54. Effective Care

54.1 Mental Health Services Update

- 54.1.1 The chair welcomed Mr Montgomery to the meeting and he spoke to the previously circulated paper regarding the reduction of beds in the move to the new Royal Edinburgh Building and the transition required. Members were moderately assured that the necessary actions were being taken to mitigate the short term risk but there were concerns and limited assurance of the long term risk of reducing bed numbers. Mr Montgomery noted that funds identified for community mental health service restructure would aid sustainability in the future.
- 54.1.2 A further update would be submitted to the Committee at the next meeting which would include information on patient impact resulting from delayed admission, delayed discharge and admission out of area and update on actions.

54.2 Update on Death in Hospital Work

- 54.2.1 Dr Maran spoke to the previously circulated paper. The Hospital Standardised Mortality Rate (HSMR) was a crude measure which measured the number of patient deaths in hospital compared to the number of expected deaths. All hospitals in NHS Lothian had an HSMR of less than one, meaning fewer patients were dying of their condition than expected, but this measure did not take into account management of individual patients.
- 54.2.2 There was not yet a consistent process for review of deaths and as part of this work a standard criteria for carrying out mortality review and a standardised review template were being developed.
- 54.2.3 It was noted that in addition to looking at contributions to the deaths of individual patients, systemic problems which may contribute to deaths also needed to be considered.

- 54.2.4 It was suggested that data on mortality by patient characteristics would be useful to ensure that there was not a disproportionate number of deaths in a particular patient group, but it was acknowledged that this analysis would be complicated as patient characteristics could also contribute to the acquiring of the disease.
- 54.2.5 Members were moderately assured that a process was in place for moving to consistent review of deaths and asked for an update on progress at the meeting in July 2017. **DF**
- 54.2.6 It was noted that learning from the review of deaths was a separate issue; this would be a new piece of work and would be discussed outwith the meeting.

55. Exception Reporting Only

55.1 Respiratory Managed Clinical Network Annual Report

- 55.1.1 It was agreed that due to the lack of leads in post for this MCN an update would be requested at the meeting in March 2017. **AMcM**

55.2 Members noted the following previously circulated papers for information:

- 55.2.1 Medical Revalidation Annual Report;
- 55.2.2 Resilience Team Annual Report;
- 55.2.3 Diabetes Managed Clinical Network Annual Report;
- 55.2.4 National Health and Social Care Standards Consultation Response.

56. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

- 56.1 Area Drug and Therapeutics Committee, 2 December 2016;
- 56.2 Clinical Management Group, 8 November 2016;
- 56.3 Clinical Policy, Documentation and Patient Information Group, 23 November 2016;
- 56.4 Divisional Dental Committee, 17 November 2016;
- 56.5 Organ Donation Sub Group, 17 November 2016;
- 56.6 Lothian Infection Control Advisory Committee, 6 December 2016;
- 56.7 Public Protection Action Group, 16 November 2016;
- 56.8 Information Governance Assurance Board, 25 October 2016.

57. Any Other Competent Business

57.1 Thanks to Dr Farquharson

- 57.1.1 This would be Dr Farquharson's last Committee meeting before his retirement in March 2017. The chair thanked him for all the support he had given on the Committee and wished him well in the future.

57. Date of Next Meeting

- 57.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 14 March 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.
- 57.2 Further meetings would take place on the following dates in 2017:
- Tuesday 9 May 2017;
 - Tuesday 11 July 2017;
 - Tuesday 12 September 2017;
 - Tuesday 14 November 2017.

DRAFT

NHS Lothian

1.6

ACUTE HOSPITALS COMMITTEE

Minutes of the Meeting of the Acute Hospitals Committee held at 2:00 pm on Tuesday 6 December 2016 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs K Blair (Chair); Ms F Ireland; Professor A McMahon; Mrs A Mitchell; Mr J Oates and Mr G Walker.

In Attendance: Mr C Briggs (Associate Director of Strategic Planning); Mr O Campbell (Business Manager); Dr B Cook (Associate Medical Director); Mr J Crombie (Acting Chief Executive); Dr E Doyle (Associate Divisional Medical Director); Ms K Dimmock (Senior Information Analyst); Mrs C Harris (Communications Manager); Mr A Jackson (Associate Director of Strategic Planning); Ms L McDonald (Site Director, Royal Infirmary of Edinburgh & Liberton Hospital); Mrs R Kelly (Associate Director of Human Resources); Mr C. Marriott (Deputy Director of Finance) and Mr P Reith (Secretariat Manager).

Apologies for absence were received from Dr D Farquharson and Mr A Joyce.

Declaration of Financial and Non-Financial Interest

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

31. Minutes of the Previous Meeting

31.1 The previously circulated minutes of the meeting held on 6 September 2016 were approved as a correct record.

32. Running Action Note

32.1 The Chair advised the Committee that a successful workshop for members of the Committee had been.

32.2 Mr Campbell advised that physiotherapy and mental health were rolling out text reminders about outpatient appointments although funding for this still required to be identified. Mr Crombie advised that a review had been undertaken of Glasgow, Forth Valley and Lanarkshire who had all implemented such initiatives and had all reported reductions in 'did not attend' rates. Work was underway to identify Departments with high volume outpatient levels and 'did not attend' rates in order to further roll out the initiative.

32.3 The Committee noted the circulated running action note and the actions taken.

33. Stroke Performance

- 33.1 Ms McDonald introduced a circulated report on the recent performance against the National Scottish Stroke Care Standards.
- 33.2 The Committee noted that all acute stroke requiring a thrombolysis would come to the Royal Infirmary or St Johns Hospital and that there was now an integrated stroke unit in the Royal Infirmary of Edinburgh similar to that at the Western General Hospital and St Johns Hospital.
- 33.3 Ongoing care would be provided in the patients own locality as soon as this was clinically appropriate.
- 33.4 Ms McDonald emphasised that the priority was to obtain thrombolysis' care within the first hour of the stroke happening. 'Swallow' screening would now be part of the front door assessment.
- 33.5 The Committee noted that there remained challenges with recruitment and retention within the multidisciplinary team and that this limited the capacity of individual staff to focus on quality improvement work.
- 33.6 There had been considerable reconfiguration of stroke services in the past few years with a creation of an integrated stroke unit on each of the acute sites but there was concern rehabilitation was difficult to deliver within a pressurised site such as the Royal Infirmary of Edinburgh.
- 33.7 Ms McDonald advised the Committee that a moderate level of assurance of 80% compliance with new Scottish Stroke Care bundle with had now been achieved. Work was underway to deal with slower flow patients and admissions.
- 33.8 The Chair expressed some concern about the capability and capacity in community services and queries whether liaison with the Integration Joint Boards on this was required.
- 33.9 Ms McDonald advised that once the first hours of specialty stroke care had been provided there were some issues in getting patients back into the community. There was not sufficient support in the community and the focus was now on addressing flow gaps in retention and recruitment in homecare.
- 33.10 The Committee noted that stroke had always had its own data management and audit manager. The current capacity would be sufficient when the integrated stroke core policy reduced the length of stay. The key was early discharge with support for those suitable and currently there were more stroke beds than required at the Western General Hospital so options were now being examined.
- 33.11 The Chair commented that the Committee was very supportive of this work particularly in the light of the current constraints and it was agreed to:
- note and support the different approach locally to measure, present and ultimately improve performance based on the national standard and
 - to take moderate assurance that the systems of control in place in conjunction with improvement work would deliver 75% for winter (January to March) and 80% thereafter.

34. Four Hour Unscheduled Care Performance

- 34.1 Ms McDonald introduced a circulated report on the current 4 hour performance drivers and activities being taken forward to improve performance.
- 34.2 The Committee noted that the 4 hour emergency access standard was a whole system measure to deliver admission, discharge or transfer for 95% of unscheduled patients within 4 hours. To deliver this the Health and Social Care system needed to deliver consistent and stable patient flow.
- 34.3 It was noted that the reasons for under performing had changed with patients now being older and frailer. Whilst the Western General Hospital had struggled to comply with targets, the Lothian performance was 94% which made it one of the better performing Scottish NHS Boards. The most important factor was the ability to focus on flow. Overcrowding was happening with 400 patients being admitted over 12 hours in February. The problem continued and 8 major operations had been cancelled that day because beds were full.
- 34.4 Improvement works Implemented so far included delivering the leadership model across the system and it was hoped that the Integration Joint Boards would be able to demonstrate their plans to facilitate discharges to the community. At present, the Integration Joint Boards did not have the capacity to provide all the support needed at home. It was hoped that local authorities could attract better qualified staff by paying more.
- 34.5 Mr Walker advised that the new contract for community care was not yet working and the rates paid were no better than those paid for supermarket checkout operators. Edinburgh Integration Joint Board had held back some money to pay for this but he felt that it would be necessary to pay more to get the necessary staff.
- 34.6 The Committee noted that Edinburgh had very few step-up/step-down beds and that this was the only way in which Glasgow had been able to manage its delayed discharges.
- 34.7 The Chair asked about readmission rates and Ms McDonald advised that NHS Lothian was consistent with the rest of Scotland.
- 34.8 The Chair commented that the Committee was disappointed to downgrade the level of assurance from moderate to limited but was supportive of the measures being taken and recognised that there was much over which NHS Lothian had no control. The chair would raise this issue at Board level. **KB**
- 34.9 The Committee agreed to note the actions being taken forward to improve performance the 4 hour standard and took moderate assurance that the systems of control in place in conjunction with the improvement work described in the paper would deliver about 90% for each month of winter (January to March) and achieve 95% by the end of the financial year.

35. Quality in Performance Improvement

- 35.1 Professor McMahon introduced a circulated report providing an update on the most recently available information on NHS Lothian's position against a range of quality and

performance measures.

- 35.2 The Committee noted that NHS Lothian was not performing as well as it had previously but the reasons for this were known. The update to Trak in mid September had adversely impacted on the submission process to the Information Services Division for waiting times records, effectively understating the size of inpatient and outpatient waiting lists and levels of activity reported. Accordingly the initial figures provided for September had now been updated. It was noted that this error only impacted on reporting in national systems and had no impact on operational reports or waits experienced by patients.
- 35.3 The Committee noted that whilst performance around cancer had deteriorated, the Boards position was where it had been protected. There had been negative movement in time to treatment guarantees but NHS Lothian was not a huge outlier.
- 35.4 Concern was expressed that the report received by the Committee was the same as went to the Board and did not contain sufficient information. In particular it was unclear of what progress was being made.
- 35.5 Professor McMahon conceded that the information received was not yet adequate and Mr Crombie agreed that better performance was required. There would be discussions that week to agree what the work programme would look like. Mr Crombie advised that now there was a template for the reports he would discuss with the Chair what information the Committee wished to see in their report. Mr Jackson advised that once these had been agreed the Acting Chief Operating Officer would be asked to produce a strategic plan and work with staff producing data for the template. It was agreed that Ms McDonald should be asked to comment on whether the figures matched actual performance and that the reports needed to be clear what had and had not been reviewed. Professor McMahon undertook to include this in the workplan. **AMcM**
- 35.6 The Committee agreed to accept the report as assurance that performance on 12 measures considered across the Board, including those relating to the hospital score card, were currently met.

36. Timetable of Assurance

- 36.1 The Committee noted the circulated proposed timetabling of assurance and Mr Jackson asked if the Committee wished to make any changes to the timetable.
- 36.2 Mr Crombie advised that the later paper on managing the outpatient waiting times action plan was a transitional paper and suggested that this be retained on the timetable of assurance.
- 36.3 The Committee agreed to this and approved the timetable of assurance.

37. Paediatric Programme Board Update

- 37.1 Dr Doyle advised the Committee that the successful recruitment drive had secured the appointment of 6 consultant paediatricians against an advertised 8 posts. These consultants would work pan Lothian and all would participate in the out of hours

work at St Johns Hospital as per the recommended model described in Option 1 in the Royal Collage of Paediatrics and Child Health Report.

- 37.2 Dr Doyle advised that the 2 remaining consultant paediatrician posts would be re-advertised in order to secure the long term future of the 24 hour paediatric inpatient services at St Johns Hospital.
- 37.3 The Committee noted that most of the 32 recommendations contained in the Royal College of Paediatrics and Child Health Report are well on the way to completion and implementation although the position would be difficult until January 2017 as the system did not have much resilience until then.
- 37.4 Dr Doyle emphasised that the current rota depended on a small number of staff although there was an increase now being seen in the willingness of staff to take on weekends as this was paid extra.
- 37.5 The Committee noted this rota was no more fragile than many others and paediatric services should not have higher benchmarks set than those for other services.
- 37.6 The Chair congratulated those who were taking part in the rotas and thanked Dr Doyle for all his work and for the progress that has been made. The Committee agreed to:
- Note the progress made to date by the Paediatric Programme Board and the implementation of the Royal Collage of Paediatrics and Child Health Recommendations.
 - Note the considerable commitment by the existing consultants at St Johns Hospital by providing resident out of hours cover during the consultant recruitment drive, ensuring that 24 hour paediatric inpatient services at St Johns Hospital could be retained during this period.
 - Notes the successful recruitment drive that had secured the appointment of 6 consultant paediatricians against an advertised 8 posts and that these consultants would work pan Lothian and all participate in the out of hours work at St Johns Hospital as per the recommended model as described in option 1 in the Royal Collage of Paediatrics and Child Health Report.
 - Note the appointment of 2 trainee advanced paediatric nurse practitioners at the Royal Hospital for Sick Children and St Johns Hospital whom once trained would both contribute to the out of hours work at St Johns Hospital.
 - Note that individual meetings had taken place with existing St Johns Hospital clinicians in relation to securing their longterm commitment to a resident out of hours rota as per option 1 in the Royal Collage of Paediatrics and Child Health Report.
 - Note the progress as to how staff and stakeholders had been informed and engaged with through this process.
 - Note the risks managed through the Paediatric Programme Board.
 - Note the decision to re-advertise the 2 consultant posts in order to secure the long term future of 24 hour paediatric inpatient services at St Johns Hospital and that the 2 posts would make up the total of 8 new consultants agreed by the Board.

38. Managing Outpatient Waiting Times Action Plan

- 38.1 Mr Crombie introduced a circulated report giving an overview of the action plans developed in order to improve the Boards performance against the new outpatient waiting times standard (12 weeks).
- 38.2 The Committee noted that there was increasing anxiety about the impact of the new waiting times targets on clinical governance. In order to improve the position some use was being made of the independent sector from 28 November and additional non recurring funding from the Scottish Government was expected.
- 38.3 The Chair expressed concern at the potential costs of switching the use of the independent sector off and on and Mr Crombie confirmed that prices were not as good as they had been previously as the independent sector had not been given time to gear up to this work. He anticipated better arrangements in the following year as a result of additional Scottish Government funding.
- 38.4 Mr Crombie confirmed that the identity of all the consultants involved in the independent sector was known and all would be completing all of their NHS work before any independent work was undertaken.
- 38.5 The Committee noted the summary of key risks and Mrs Mitchell commented it would be helpful to see the probability and level of severity of these risks.
- 38.6 The Committee:
- Noted the action plan as outlined in the circulated report.
 - Took limited assurance that the actions outlined in the paper would result in a reduced trajectory for the number of patients waiting over 12 weeks for a new outpatient appointment from 20,009 to 12,626 in March 2017.

39. The Lothian Hospitals Plan

- 39.1 Mr Briggs introduced a circulated report outlining the content of the Lothian Hospitals Plan and the approach to further consultation on the plan.
- 39.2 The Committee noted that the Lothian Hospitals Plan was a strategic direction of travel and a planning approach, not just a plan but a framework and an approach to developing services over the next few years. Action plans and business cases would be brought back over the following year and beyond and the plan would be structured around 3 sites and 3 key themes. These were: St Johns Hospital, the Western General Hospital and the Royal Infirmary of Edinburgh and the 3 themes would be medical, elective and cancer services.
- 39.3 St Johns Hospital would be an elective care centre for Lothian and for the South East Scotland region, incorporating highly specialist head and neck, plastics and ENT services as well as continuing to provide the district general hospital services for the people of West Lothian.
- 39.4 The Western General Hospital would provide the cancer hospital for South East Scotland incorporating breast, urology and colorectal surgery and the Royal

Infirmery of Edinburgh would be South East Scotland Emergency Care Centre incorporating a major trauma centre, orthopaedic services, neurosurgery and children's tertiary care.

- 39.5 In addition, the Royal Edinburgh Hospital would be Edinburgh's inpatient centre for highly specialist mental health and learning disability services, incorporating regional and national services.
- 39.6 The Committee noted that the Strategic Planning Committee was sponsoring the hospitals plan and it was noted that medical services were the responsibility of integration Joint Boards to commission plan and approve.
- 39.7 The paper would be going to Lothian NHS Board and it would be necessary to agree with the 4 Integration Joint Boards how consultation on medical services would be undertaken. It was intended to bring the final plan with full details forward in the first quarter of 2017/18.
- 39.8 The Chair congratulated Mr Briggs on the report and the plan and asked how support would be provided to the Integration Joint Boards in terms of knowledge, experience and skills.
- 39.9 Mr Briggs advised that work was underway to establish a Medical Specialties Programme Board to consider existing plans and present a number of options. A clear direction of travel had to be agreed and would require a significant amount of work. The involvement of the Integration Joint Boards would be a huge cultural shift for consultants.
- 39.10 Mr Walker commented that this helped significantly with the Integration Joint Boards and emphasised the need for timelines to follow the consultation exercise. He suggested that the report be submitted to the Integration Joint Boards as soon as possible. Mr Briggs advised that timelines would be discussed at the January Board Development Day.
- 39.11 Mr Oates emphasised that timing would be of the essence and the consultation would need to be concluded by the end of the current financial year.
- 39.12 The Committee agreed to:
- Note the content of the Lothian Hospitals Plan, specifically the strategic headlines for each acute hospital site as detailed in the report.
 - Agree the proposals for future consultation and development of the planning approach, and specifically the approach to 'set aside' (planned by Integration Joint Boards) and 'retained' (planned by NHS Lothian) Services.

40. Revised Management Arrangements

- 40.1 Mr Crombie advised the Committee that, in the anticipation of a phased return to work by the Chief Executive after December, he had asked Mrs Campbell and Mr Tyrothoulakis to extend their acting roles to the end of March 2017.
- 40.2 The Committee noted that all of the acting staff had performed well in their roles.

41. Divisional Financial Performance - October 2016

- 41.1 Mr Marriott introduced a circulated report providing an overview of the Division's year to date and forecast outturn financial performance together with an update on progress against agreed recovery planned actions.
- 41.2 Mr Marriott highlighted the key overspending area, particularly medical staffing where expenditure was £395k overspent in the month with the position continuing to reflect the significant pressure within the junior medical staffing budgets with in-month pressure of ££591k. The year to date position was now £2.137m overspent including an overspend of £2.912m against junior medical staffing.
- 41.3 It was noted that nursing expenditure in-month was £41k overspent (£1.325m year to date). This position was slightly worse than month 6, however it continued to represent a significant improvement on the quarter 1 performance.
- 41.4 The acute prescribing position had improved further in the month (£424k underspent) resulting in a year to date underspend of £1.256m.
- 41.5 It was noted that medical supplies performance had deteriorated sharply in-month (£903k) resulting in a year to date position of £1.627m.
- 41.6 The Committee noted that the key risk was in the delivery of recovery actions and these had all been reviewed at the midyear review.
- 41.7 Mr Marriott went through the elements of additional resources used to manage the financial position and Mr Crombie advised that the emphasis had been moved from achieving savings to giving managers a budget and having them identify how they would deliver services whilst addressing any issues. He explained that the risk rating increased when patients were put into areas not geared up for them and the emphasis was being placed on patient safety and Mr Marriott emphasised that the intention was to balance performance, safety and money.
- 41.8 In response to a question from Mr Oates, Mr Marriott advised that any actions not yet achieved now had a recovery plan and that expenditure was about on trend. The Director of Finance would give a more detailed report at the Board meeting the following day.
- 41.9 The Committee agreed to note the Division's financial performance in October of a £6.862m overspend.

42. Financial Plan 2017/18

- 42.1 Mr Marriott introduced a circulated report giving an overview of the NHS Lothian financial plan and those aspects of the plan which were relevant to the University Hospitals position.
- 42.2 The Committee noted that the Scottish Government budget would be announced on 15 December 2016 and whilst it was anticipated that for 2017/18 NHS Lothian would have an additional £122m costs, the revenue from Scottish Government was not yet

known. It was, however, anticipated that there would be a gap between the Board's financial allocation and its anticipated expenditure of around £50m.

42.3 The Committee noted that Finance would be analysing the budget and its implications for NHS Lothian and working with Scottish Government to finalise the numbers.

42.4 The Committee noted that the Scottish Government was interested in proposals for a 5 year plan but that the longer term issue was the long term sustainability of services and the resultant service changes on which a substantial amount of work would be carried out over the next few months.

42.5 The Committee agreed to:

- Note the forecast deficit highlighted in the circulated report to the Finance and Resources Committee and that further details in relation to acute performance provided in the paper.
- Recognise the function of the Finance and Resources Committee and the review of the overall NHS Lothian plan and its role in determining the level of assurance to be taken from the draft plan.

43. Waiting Times Governance

43.1 The Committee noted a circulated report giving an update on waiting times governance since the previous report in June 2016.

43.2 The Committee noted:

- A number of issues had been identified in regard to the provision of data to ISD. Significant amongst those highlighted were the backlogs of SMR submissions from across Lothian and the provision of outpatient waiting time information.
- Whilst problems in submitting data for national publication of waiting times at Edinburgh Dental Institute had been resolved, a system update to Trak had impacted on the ISD's release on 29 November.
- Specific governance issues being progressed in mental health, cancer and accident and emergency.
- That the quarterly update to the Scottish Government of waiting times governance, highlighted the area of additional needs as an area requiring improvement and an update on the national discussions to move this forward.
- Sampling of waiting time records had informed actions underway to support improvement in relation to practice within the dental institute and also in the sending of letters more widely.
- That monitoring reports had identified a number of areas for improvement but no issues of significant concerns.
- A number of updates had been made to standard operating procedures.

44. Quality of Papers and Debate

44.1 The Committee noted that the quality of papers had been very good but that future agendas should be no longer. It was agreed that Directors should make it clear to staff producing papers what information the Committee wished to receive.

45. Committee Changes

45.1 The Chair reminded the Committee that this was Mr Reith's last meeting prior to his retirement at the end of the year and the Committee expressed their appreciation for his work on the Committee's behalf. The Committee also noted that this would be Mr Walker's last meeting as his term of office expired at the end of January 2017 and the Committee thanked him for work as a member of the Committee.

46. Date of Next Meeting

46.1 It was noted that the next meeting of the Committee would be held on Wednesday 22 February 2017 at 2pm in a meeting room to be confirmed.

NHS Lothian

Acute Hospitals Committee

Minutes of the meeting of the Acute Hospitals Committee held at 14:00 on Wednesday 22 February 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms K. Blair, Non-Executive Board Member (chair); Dr B. Cook, Medical Director, Acute Services; Professor A. McMahon, Nurse Director; Ms A. Mitchell, Non-Executive Board Member; Mr J. Oates, Non-Executive Board Member.

In Attendance: Ms S. Ballard-Smith, Nurse Director, Acute Services; Ms J. Campbell, Interim Chief Officer, Acute Services; Mr O. Campbell, Business Manager, Acute Services Directorate; Ms G. Cunningham, General Manager, Royal Infirmary (item 48.4); Ms W. Dale, Strategic Planning, Edinburgh Health and Social Care Partnership (item 50.2); Ms K. Dimmock, Senior Information Analyst; Ms Joan Donnelly, Outpatients Service Director (item 48.1); Ms F. Ireland, Assistant Director, Nursing Workforce and Business Support; Dr L. Jones, Consultant Paediatrician (item 49.1); Mr R. Mackie, Senior Information Analyst; Mr C. Marriott, Deputy Director of Finance; Ms F. Mitchell, Site Director, Royal Hospital for Sick Children (item 49.1); Ms B. Pillath, Committee Administrator (minutes); Ms S. Walter, Capacity Planning Manager, Outpatients (item 48.1).

Apologies: Dr D. Farquharson, Medical Director; Ms T. Gillies, Medical Director; Mr A. Joyce, Employee Director; Ms M. Whyte, Non-Executive Board Member.

Chair's Welcome and Introductions

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

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

47. Minutes from Previous Meeting (6 December 2016)

47.1 Subject to one amendment to paragraph 34.8 the minutes from the meeting held on 6 December 2016 were approved as a correct record.

47.2 The updated cumulative Committee action note had been previously circulated. The chair advised that the action note would be updated more consistently from now.

48. Performance Assurance

48.1 Outpatient ≤12 weeks

48.1.1 A paper had been previously circulated and Ms Campbell gave a presentation showing the performance data for patients waiting over 12 weeks for an outpatient

appointment. It was noted that the trajectory for the end of March 2017 was still very high, even in comparison to the first quarter 2016-17 when the private sector was not being used. Ms Campbell explained that this was because the impact of stopping use of the private sector in April 2016 had taken a while to show its effect on the number of patients waiting over 12 weeks. Although the Board had made the decision to use the independent sector again in November 2016, the end of March position would still remain high due to demand exceeding capacity.

- 48.1.2 Ms Donnelly gave a presentation on the strategy for outpatients which was in line with the Scottish Governments strategy of increasing the number of patients receiving care closer to home and reducing patient visits to hospital which were of limited or unclear value. Ms Walter presented the workstreams that were in progress to identify demand and capacity and to manage challenges.
- 48.1.3 Ms Campbell noted that NHS Lothian had a robust process for managing attendances and that work was in progress to redesign outpatient services by reducing demand and optimising activity in a modern sustainable way.
- 48.1.4 The Integration Joint Board role in outpatient services was important and this would be part of the remit of a strategic board that would include all Integration Joint Boards and NHS Lothian.
- 48.1.5 It was planned that about 1,000 patients would receive vascular surgery in the private provider The Edinburgh Clinic, but this was put on hold due concerns relating to the hospital environment. A number of recommendations had been made and action had been taken by the Clinic; following a further visit on 23 February 2017 it was hoped that they could resume provision of services anticipating that 200 of the 1,000 patients originally intended would be treated before the end of March 2017.
- 48.1.6 The Committee requested that the next paper on this item should include more detail on the impact of the actions and workstreams in progress to improve the situation. This paper should also include information that would inform the risk profile and prioritisation of any available funding and allow the link between financial efficiency and performance to be considered. Ms Campbell agreed to include this detail in the next paper. **JC**
- 48.1.7 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. In the context of both the paper and the presentation and discussion, limited assurance in relation to performance was given, although recognition that systems of control were in place was accepted. Members accepted the recommendations laid out in the paper.
- 48.2 Inpatient and Day Case Treatment Time Guarantee \leq 12 weeks
- 48.2.1 A paper had been previously circulated and Ms Campbell gave a presentation showing performance data for patients waiting for more than 12 weeks for inpatient and day case treatment.

- 48.2.2 Again members asked that future papers on this area give more context on the impacts of actions taken on performance data. Ms Campbell agreed and noted that now the Theatre Improvement Programme Board was in place and data was available the next step was to use the data to target improvement. **JC**
- 48.2.3 It was suggested that it had taken a long time to get to the stage of having the programme board set up, but Ms Campbell noted that it was important to have an effective process in place and that all the staff involved were already under pressure with day to day work. A number of pieces of work were now in place but they would take time to take effect.
- 48.2.4 Dr Cook noted that workforce was a key area of concern as staff were covering for vacancies in all areas which affected time to do other work. This was a problem for all the Scottish Health Boards. Professor McMahon advised that there was a focus on training, recruitment and retention of staff in substantive posts and that there was a Scottish Government consultation out currently on workforce planning including regional planning.
- 48.2.5 Members accepted the recommendations laid out in the paper and accepted limited assurance in the context of the paper along with the presentation and discussion.
- 48.3 Referral to Treatment ≤18 weeks
- 48.3.1 Ms Campbell showed a chart giving the outpatient and treatment time guarantee performance combined, showing the deteriorating performance as described in the two papers. The slide was noted and limited assurance agreed.
- 48.4 Unscheduled Care ≤4 hours
- 48.4.1 The chair welcomed Ms Cunningham to the meeting and she spoke to the previously circulated paper. The concerns highlighted were in relation to the number of delayed discharges, and the capacity pressure caused by these.
- 48.4.2 A ward had been opened for delayed discharge patients. It was acknowledged that this was not the ideal solution but it was safer than boarding patients on wards of other specialities, and patient and staff experiences were improved as a specific team was looking after the patients and were not reliant on ward rounds from other areas. This also reduced the risk of overcrowding at front door areas.
- 48.4.3 Performance on the 4 hour target was relatively good, with the previously indicated trajectory of 90% achieved, but it was noted that this hid the impact on staff and patient experience of managing patient flow in terms of boarding patients and cancellation of elective operations; this also had an effect on treatment time performance.
- 48.4.4 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. **GC**
- 48.5 Quality and Performance Report

- 48.5.1 The paper had been previously circulated. Some of the areas of performance had been covered in the previous items. It was noted that the Integration Joint Boards would give presentations at the Board development session in March 2017 on actions that would be required to get to a position of 85% occupancy of unscheduled beds; this would require detailed actions on reducing attendances and reduction in delayed discharge numbers and occupied bed days.
- 48.5.2 It was noted that the situation regarding outpatient activity and treatment time guarantee was the same throughout Scotland and regional planning in the future could be helpful.
- 48.5.3 The Committee agreed that the focus of performance reporting needed to change from explanations of situations to actions for improvement, solutions, and impact of work done.

48.6 Timetable of Assurance

- 48.6.1 Members accepted the previously circulated draft timetable of assurance. It was noted that in areas where the Committee had taken limited assurance a further update should be taken at each meeting until there was an improvement. It was anticipated that updates reports could be accepted without detailed discussion, leaving time to discuss new areas.

49. Clinical Governance

49.1 Update on NHS Lothian's Medical Paediatric Service

- 49.1.1 The Chair welcomed Ms F. Mitchell and Dr Jones to the meeting and Ms F. Mitchell spoke to the previously circulated paper on the work of the Paediatric Programme Board which was set up in response to the recommendations of the Royal College of Paediatricians review of the service. Five of the eight new paediatrician posts had been recruited and interview dates set for the remaining three posts.
- 49.1.2 Dr Jones gave some background information about the paediatrics service and the system of sub specialty trained paediatricians cross covering general paediatrics, as well of the complexity of the service. This system meant that all specialties were under pressure but withdrawing input in general paediatrics would increase pressure there. The review had not made any recommendations regarding this and it was difficult to recruit general paediatricians who were also sub specialty trained. Dr Cook noted that the separation of general acute services from the acute specialities in adult services had resulted in further pressures for general medical staff who did hard out of hours work with no specialty interest; in his opinion it would be a mistake to also go down this route in paediatrics.
- 49.1.3 Members accepted recommendations 2.1 to 2.7 of the report. Recommendation 2.8 asked for moderate assurance to be taken that long term sustainable model for out of hours inpatient paediatric care at St John's Hospital would be achieved by autumn 2017, but the Committee was not able to accept this assurance for a future date and agreed to accept limited assurance due to the fragility of the proposal.

- 49.1.4 Recommendation 2.9 of the report asked the Committee to agree an appropriate process to address the pressures faced by sub speciality paediatrics services. The Committee asked that the Programme Board bring recommendations for possible solutions to these pressures to the Committee for acceptance. **FM**

50. Corporate Governance

50.1 Integration Joint Board Direction for 2017-18

- 50.1.1 Members noted the previously circulated paper which included the strategic directions of East Lothian and Midlothian Integration Joint Boards. The process of agreeing these directions of Edinburgh and West Lothian Integration Joint Boards was still in progress.

50.2 Edinburgh Integration Joint Board Flow Programme Board

- 50.2.1 The Chair welcomed Ms Dale to the meeting and she gave a presentation on the programme board set up between Edinburgh Integration Joint Board and NHS Lothian to get a better understanding of the position in relation to delayed discharge from hospital. The programme had been in place for one year and was now at the stage of reviewing the achievements of the workstreams undertaken and deciding on new areas of work. Ms Dale described the impact and reduction of bed days required as a result of some of the workstreams.
- 50.2.2 The programme board had been a positive example of how the Health Board and the Integration Joint Board could work together.
- 50.2.3 The Chair thanked Ms Dale for the helpful presentation, noting that the programme board reported to the Integration Joint Board but was of interest to Acute Hospitals Committee because of the affect delayed discharge had on the service.

51. Fiscal Governance

51.1 Finance Out-turn and Month End Position

- 51.1.1 A paper had been previously circulated. Mr Marriott advised that a break even position was expected for the end of this financial year, and the focus was now on next year; the new pressures, the recurrence of pressures from this year, and the recovery of finances.
- 51.1.2 Members accepted the recommendations in the paper to note the position.

52. Items for Information

52.1 Quality of Papers and Debate

- 52.1.1 The Chair noted that there was an inconsistency between the papers and the presentation of data and Ms Campbell agreed to implement a standard format of reporting in future papers. **JC**

53. Any Other Business

53.1 Healthcare Environment Inspection, Royal Infirmary

53.1.1 Ms Ballard-Smith reported that Healthcare Environment Inspectorate (HEI) had visited the Royal Infirmary on 15-17 February 2017. Initial feedback on cleanliness and patient equipment had been good, and the patient feedback was very good. Areas for improvement included better training on use of new cleaning products; this was being addressed. The final report would be available in 8 weeks on the Healthcare Improvement Scotland website and would go to the Healthcare Governance Committee for information.

54. Date of Next Meeting

54.1 The next meeting of the Acute Hospitals Committee would take place at **14.00** on **Tuesday 30 May 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

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

- Tuesday 4 July 2017;
- Tuesday 29 August 2017;
- Tuesday 7 November 2017.

DRAFT

NHS Lothian

1.7

STAFF GOVERNANCE COMMITTEE

Minutes of a Meeting of the Staff Governance Committee held at 9:30am on Wednesday 26 October 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr A Joyce (Chair); Mrs J Butler; Dr D Farquharson; Councillor D Grant; Mr B Houston; Mrs F Ireland; Councillor C Johnstone; Mrs A Mitchell and Mr J Oates.

In Attendance: Mrs J Campbell (Acting Chief Officer); Mr J Crombie (Acting Chief Executive); Mrs R Kelly (Associate Director of Human Resources) and Mr P Reith (Secretariat Manager).

Apologies for Absence were received from Mr S McLaughlin and Professor A McMahon.

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.

36. Minutes of the Previous Meeting

36.1 The circulated Minutes of the Staff Governance Committee Meeting held on 27 July 2016 were approved as a correct record.

37. Review of the Staff Governance Committee - Proposals

37.1 The Chair advised the Committee that he had discussed the workings of the Committee with the Board Chairman, the Interim Director of Human Resources & Organisational Development and the Associate Director of Human Resources and it had been concluded that the Committee could work more effectively than it currently did and that the agenda could have more structure.

37.2 Mrs Butler introduced a circulated report detailing proposals to refresh the work of the Staff Governance Committee to ensure that it was able to fulfil its scrutiny and assurance roles to the Board around staff governance.

37.3 The Committee noted that the terms of reference had last been reviewed in June 2013 and were very much based on detail included in the staff governance standard as to the role of the Staff Governance Committee. However, the remit did not currently reflect the assurance role that the Committee should have in terms of the staff governance agenda and the need to provide assurance to the Board on the overall performance of NHS Lothian in relation to staffing matters.

37.4 The Chair advised that his current role as Chair of the Committee did not allow him to discharge his role as Employee Director at meetings of the Committee as effectively

as possible. He had discussed this with the Staff Side organisations which had agreed they would be content if the decision was taken that the Employee Director did not have to be the Chair of the Committee but remained a member.

- 37.5 Mrs Butler advised that the annual survey of members in preparation of the Annual Staff Governance Committee report had identified concerns in terms of the development needs of the Committee members and it was felt that it would be helpful to produce an induction pack for new members and existing members of the Committee to include relevant documents such as the Terms of Reference, Staff Governance Standard and Everyone Matters documentation.
- 37.6 It was also being proposed that a development session be held either at the next scheduled meeting in January 2017 or on an alternative date, covering the Staff Governance Standard, Everyone Matters and a presentation around the assurance role of the Committee, partnership arrangements, iMatter etc. and any other areas members of the Committee would find helpful to include in such a development session.
- 37.7 The Committee noted that the sub structure currently had the Health and Safety Committee and the Remuneration Committee reporting to the Staff Governance Committee. The terms of reference of the Remuneration Committee prescribed and the inclusion of the Health and Safety Committee made some sense given the clear links to staff safety, although it was recognised that the role and duties were wider than staff. It had been felt however that more frequent extracts of the minutes of these meetings needed to be presented to the Committee so that it could be assured around these areas. Whilst there were no proposals to change the Committee sub structure at this stage, consideration was being given to the establishment of a Staff Experience Steering Group which would pick up issues around the implementation of iMatter, the values work and also the wider staff experience agenda.
- 37.8 It was noted that there was no specific structure to the current agenda and in future it was proposed that the agenda be based on the priorities in Everyone Matters: 2020 workforce vision. The five priority areas covered by Everyone Matters were:
- Healthy organisational culture
 - Sustainable workforce
 - Capable workforce
 - Workforce to deliver integrated services
 - Effect leadership and management
- 37.9 Papers would be provided to the Committee under each of the relevant headings to show the work that was being undertaken in each of the areas which would also assist with the assurance requirement. Appropriate members of staff could be invited to the meeting to discuss particular aspects of ongoing work to assist with providing the assurance to the committee. An annual agenda timetable would also be developed for the committee showing when certain reports needed to be considered to meet Scottish Government and Board deadlines.
- 37.10 The Committee noted that all the Board Governance Committees were adopting a new format for papers so that it was very clear precisely on what assurance was being provided to the Committee by bringing a paper on a particular issue. A workforce report was also being developed for the Committee which would bring together all of the relevant workforce indicators showing trends and highlighting areas for improvement to further assist with the assurance and scrutiny role.

- 37.11 Mrs Butler advised that whilst the quarterly frequency of meetings had been confirmed earlier in the year, this did not match the other governance committees and it was being proposed that the Committee should meet five times per year.
- 37.12 Mrs Mitchell welcomed the proposal and commented that there was a need for a root and branch review of Committees, in particular the Health and Safety Committee.
- 37.13 Mrs Butler advised that a new Director of Occupational Health had been appointed and she would be happy to review this with him and for it to be discussed at the forthcoming development session.
- 37.14 Mr Houston advised that there had been some concern at Board and Executive level over the need to escalate health and safety issues and he agreed that the sub structure for health and safety should be reviewed.
- 37.15 The Chair reminded the Committee that the Remuneration Committees role was statutory and the highly confidential nature of the business meant that only extracts of minutes could be provided.
- 37.16 Mr Crombie emphasised the importance of engagement with Committee members and supported the introduction of a performance report to provide assurance to the committee.
- 37.17 Councillor Grant intimated his support of the proposals, particularly the proposed agenda format as he found the current structure confusing.
- 37.18 Mr Oates endorsed the earlier comments and proposed that there should also be a specific item on the risk register as it pertained to the Staff Governance Committee.
- 37.19 The Committee agreed to approve the revised terms of reference for the committee for submission to the Lothian NHS Board for approval and supported the implementation of the recommendations contained in the circulated paper with the inclusion of a standing item on the risk register.

JB

38. Staff Governance Monitoring Return - 2015/16 Feedback Letter

- 38.1 Mrs Butler introduced the circulated correspondence from the Head of Staff Governance at the Scottish Government providing comments in relation to the staff governance monitoring return for 2015/16 and the PIN compliance template and summary of the 2016/17 Staff Governance Action Plan.
- 38.2 The Committee noted that the Board had been congratulated on implementing the 'Courage to Manage programme' and on the 27% increase in staff indicating that they were aware of NHS Lothian's values. It was also noted that there was some criticism about the responses to the staff questionnaire question 'did you agree a personal development plan' or equivalent (88%) which was not reflected in the eKSF status for NHS Lothian which showed only 31%. The Committee noted that the online eKSF system was widely accepted as being not fit for purpose and an improvement plan was being developed and would include monitoring performance via the workforce dashboard, which enables monitoring down to ward or equivalent level.

- 38.3 Mr Crombie commented that the eKSF system was cumbersome and he was keen to see recommendations on improving the system, particularly given the successes in respect of mandatory training compliance
- 38.4 Mrs Kelly advised that the replacement for eKSF was anticipated in the next few months and it was hoped that this would be a significant improvement.
- 38.5 The Committee noted the position.

39. Mandatory Training Compliance

- 39.1 Mrs Butler introduced a circulated report giving an update regarding actions being taken to improve mandatory training compliance.
- 39.2 NHS Lothian was showing, on average, above 80% compliance and five of the mandatory topics and above 70% compliance in the remaining four topics.
- 39.3 All subjects had evidence of some improvement over the last quarter, with violence and aggression, equality and diversity and information governance changing rating from light to dark green. Public Protection had also changed rating from amber to light green and information governance had shown the greatest increase in compliance with 81% at the end of September. NHS Lothian was therefore on track to achieve the Information Commissioner's target of 85% by the end of November.
- 39.4 The Committee noted that work being undertaken in facilities to use a DVD and tool box programme to reach staff who did not have access to computers was particularly worthy of mention. A special programme in respect of health and safety in facilities was now in place and being rolled out.
- 39.5 The Committee agreed to note the progress made to date and supported the plans for continued performance improvement.

40. Whistleblowing Update

- 40.1 Mrs Kelly introduced a circulated report on the current actions being taken in relation to whistleblowing and detailing the action plan for the coming months.
- 40.2 The Committee noted that the Board's policy was now in line with the PIN Guideline to make the process for staff wishing to raise a concern more robust. The initial point of contact for staff to raise a concern was with their line manager. However, if the member of staff felt that their concern had not been addressed properly by their line manager or could not be raised with the line manager the policy now had 4 named contacts at Stage 2 with whom staff could raise their concern. These were the Nurse Director (Acute), Medical Director (Acute), Medical Director (Primary Care) and the AHP Director. Named contacts had also been put in place at Stage 3 and these were the Chief Executive, Nurse Director and Medical Director. Appropriate training was now being sourced for these individuals to ensure that they were able to undertake this role effectively. The policy had been through the Human Resources Policy Group and approved by the Lothian Partnership Forum and would go on HR Online shortly. In addition to the training for staff, further training for staff side and management colleagues would also be provided and publicity arranged through the

Communications Department. There would also be a need to put in place monitoring arrangements.

- 40.3 The Committee noted that Mrs Mitchell was the Board's whistleblowing champion and would need to be kept apprised of any issues raised.
- 40.4 It was noted that the policy would be published online and a regular report would come to the Staff Governance Committee on progress.
- 40.5 Mrs Mitchell commented that there had only been 1 whistleblowing report in the past year which was not satisfactory. Managers had to be advised of the policy and what they had to do and a mechanism to provide adequate assurance had to be devised and implemented.
- 40.6 The Chair commented that in his experience the policy was used very rarely by staff.
- 40.7 Councillor Grant sought confirmation that any actions would have already taken place before reports came to the Staff Governance Committee and Mrs Kelly advised that this was the case as actions would be taken by management and not Board members.
- 40.8 The Committee agreed to note the revised whistleblowing policy and supported the circulated whistleblowing action plan.

41. Nursing and Midwifery Revalidation

- 41.1 Mrs Ireland introduced a circulated report giving assurance that the new three yearly process of Nursing and Midwifery Council Revalidation for nurses and midwives which commenced on 1 April 2016 had been successfully implemented in NHS Lothian.
- 41.2 The Committee noted that the work to date to ensure that NHS Lothian's registered nurses had successfully re-registered using the revalidation process. To date only 5 nurses and midwives in NHS Lothian had not revalidated of which were 2 were staff who were retiring, 1 was on long term sick leave, 1 could not afford the fee and 1 was accidental.
- 41.3 Mrs Kelly advised that national discussions were still continuing on how to deal with staff who did not revalidate as there was currently no consensus. The NHS Lothian current policy was to pay such staff the highest non registered grade but this had not received support nationally.
- 41.4 Mrs Mitchell questioned whether the next revaluation in 3 three years would lead to increases in the number of staff retiring and Ms Ireland advised that this should not be the case and registration was something that was being done in any event.
- 41.5 It was noted that revalidation was now also on the e-rostering system and would flag up to managers when nurses were due to register.
- 41.6 The Chair asked if there was any feedback on whether any nurses re-registering had been asked to prove the completion of the necessary hours of clinical work. Mrs Ireland advised that it was more likely that nursing staff outside the NHS where there were fewer mandatory structures in place would be monitored and checked.

- 41.7 Councillor Grant asked if there were any measures in place to help staff who could not afford the registration fee and Mrs Ireland advised that it was possible to be paid in monthly instalments.
- 41.8 The Committee noted the work undertaken to date to ensure that NHS Lothian's nurses and midwives successfully revalidated . It was also noted that ongoing support had been put in place for all nurses and midwives going through revalidation from 30 September 2016 onward.
- 41.9 The Committee noted that the revalidation process was being monitored by management and congratulated Ms McGuinness and her team on the successful outcome of their hard work.

42. Safe Nurse Staffing Levels

- 42.1 Mrs Ireland introduced a circulated report detailing the ongoing work around safe nurse staffing levels and providing a moderate level of assurance that there was operational delivery against key standards of the staff governance agenda.
- 42.2 The Committee noted that this would be a regular report under the new agenda in the category of sustainable workforce. A lot of work was being undertaken in this area and NHS Lothian had a timetable to ensure compliance with the Scottish Government requirement for the national workload and workforce planning tools to be completed on an annual basis. This annual process took account of the professional judgement of the nursing and midwifery staff on duty during the census period, the calculated staffing levels for the patient acuity using the appropriate specialty tool, local indicators such as vacancy rates and use of supplementary staffing and a series of care quality measures.
- 42.3 These metrics were triangulated and the Associate Nurse Directors and Chief Nurses were required to take forward prioritised proposals for investment to local management teams. Thereafter, the Deputy Director of Corporate Nursing would take a collated position to the Director of Nursing for review and for inclusion in the financial plan where prioritised staffing deficits were not able to be addressed by local management teams.
- 42.4 The Committee noted that a number of policies, including the use of agencies were examined. Nursing staff were continuing to be recruited and the gap in the number of established posts was reducing so the overall risk level should shortly be reduced. Rather than specifying a minimum number of nursing staff which would be meaningless in terms of patient safety staff would be deployed to areas of greatest need.
- 42.5 Mrs Ireland advised the committee that a 3 year programme of work required to be undertaken both nationally and locally to determine and plan for the the legislation and Mr Crombie advised that a national working group had been established to work out how to manage the exercise.
- 42.6 The Committee noted that this was a complex area of practice and that the Nurse Director would chair a local group parallel to the national group

- 42.7 Mrs Mitchell commented that it would be useful to see key areas of concern in subsequent reports rather than just an organisational overview..
- 42.8 The Committee agreed to take a moderate level of assurance that the following staff governance standards were being considered and that in relation to nurse staffing levels the staff governance standard requirements were being met:
- The personal, health and wellbeing of patients and staff should be paramount in the design and operation of services
 - Staff were engaged and involved in decisions that affected them with the opportunity influence such decisions
 - Staff were engaged and involved in strategic developments
 - Partnership working was embedded and mainstreamed within each NHS Board
 - Service development and organisational changes were planned and implemented in partnership, and with effective staff engagement
 - A comprehensive workforce plan, based on these developments and changes, was developed in partnership
- 43. Health and Safety Committee**
- 43.1 The Committee noted the circulated minutes of the Health and Safety Committee meeting held on 30 August 2016.
- 44. Lothian Partnership Forum**
- 44.1 The Committee noted the circulated minutes of the meeting of the Lothian Partnership Forum held on 12 July 2016.
- 45. Workforce Organisational Change Group**
- 45.1 The Committee noted the circulated minutes of the Workforce Organisational Change Group meeting held on 26 September 2016.
- 46. Date of Next Meeting**
- 46.1 It was noted that the next meeting of the committee would be held on Wednesday 25 January 2017 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

DRAFT

NHS Lothian

Staff Governance Committee

Minutes of a Meeting of the Staff Governance Committee held at 9:30am on Wednesday 25 January 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr A Joyce (Chair); Mrs A Mitchell; Mrs J Butler; Councillor C Johnstone; Dr D Farquharson; Councillor D Grant; Ms H Fitzgerald; Mr B Houston; Mr S McLaughlin and Mr J Oates

In Attendance:

Mrs J Campbell (Acting Chief Officer); Mr J Crombie (Acting Chief Executive); Mrs R Kelly (Associate Director of Human Resources); Dr A Leckie (Director Lothian Occupational Health and Safety Service); Ms A Burnett (Communications Manager); Mr A Payne (Corporate Governance Manager); Mr M McKelvie (HR Information Systems Manager) and Mr C Graham (Board Secretariat)

Apologies for Absence were received from Mr D Small; Prof. A McCallum and Prof. A McMahon.

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.

47. Assurance and Scrutiny

- 47.1 Mr Payne outlined plans to change how committees carried out the role of providing appropriate governance and receiving adequate assurance. The circulated paper outlined these plans. The various level of assurance were noted as significant; moderate; limited; none and not assessed yet. These levels of assurance would help the committees in carrying out their role and there would also be amended guidance for those preparing reports around what was now expected.
- 47.2 This approach would also see the building up of a record of assurance as part of evidencing good governance decisions and promote a shared common language around assurance. Mr Houston stated that this approach would be extremely helpful once fully applied at Board level and people adapted to its use.
- 47.3 Mr Payne stated that this remained a learning process and feedback and amendments were welcomed. It was noted that the author of a paper to the Board or a committee may make a recommendation of assurance level but this may or may not be accepted and the option to change the format of the recommendation would be retained.

47.4 Committee Annual Reports

- 47.4.1 Mr Payne reported that information included as part of the governance committee statements was being reviewed. This would help to make sure annual reports told us what we need to know and would give a positive statement of what assurance the committees had covered. This would also be an alternative form of annual report.
- 47.4.2 The new approach had already been supported at the Audit and Risk Committee and Board Chairs Committee. The approach would simplify things for each committee and if used throughout the year would make production of annual reports easier whilst providing assurance over what had been covered. The Committee agreed to the proposed approach.

48. Ensuring the Right Thing Happens in Practice Every Time

- 48.1 Mr Payne introduced the report presenting the action plan for Ensuring the Right Thing Happens in Practice Every Time. It was noted that this action was prepared in response to the issues raised in an internal audit on Compliance with Policies & Procedures and had been submitted to the Board on 7 December 2016.
- 48.2 The Audit & Risk Committee received an update on the action plan on 5 September 2016 and agreed that it should be presented to the Board, together with an account of how executive management are monitoring the project.
- 48.3 Mr Payne stated that the action plan sets out a large programme of work. The nature of the subject means that it is an area which will always require continuous development and monitoring. It related to organisational culture; how the organisation works and how it has systematically gets assurance on the adequacy and effectiveness of policies and procedures. It was noted that there had been ten action areas for the Board which had been agreed by the Corporate Management Team. These recommendations had now all been closed down by the internal auditors.
- 48.4 Mr Payne added that it was also planned to improve material on the intranet and internet as well as looking at better use of software systems for distribution of materials. This was about what could be done corporately to make things easier for people.
- 48.5 The Committee noted the report and update.

Mr Payne left the meeting.

49. Everyone Matters

- 49.1 Mrs Butler gave a short high level presentation providing a recap on the staff governance standard. The presentation covered:
- Roles and Responsibilities
 - Evidence and Monitoring Arrangements
 - Everyone Matters: 2020 Workforce Vision
 - Implementation Plans
 - Examples of NHS Lothian Innovative Work

49.2 This included five priority areas contributing towards a well informed Board:

- Healthy organisational culture
- Sustainable workforce
- Capable workforce
- Workforce to deliver integrated services
- Effective leadership and management

49.3 There was discussion on workforce plans; systems; stakeholders; consultation; modern apprenticeships; health and social care integration; supporting sustainability and regional workforce planning.

49.4 The Committee noted that the Scottish Government were currently reviewing the Staff Governance Standard requirements so there was no need to provide a return this year. The outcome of the review was awaited; this would hopefully be produced in May following review from the Cabinet Secretary. Mrs Butler would bring updates back to the Committee as appropriate.

JB

50. Health and Safety Committee

50.1 Dr Leckie reported on his first impressions of the operation of the Health and Safety Committee since his recent appointment as Director for the Lothian Occupational Health and Safety Service. It was noted that he had attended one meeting and chaired one meeting.

50.2 It was clear that there were many different approaches to governance and that each Health Board was different. Dr Leckie stated that the Health and Safety Committee received lots of information on good work undertaken which was then simply noted. Similarly some significant risks had not been identified and escalated. There was a need for clarity and effectiveness of the escalation process. The question was whether the board was adequately sighted on the risks. Dr Leckie proposed that a full paper be brought back to the Committee for discussion.

50.3 The Committee agreed that a formal paper was required around risks and that the Corporate Management Team also needed to be briefed on this. Mr Crombie agreed to assist Mr Leckie in the preparation of a formal paper.

AL/JC

51. Workforce Dashboards

51.1 Mrs Kelly introduced the workforce dashboard. It was noted that months had been spent making information available to managers through the use of dashboards. These dashboards can be interrogated down to area and team level and can be very helpful for sharing of information with partnership colleagues; tracking of mandatory training compliance; sickness absence; standardised reporting and consistency.

51.2 Mr McKelvie gave a live demonstration of the dashboard system covering access dependant and default areas; setting up subscriptions to particular dashboards; workforce indicators; filtering searches; aggregated data over multiple areas and custom views.

51.3 There was discussion on training for staff, it was noted that analytical services were providing face to face sessions and Mr McKelvie was also contactable.

Mr McKelvie left the meeting.

52. Minutes of the Previous Meeting

52.1 The circulated Minutes of the Staff Governance Committee Meeting held on 26 October 2016 were approved as a correct record, subject to the following amendment:

- Add Helen Fitzgerald to the list of those present

53. Matters Arising

53.1 Staff Governance Committee Review - It was noted that the revised terms of reference had been signed off at the December Board meeting. Mrs Mitchell would be taking over as Chair of the Committee from Mr Joyce, who would remain a member.

53.2 There was discussion on an induction pack for new members. Mrs Kelly stated that the Scottish Government were developing a Non Executive Director booklet around workforce which would cover aspects such as staff governance. It was agreed to bring the booklet to the Committee when available.

RK

54. Organisational Culture – Follow up of PwC and Bowles Report Action Plans

54.1 The Internal Audit report was noted. Mrs Butler stated that the report was an audit of management culture following previous issues around waiting times. The Audit and Risk Committee chair had asked the auditor to include a review of some actions.

54.2 Overall the report was positive with 100% of the PwC and 94% of the Bowles actions being completed. The report showed clear improvements around culture but there remained some outstanding actions.

54.3 Around staff governance there was a concern that the Committee had not been fully sighted as the last update to the Committee had been in January 2014. There was to be a proposal to the Corporate Management Team to consider appropriate mechanisms for ongoing work across the organisation, embedding culture and wellbeing. A paper would come back to a future meeting of the Committee.

54.4 The Committee were content with the report. It was noted that there remained actions to be closed out, including making sure the Staff Governance Committee had appropriate oversight.

55. National Staff Experience Measurement Letter

55.1 Mrs Butler reported that it had been agreed that the previous national annual Staff Survey be discontinued and that future national staff experience be measured using the iMatter Continuous Improvement Model (iMatter) supplemented by a short complementary questionnaire. The complementary questionnaire will be distributed to all staff via the NHSScotland Employee Engagement IT Portal. The Committee noted the new approach.

56. Whistleblowing Update

- 56.1 Mrs Kelly updated the members of the Committee on progress with the current actions that are being taking in relation to Whistleblowing as outlined in the action plan agreed at the last meeting of the Staff Governance Committee. The progress was noted.
- 56.2 Mrs Kelly reported that the policy and process had been revised, updated and approved; there was named contacts for stage two and three; training had been organised; HR Online had been updated with the new pages set to launch imminently and that there would be continued review and updated as required. There were also plans to work with the Communications Team around social media as well as updates being sent to local partnership forums.
- 56.3 It was noted that a form around monitoring arrangements had been agreed with Mrs Mitchell, as Whistleblowing Champion, and that NHS Lothian had been included in the Scottish Government pilot for monitoring of cases raised. Numbers of cases raised would be brought to future meetings.
- 56.4 Mr Joyce asked about tracking of concerns raised. If staff raised concern via the whistleblowing policy then this was clear but for others not using the policy how was this picked up. Mrs Butler stated that concerns coming through the Employee Relations (ER) team were not always explicit and there remained ongoing work around this. ER had been included in the planned named contacts training.
- 56.5 Mrs Mitchell asked about potential conflict of interest with her being the Board's whistleblowing champion and taking over as chair of the Committee. The Committee agreed that there was no conflict as whistleblowing was accountable to the Board Chairman and not the Committee.

57. Sickness Absence Progress

- 57.1 Mrs Butler reported that the paper had previously been submitted to the Audit and Risk Committee on 5 September 2016 and showed sickness absence performance against the 4% standard. It was noted that this was a long standing target and was important to realise that no health board had ever achieved this standard. The Audit and Risk Committee had agreed that the 4% standard was a matter for Staff Governance Committee to consider. The Committee noted the content of the paper shared with the Audit and Risk Committee and the rationale for proposing a revised way forward.
- 57.2 There were discussions on the changing demographic of the workforce and the wider health and wellbeing strategy for NHS Lothian staff. It was accepted that there need to be more proactive work around keeping staff healthy and staff aspiring to look after their own health.
- 57.3 There was also discussion on the support available to managers dealing with absenteeism. Mrs Butler stated that support was provided around difficulty discussions and bespoke training could be arranged with the employee relations team. Mr Joyce added that staff side would provide support to people that were genuinely ill. It was noted that a stakeholder event would be arranged for spring 2017.

57.4 The Committee supported the development of a Health and Wellbeing Strategy for NHS Lothian over the next 6 months, for implementation during the following 18 months.

58. Mandatory Training Compliance

58.1 Mrs Butler reported that the standing report to the Committee was showing improvement. It was noted that dashboards were being used to clearly highlight areas that were performing less well. The 20% increase in compliance within Facilities following health and safety tool box talks was welcomed. However it was accepted that tool box talks were not suitable for all staff groups.

58.2 Councillor Grant asked if there was any particular reason why fire training compliance appeared slow to improve. Mrs Butler stated that she would investigate this further and report back to the Committee.

JB

58.3 The Committee noted the progress made to date and supported the plans for continued performance improvement.

59. Medical Revalidation

59.1 Dr Farquharson introduced the report outlining the outcome of the review by Healthcare Improvement Scotland (HIS) of NHS Lothian's progress on medical revalidation in 2015-16. The Committee noted the outcome of the HIS assessment and the relationship between NHS Lothian; St Columba's and Marie Curie hospices for medical revalidation.

60. KSF - PDPR

60.1 The Committee noted the report giving an update on the actions being taking to improve NHS Lothian's KSF/PDPR compliance.

60.2 Mrs Butler outlined the current issues around compliance; recording and the system itself. The paper showed the proposed plans to address poor performance. The Committee noted that the National contract for eKSF runs out in March 2018 and that this would cause a gap as the new replacement HR system would not be available. Therefore an interim solution needed to be found.

60.3 There was discussion on the options and it was felt that it would be simpler to revert to the Empower system to register PDPR completion as a stop gap. From April 2018 there would be a different recording mechanism, with the process being decided at National level.

60.4 The Committee supported the recommendations for plans to improve performance and ensure compliance with KSF/PDPR.

61. Health and Safety Committee

61.1 The Committee noted the circulated minutes of the Health and Safety Committee meeting held on 30 August 2016.

62. Lothian Partnership Forum

62.1 The Committee noted the circulated minutes of the meeting of the Lothian Partnership Forum held on 8 November 2016.

63. Workforce Organisational Change Group

63.1 The Committee noted the circulated minutes of the Workforce Organisational Change Group meeting held on 28 November 2016.

64. Any Other Competent Business

64.1 Chair of Committee – It was noted that Mr Joyce would be standing down as Chair, with Ms Mitchell taking over. Mr Houston recorded thanks to Mr Joyce, who would remain a member of the Committee.

65. Date of Next Meeting

65.1 It was noted that the next meeting of the committee would be held on Wednesday 29 March 2017 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

DRAFT

NHS Lothian

1.8

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 9.30am on Thursday 8 December 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG.

Present: Mr B Houston (Chair); Mrs J Anderson; Mr M Ash; Mr C Briggs; Ms J Campbell; Mr J Crombie; Dr D Farquharson; Councillor D Grant; Mr M Hill; Ms F Ireland; Mr A Joyce; Mr P Johnston; Professor A McMahon; Professor A McCallum and Mr D A Small.

In Attendance: Ms L Colley; Dr C Gorman (for item 37); Mr I Graham (for item 37 & 38); Mrs C Harris; Mr M Hurst (for item 37); Mr P McLaughlin (for item 38) Mr D Weir.

Apologies for absence were received from Mr T Davison, Mrs S Goldsmith and Mr G Walker.

33. Declaration of Financial and Non Financial Interest

33.1 The Chairman reminded members that they should declare any financial and non financial interest that 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.

34. Minutes of the Previous Meeting Held on 11 August 2016

34.1 The minutes of the previous meeting held on 11 August 2016 were approved as a correct record.

35. Matters Arising

35.1 There were no matters arising not covered elsewhere on the agenda.

36. Strategic Planning Committee

36.1 The Committee were advised that following the 14 October workshop around the future of the Strategic Planning Committee that it had been decided to undertake a review of the terms of reference and membership of the Committee. A number of other Board Committees had also looked at their remit. The circulated paper therefore reflected the outputs from the 14

October meeting and contained recommendations about future membership and the modus operandi for future meetings.

- 36.2 The Committee noted that the timing of the recommendations was appropriate given the development of the Information Strategy and the Local Development plan both of which would require a Strategic Planning Committee overview. The intention was that the membership would represent the totality of the health system including Integration Joint Boards (IJBs) and this would strengthen commitment particularly around the ongoing development of the Acute Hospitals plan and the Primary Care Strategy. It is also important that the revised recommendations were more robust issues around the assurance and governance process. The intention was that for 2017/18 a Strategic Planning Committee workplan would be developed and this would be brought back to a meeting early in the new year. **AMcM**
- 36.3 The Acting Chief Executive commented that he felt that the paper was clear and that he was impressed with the proposals around how the Strategic Planning Committee would interface with IJBs and that this engagement would require to be held through both planning forums and IJB Boards. He recalled that previous feedback had suggested that governance was vague and there was a need to determine clear pathways. Professor McMahon advised that he would provide a schematic to address this issue. It was noted that currently there were formal and informal structures in place and it would be helpful to ensure moving forward greater engagement with Chief Officers. This had been demonstrated around the AMU business case where the governance process had been felt to be the wrong way around prior to recommendations being submitted to the Finance and Resources Committee. The Committee were advised that senior finance and senior planning colleagues in NHS Lothian had regular meetings. **AMcM**
- 36.4 The point was made with reference to improving the health and care of people in Lothian that each IJB had a planning group. There was a need for clarity from a Strategic Planning Committee perspective about ownership and reporting arrangements. The Committee were advised that at the Acute Hospitals Committee the Lothian Hospitals Plan had been discussed where issues around primacy had been discussed. A schematic would be produced to show the position with it being recognised that the system was in a period of transition. The suggestion was made that once a schematic had been produced that this could be discussed further with the Strategic Planning Committee maintaining a clearing house role. **AMcM**
- 36.5 The point was made in respect of membership and the reference to 'developing peoples health' that this went beyond a single IJB. There was a desire for leadership to be specific with reference being made to the recent Audit Scotland report. It was felt that the Strategic Planning Committee would be an ideal vehicle from which to demonstrate this leadership. There was a need in respect of the membership to be explicit about this from an IJB perspective with the point being made that rather than determining membership as being the Chair/ Vice Chair of the IJB that membership could be changed to include Executive and Non Executive Board members. The

point was made that the timing and reviewing of the Strategic Plan was contained within IJBs as it was they who issued directions and in that regard there as a need for meetings/ agendas to be synchronised in order to ensure a smooth planning pathway. The point was made that community planning also required to be considered.

- 36.6 The Strategic Planning Committee were advised that paragraph 3.6 in the circulated paper attempted to summarise outcomes around what the Strategic Planning Committee should do and the intent of this paragraph had been to confirm leadership arrangements. Reference was made to national reports where it had been concluded that Health Boards needed to bring together key players within their systems. The committee were reminded about debate at the previous meeting where it had been agreed that the Strategic Planning Committee rather than being a receiving vehicle should be a prodding Committee and this perhaps required to be reflected in more detail in the paper.
- 36.7 The Committee noted in respect of governance arrangements that there was a need to be clear about where to take work that that was generated before it came to the Strategic Planning Committee for approval. It was noted that strong bureaucracy was important around the sign-off of any arrangements.
- 36.8 The point was raised that at this stage it was not felt that there was clarity around the delineation between IJB Planning Committees and the Strategic Planning Committee. It was felt that there were opportunities to learn from other areas and that these lessons should be embedded within the Strategic Planning Committee intent. It was suggested that there were examples of good practice in England and that the Strategic Planning Committee should be invited to give consideration to these areas as part of its revised remit.
- 36.9 The point was made that IJBs had responsibilities around the NHS Lothian growing population. In the hospitals plan there was a clear catchment area to be served through the production of a pathway approach. Quality and innovation was also important although this was not delegated to IJBs and included research and development and training where collaborative responses were needed. There was a need to be clear that there was an understanding of what respective parts of the organisation were signed up to.
- 36.10 Mr Johnston commented that whilst he welcomed the approach that its success would be around the extent of IJB buy-in. He commented that he had not been aware of any IJB input and was unclear about the role of IJBs in setting the agenda. He commented that there was a danger that IJBs might feel that actions were being done to them by NHS Lothian.
- 36.11 Professor McMahon commented that he would attend each IJB and ensure there was clarity around working relationships. He commented that the workplan would try to engage on these issues. There was a need for connections with all partners and for clarity around who had primacy of responsibility. It was suggested the that this would be developed through

shared thinking and through a testing process which it was hoped people would sign up to.

AMcM

- 36.12 The suggestion was made that reducing infrastructure would bring benefits particularly in respect of the concept of the Strategic Planning Committee becoming a prodding vehicle with members determining the issue they wanted to discuss. It was felt that the strengthening of IJB representation would help the committee to move its focus to a point where it became self reinforcing.
- 36.13 The point was made that further consideration was needed around the relationship between the Strategic Planning Committee and the Acute Hospitals Committee as well as reinforcing links with IJBs. It was suggested that this position would become clearer through the development of the schematic and governance arrangements.
- 36.14 The point was made in respect of leadership that there were opportunities for joint ownership and the suggestion was made that there would be benefits in the Chairman meeting with Chairs of IJBs in order to obtain suggestion on the future working model and to determine how the Strategic Planning Committee could add value.
- 36.15 The Chairman commented that as detailed by the discussion at the meeting that this was an area of highlevel complexity. He felt that the mechanics of the process were relatively simple in respect of the production of the schematic including the acute hospitals link. He suggested there would be merit in using this as a first step for conversations with IJBs about things that needed to be addressed and thoughts on how this would work. He commented however that the secondary strand of prevention would require conversations around other fora's about how to pull together a prevention agenda to change the paradigm of Health and Social Care. He reminded colleagues that issues around this had been discussed at the Board Development Session and had resonated with everyone around the table. He commented that the Strategic Planning Committee required good processes and appropriate participation. He commented that at a high level the Strategic Planning Committee should be used to develop game changing initiatives. The Chairman commented that although the Strategic Planning Committee might initially undertake a coordinating role that there would be a need for it to evolve into a leadership role irrespective of the participants around the table in order to develop the prevention agenda to improve outcomes for communities.
- 36.16 The suggestion was made that rather than the Chairman meeting with IJB Chairs that there would be benefit in a short paper being produced for consideration with IJB Boards containing proposals. It would be useful if the paper contained a clause which would allow IJBs to review any agreed position after a 9 month period. It was suggested this would help to frame the wider position. Professor McMahan commented that this was a positive suggestion and it would be helpful if partnership colleagues could sponsor the

production of the paper to include issues around the previously discussed schematic paper.

36.17 The Acting Chief Executive noted a need for shared accountability in respect of the anxieties around the paper. He felt that the production of a jointly developed paper would demonstrate a real expression of joined up working and suggested that Professor McMahon develop this through the Chief Officer Forum. He commented that he was anxious about there being too much Chief to Chief engagement and that Chairs and Deputy Chairs needed to be more central to the debate.

AMcM

36.18 The point was made that in May 2017 there would be Local Authority Council Elections and that councillor representation on IJB Boards might change and that any papers should bear this in mind and there would be a requirement for a learning curve for any new members. It was suggested that this was part of the on-going evolutionary process.

36.19 The Strategic Planning Committee agreed the principle and direction of travel around the revised membership. It was also agreed that a schematic paper would be produced and would be endorsed by the Strategic Planning Committee and the four IJBs. It was agreed that the preceding issues would be used to inform a workplan which would come back to the Strategic Planning Committee in April / May 2017.

AMcM

36.20 The point was made that there was a need to consider how to create champions in the concept when preparing the paper as this would be important to success moving forward. Mr Briggs commented that there was need for engagement with Non Executives and members of the IJB rather than this just being led by himself and Professor McMahon.

36.21 The Strategic Planning Committee agreed the recommendations contained in the circulated paper subject to the comments made at the meeting.

37. Lothian Hospitals Plan

37.1 Mr Briggs introduced the paper advising that Mr Martin and Dr Gormam had been involved in its production and it was important that they were at the meeting to hear the debate. The Strategic Planning Committee received a detailed presentation outlining 9 months of work with it being stressed that this did not represent an end point and that the plan would be iterative. Copies of the presentation were circulated to Committee members following the meeting.

37.2 The consultation process was explained with it being noted that each IJB had a representative on the Acute Hospitals Committee as well as there being GP representation.

37.3 Professor McMahan commented that before IJBs issued Directions there would be a need for them to understand the outcomes for the population and

to consider feasible ways of achieving these. Mr Briggs commented that currently the only mechanism NHS Lothian would have to reject Directions on the basis that they would be impeding the delivery of legislative requirements around the provision of safe care. The Acting Chief Executive commented that in any event IJB directions should not come as a surprise and mechanisms should be in place between respective organisations. He commented that in particular the Midlothian process was good and allowed people to evolve thinking.

- 37.4 An update was provided in respect of elective care and the rationale for the Eye Pavilion being situated at the Royal Infirmary of Edinburgh given that ophthalmology was essentially a short stay discipline. It was commented that issues around adjacency to the children and neurosciences services were important and both of these would sit on the Royal Infirmary of Edinburgh site. The business case had also highlighted opportunities to work with the University of Edinburgh and Scottish Enterprise. It was commented that although the bulk of work was around outpatients that the key clinical rationale was around adjacency. It was noted that the business case submitted to the Scottish Government provided significant detail about the rationale for the siting of the facility.
- 37.5 The Committee were advised that during the development of the hospital plan that discussions had been held with other Health Boards in respect of elective issues. Other Health Boards were looking at how to improve the way that their estate and workforce worked. It was anticipated that some workstreams might move towards NHS Lothian. There was also issues from a national perspective around short stay surgery. The suggestion was made that there was a desire for the Lothian Hospitals Strategy to morph into a South East of Scotland perspective.
- 37.6 Mr Small referred back to the headlines for each site and welcomed the fact that the reprovided Royal Edinburgh Hospital would host a specialist inpatient unit for use by East and Midlothian patients. It was further noted that if phase 2 of the Royal Edinburgh Hospital was approved then specialist rehabilitation would also be provided.
- 37.7 The point was made that the circulated paper set out a framework as well as listing the headlines. It was felt that the paper provided a planning framework which provided real clarity.
- 37.8 The committee agreed that there would be value in the proposals being discussed by IJBs in order that they would have responsibility to work around the delivery of the plan therefore reducing the need to issue Directions that might cut across the plan.
- 37.9 The Acting Chief Executive commented that it was important not to underestimate the job yet to be undertake and that the unscheduled care element detailed in the paper and the clarity of process was helpful in order to ensure that there were no tensions around responsibilities and outcomes.

37.10 The Strategic Planning Committee agreed the recommendations contained in the circulated paper.

38. Edinburgh Cancer Centre Strategic Assessment

38.1 Mr Graham commented that he was representing Mrs Goldsmith who was unable to attend due to another commitment. He advised that the Scottish Government had changed the capital investment guidance with there now being a requirement to undertake a strategic assessment in order to confirm governance, remit and direction.

38.2 The Scottish Government had asked for a strategic assessment for the Edinburgh Cancer Centre and the Board's response to that. He advised that the circulated paper provided that detail of information and that supporting documentation was contained as appendix 2.

38.3 Mr Briggs emphasised that the strategic assessment came from the strategic plan and set the framework for the Scottish Government, regional partners and the public. He commented that there was an expectation that other issues would come forward linked to the hospital plan.

38.4 The Committee agreed the recommendations contained in the circulated paper.

39. Royal Edinburgh Hospital Campus Development – Phase 1

39.1 The Committee were reminded that the Royal Edinburgh Hospital had previously been identified as one of the strategic stakes in the ground. The Committee were advised that NHS Lothian had taken possession of the keys for phase 1 of the Royal Edinburgh Hospital earlier in the week. The facility was based on single rooms. Staff induction and the planning of the new move was underway but the new building however brought some challenges given that the planning assumption had been that there would be no delayed discharges with this not currently being the position. In addition bed numbers had been reduced through the planning assumption on the basis that community responses and resources would be available.

39.2 The Committee noted in respect of old age psychiatry that the rapid response team had been established in Edinburgh to support people out of a hospital into the community and this work would commence in the following week. In respect of psychiatry of old age beds these had been reduced although 15 new beds would become available in a new care home due to open in February 2017. GP support had been agreed and discussions were underway around nursing support. It was noted that within the system that there were 6 beds where patients were being funded for the length of their life.

- 39.3 It was suggested that performance around psychiatry old age was currently at amber and that the Royal Edinburgh Hospital for the past 3 months had been running at an occupancy rate of 115% in respect of acute adult beds and this position looked to be a continuing one. It was noted that agreement around community facilities had not yet been agreed.
- 39.4 Professor McMahon advised in respect of adult acute beds that further work was being undertaken around anti-ligature work. Contingency plans were being considered in respect of adult acute beds in the event that a community response might not be available. It was noted that all of these issues would be discussed at the Corporate Management Team later in the day and that all aspects of performance and capacity around the Royal Edinburgh Hospital was monitored on a weekly basis. The suggestion was made in respect of psychiatry of old age services that there was a risk that this might move from amber to red status performance.
- 39.5 The Committee noted that phase 2 proposals were going through the governance process and would include the move of rehabilitation beds from the Astley Ainslie Hospital to the Royal Edinburgh Hospital. These discussions would involve all partnerships as would further discussions around phase 3.
- 39.6 The Committee noted that the major context at the moment was that there was no adult acute beds in the community and the Scottish Government were undertaking a coordinating role in this regard. However despite this capacity was not available.
- 39.7 The committee agreed the recommendations contained in the circulated paper.

40. Primary Care Programme Board

- 40.1 The Acting Chief Executive commented that the circulated paper had been developed following the primary care summit. The issue had been considered at the Board the previous day particularly in respect of the availability of recurrent investment which would equate to £2m in 2017/18 and move to a £5m recurring position in 3 years time. A key aspect moving forward had been the proposal to create a Primary Care Programme Board which would be Chaired by the Medical Director Designate. The Committee noted that the circulated paper characterised the process moving from the summit event to the current position and highlighted tensions round the role of primary care and IJBs with the proposed membership being intended to reduce these tensions. The Acting Chief Executive commented that the remit was broad and that the first role of the Programme Board would be to hone down on this. The Programme Board would provide a framework for strategic decisions around the use of the recurrent resource.

- 40.2 The Acting Chief Executive commented that the paper still required to be discussed by the GP Subcommittee and that the content might change based on these deliberations.
- 40.3 Ms Ireland commented that there was a role for the Area Clinical Forum in this area as the issues were much wider than just practitioner focus. She felt that the Area Clinical Forum should be represented in the membership of the Programme Board particularly as it was involved in ongoing dialogue around primary care workforce. The Acting Chief Executive advised that he would take on board these points. Mr Briggs commented in terms of membership that IJB Professional Advisory Committee members were involved and this would lead to a broader clinical input.
- 40.4 Mr Johnston commented that Midlothian IJB had expressed reservations about the proposals suggesting that there was a conflict between Lothian wide expectations and the opportunity to deliver local solutions. There was a concern that the direction of travel focused on a single one system fits all approach rather than encouraging locally developed solutions.
- 40.5 The Chairman commented that it was important that there was a fair representation of views. Mr Small commented that Chief Officers had submitted comments that had reflected debate and had recognised that some issues needed to be Lothian wide and others more locally focussed. He commented however that a key issue would be around obtaining a balance and ability to include local flexibility.
- 40.6 The Acting Chief Executive commented that he recognised this as a genuine concern but he stressed it had not been the intention to provide central direction and that a process was in place for local systems to prioritise their bids against the £2m of available money. He commented that he was happy to adapt the text in the circulated papers to provide assurance around the anxieties raised. He stressed however that it was not the intention to impose a Lothian model.
- 40.7 Mr Johnston commented that he welcomed the response from the Acting Chief Executive and was happy to engage and have further dialogue on this basis.
- 40.8 Mr Ash commented that he had not had specific discussions around the proposed paper but suspected that within his IJB similar issues might be prevalent. He commented that in respect of delegated functions that the IJBs would work with local GP groups. He felt that the Lothian wide group would need to demonstrate added value to what was happening on a local basis. He felt that a key starting point would be if the four IJBs and primary care teams agreed to share information. He advised in respect of the integrated care fund in East Lothian that the focus was to place people in GP surgeries. Mr Ash commented that it should be appropriate for collegiate decisions to be taken around the use of the £2m investment fund which would reflect both central and local needs. Mr Ash questioned whether there was requirement for the Chair to discuss issues with IJBs. He further commented that the

Programme Board having an Executive Director Chair sent out the wrong message and would be automatically viewed in some parts of the localities as being an NHS Lothian led operation. The point was made that the primary care resources related to IJBs and it would be important that they had a key role in determining the final destination of the investment monies.

- 40.9 Mr Ash suggested there would be more benefit in establishing a group led by IJBs with the involvement of other key stakeholders and that this process should be about coordinating and supporting what was going on.
- 40.10 Mr Johnson reiterated the fact that in the paper the strategically coherent comment suggested a one system fits all. He suggested that comments made in the following paragraph were overplayed and this increased the concern.
- 40.11 Professor McMahon commented that the intention was that the Primary Care Board would look at strategic primary care issues and this would be reflected in the remit of the Committee. He commented that an immediate first piece of work had been to identify that a strategy was in place to address issues around training research and development and third sector engagement. He commented that further shaping of proposals needed to come from the ground up through IJBs and that the economies of proposed programmes needed to be looked at on a cross Lothian basis. He suggested that this was part of the process that could add value and would not cut across the responsibilities of IJBs.
- 40.12 The point was made that it would not be sensible for IJB Directions to set themselves against the South East Scotland development plan. Mr Ash pointed out that GP services were the key drivers for locally based service development.
- 40.13 The Acting Chief Executive concluded by commenting that he felt that the principle was supported although the descriptors in the paper were not. He suggested that it would be appropriate to hand the process to IJBs in order for them to suggest how the process should be taken forward to include an appropriate mechanism for this to happen. It would be important that the timeline and the detail around the revised remit was considered by each IJB. A timeline of the end of January was agreed for this work to be undertaken.
- 40.14 The Committee agreed the a revised proposal would be developed by IJBs and would be considered at the 9 February 2017 meeting of the Strategic Planning Committee.

41. Date and Time of Next Meeting

- 41.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on 9 February 2017 in meeting room 7, Waverley Gate, Edinburgh.

DRAFT

STRATEGIC PLANNING COMMITTEE

Minutes of the meeting of the Strategic Planning Committee held at 9.30 on Tuesday 9 February 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 M. Hill, Non-Executive Board Member; Professor A. McMahon, Executive Nurse Director; Professor A. McCallum, Director of Public Health and Health Policy; Mr T. Davison, Chief Executive; Ms T. Gillies, Medical Director; Ms S. Goldsmith, Finance Director; Mr P. Murray, Non-Executive Board Member.

In Attendance: Mr C. Briggs, Associate Director, Strategic Planning; Ms J. Butler, Interim Director of Human Resources; Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Ms A. Cumming, Strategic Programme Manager; Ms F. Ireland, Associate Director, Nursing Workforce and Business Support; Ms C. Harris, Head of Communications; Ms E. McHugh, Chief Officer, Midlothian Health and Social Care Partnership; Ms T. McKinley, Information Governance Manager (item 3.1); Ms B. Pillath, Committee Administrator; Ms M. Pringle, Head of Strategic Planning, Finance Directorate.

Apologies: Ms J. Anderson, Partnership Representative; Dr D. Farquharson, Medical Director; Mr D. Grant, Non-Executive Board Member; Mr Peter Johnston, Non-Executive Board Member; Mr A. Joyce, Employee Director; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership;

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.

42. Minutes and Actions from Previous Meeting (8 December 2016)

42.1 The minutes from the meeting held on 8 December 2016 were approved as a correct record.

43. The People's Health

43.1 Alcohol and Drug Partnerships

43.1.1 Ms McKinley gave a presentation on initial suggestions for implementing the 23% reduction in funding from the Scottish Government for Alcohol and Drug Partnerships of £2.5 million. The suggestions had been made following collaboration with key stakeholders. Any decisions would be taken through the relevant governance process.

43.1.2 It was noted that this was a cut in spending across important services for vulnerable group of people. The Scottish Government reduced funding in this area but with the

expectation that the Health Board would fund the shortfall from its remaining budget. The initial stance has been that NHS Lothian would be unable to find this money from elsewhere and so would consider ways to mitigate the risk of reduced funding. An alternative would be to ask Integration Joint Boards to make an efficiency saving to invest in this service as this would spread the reduction more equally across services.

- 43.1.3 In relation to how the Alcohol and Drug Partnerships were funded, it was noted that the Partnerships were separate bodies which included Police, Local Authority, Health and Third Sector membership. Funding for the groups were ring fenced by the Scottish Government but came via the Health Board.
- 43.1.4 It was agreed that it was not possible to continue to provide the service in the same way with a 23% reduction in funding, and that service change would be required to do this. It was noted that service redesign could be desirable but that it was important that performance was monitored through the governance process. Some of the suggestions in the presentation could contribute but others were controversial amongst stakeholders.
- 43.1.5 Ms Goldsmith advised that there had not yet been detailed consideration of whether some of the £2.5 million reduction could be funded from elsewhere and so avoid concentrating reduced service in this single vulnerable area. This could be considered. Ms Pringle noted that the Edinburgh Health and Social Care Partnership had decided to make a proposal to make up some of the funding through the Social Care fund.
- 43.1.6 Mr Davison suggested that the focus should be on how to redistribute resources in order to reduce the impact on the Alcohol and Drug Partnerships; there was no requirement to apply the £2.5 million reduction all to the one service. This had also been discussed at Integration Joint Boards.
- 43.1.6 There was discussion about governance arrangements for the Alcohol and Drug Partnership and how the Board could be content that it had oversight of performance when changes took place. Alcohol and Drug Partnerships were part of the community partnership framework but were not accountable to the Integration Joint Boards or to the Health Board. They were set up by statute and submit an annual report to the Scottish Government. In practice they could be considered to be multi-agency strategic groups which help inform strategy and feed into the Integration Joint Boards.

44. Integration

44.1 Direction for 2017-18

- 44.1.1 A paper had been previously circulated. The Committee was invited to share its views on the Integration Joint Board strategic directions for 2017-18.
- 44.1.2 There was variation between the Integration Joint Boards on how clear their strategic directions were and how they communicated this with the Health Board. Midlothian had a clear strategy and good communication with the Health Board, and East Lothian was also in a good position. West Lothian needed more work on direction. Edinburgh had so much in its strategic plan that its priorities were not clear.

44.1.3 There was discussion about the relationship between the Health Board, the Integration Joint Boards and the Local Authorities. There needed to be more understanding on both sides of what the performance and reporting requirements were and what could be expected while operating within the current system. This would improve as interactions became more familiar.

44.1.4 Ms Goldsmith noted that there were some areas of the Integration Joint Board strategic plans regarding Liberton Hospital and the Royal Victoria Hospital that it would be important to have clear direction on as soon as possible to inform the NHS Lothian's strategy in terms of assets and capital projects.

44.2 Governance Schematic

44.2.1 Mr Briggs presented his initial ideas of the complex governance relationships between the Integration Joint Boards and NHS Lothian. Further discussion and experience would improve understanding of how this would work.

44.2.2 Professor McMahon noted that governance should work both ways between the Health Board and the Integration Joint Boards and that NHS Lothian should be giving the Integration Joint Boards an annual report which would allow them to see where NHS Lothian had met its targets. This had not yet been done.

44.2.3 It was agreed that a further paper on the process and practice of the governance arrangements would be considered at the next meeting. The next step would be consideration of how to use this relationship to make improvements. **AMcM**

44.3 Primary Care Programme Board

44.3.1 Ms McHugh spoke to the previously circulated paper which set out the proposed remit of the Primary Care Programme Board.

44.3.2 Professor McCallum suggested that an impact assessment should have been carried out as this was a significant driver in terms of health inequalities, and that there should be some public health input, either as a member of the Programme Board or in an advisory capacity.

44.3.3 Ms Gillies noted that the Programme Board was an opportunity to raise morale, ensure a stabilised position and reduce the risk of recruitment problems by demonstrating a willingness to invest in and support primary care services.

44.3.4 Mr Davison suggested that the remit should be changed to reflect the status of the group in giving oversight of both the strategic plan and the delivery of primary care services and should reflect NHS Lothian's part in delivery of services as well as the Integration Joint Boards' part in giving strategic direction. The group should be co-chaired between the Integration Joint Boards and NHS Lothian.

44.3.5 Members agreed that a group needed to be put in place as soon as possible to respond to the current crisis and that this should not be delayed by agreement of

remit and should go ahead as an operational group looking at the sustainability of the service in the meantime.

- 44.3.5 Ms McHugh agreed to bring the comments made on the remit back to the group. This would then be discussed at the Corporate Management Team and the agreed remit would be submitted to future Strategic Planning Committee. **EMcH**

5. Lothian Hospitals Plan

5.1 Acute Medical Unit, Royal Infirmary

- 5.1.1 Mr Briggs presented the previously circulated paper. There would be a focus on alternatives for treating patients who were currently admitted for fewer than 24 hours. This would be discussed by Integration Joint Boards at their next meetings in March. The work done needed to be in all Integration Joint Boards and performance measures needed to be put in place, all Chief Officers would be asked to look at this.

5.2 Royal Edinburgh Hospital Phase 1

- 5.2.1 Professor McMahon advised that the moves for the first phase of the project at the acute brain injury unit had been successful. There were no unfunded beds still open and the unit was at 100% capacity; previously 115%. This would be discussed further at the Corporate Management Team meeting on 13 February 2017.

6. Pan Lothian Business

6.1 Local Delivery Plan

- 6.1.1 Members accepted the recommendations laid out in the previously circulated paper.

6.2 Workplan for 2017-18

- 6.2.1 Mr Briggs presented the draft work plan. This would be circulated to members for feedback. **BP**

- 6.2.2 It was noted that Integration Joint Board chairs and Chief Officers were members of this Committee and would therefore have input into the workplan.

6.3 National Delivery Plan for Health and Social Care

- 6.3.1 The paper had been previously circulated. Ms Butler noted that the Scottish Government had a national workforce plan out for consultation for publication in May 2017. The plan would cover local, regional and national workforce planning and there had been early discussion between Human Resources Directors of the different Boards on how regions could collaborate.

7. Date of Next Meeting

- 7.1 The next meeting of this group would take place at **9.30 on Thursday 13 April 2017** in **Room 7**, second floor, Waverley Gate.

- 7.2 Further meetings in 2017 would take place on the following dates:
- Thursday 8 June 2017;
 - Thursday 10 August 2017;
 - Thursday 12 October 2017;
 - Thursday 14 December 2017.

AUDIT & RISK COMMITTEE

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 5 December 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms J. McDowell (chair), Non-Executive Board Member; Mr M. Ash, Non-Executive Board Member; Cllr. D. Grant, Non-Executive Board Member; Ms C. Hirst, Non-Executive Board Member; and Mr P. Murray, Non-Executive Board Member.

In Attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Ms J Butler, Director of Human Resources; Mr C Brown, Scott Moncrieff; Ms J Brown, Chief Internal Auditor; Ms J Campbell, Interim Chief Operating Officer; Ms E Clemente, National Trainee; Mr J Crombie, Interim Chief Executive; Mr D Eardley, Scott Moncrieff; Ms S Goldsmith, Director of Finance; Ms S Knight, National Trainee; Mr C. Marriott, Deputy Director of Finance; Professor A McMahon, Executive Director Nursing Midwifery and AHPs. Professor A McCallum, Director of Public Health and Health Policy; Ms J Morrison, Head of Patient Experience; Mr J. Old, Financial Controller; Mr A. Payne, Corporate Governance Manager; Ms L Baird, Committee Administrator.

Apologies: Ms D Howard, Head of Financial Services; Mr B. Houston, Board Chairman.

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.

Welcomes and Introductions

The Chair welcomed everyone to the meeting. She introduced Ms Stephanie Knight and Ms Eleanor Clemente, National Trainees attending the meeting to gain experience.

29. Minutes and Actions from the Previous Meeting (5 September 2016)

29.1 The minutes and action note from the meeting held on 5 September 2016 were approved as a correct record.

30. Matters Arising

30.1 Matters arising from the Meeting of 5 September 2016 – The Committee accepted the update on the actions detailed within the Running Action Note.

31. Risk Management (assurance)**31.1 NHS Lothian Corporate Risk Register**

31.1.1 Ms Bennett drew the Committees attention to the revision of the patient experience risk to reflect action required following the meeting with the Ombudsman.

- 31.1.2 In response to the Chairs question Ms Bennett advised that Healthcare Governance Committee had assessed the level of assurances provided in respect of plans to mitigate risks pertinent to themselves as set out in the Quality and Performance Report and associated committee papers. It was clarified that other governance committees are being asked to do the same.
- 31.1.3 It was noted that an asterisk signifies that the risk was out with risk appetite; however this had not been applied to the patient experience risk. Further discussion on this matter was required however it was noted that at present the patient experience was not out with risk tolerance.
- 31.1.4 In response to the Chair's request Ms Bennett agreed to review the wording relating to staff absence risk tolerance to make it clearer in advance of the next meeting. **JB**
- 31.1.5 The members discussed the interpretation of performance against the risk tolerances. The members acknowledged that performance may fall within tolerance for a very short period of time, and there is a risk that the information is misinterpreted where the performance is unsustainable and can easily fluctuate out of tolerance. It was suggested that a GREEN status could be used when performance has been within tolerance for 3 months or more, and AMBER where the performance is within tolerance but this has been the case for less than 3 months. Mr Crombie stated that a considered piece of work was required on this, and it could be taken forward with the Committee to develop a solution.
- 31.1.6 Ms Bennett advised that she would be keen to get the Committee's views on how data should be presented at future meetings, and agreed to explore this issue further with the Committee chair. **JB**
- 31.1.6 Mr Murray noted the £6,973k overspent for the year-to-date and questioned whether this was attributed to unachieved savings plans. Ms Goldsmith advised the majority of the overspend related to prescribing, junior doctors and savings but could not immediately confirm the proportion that was attributed to unachieved savings. However she advised that the Finance and Resources Committee has raised concerns, and financial recovery will be monitored on a monthly basis and the Efficiency and Productivity Committee has been reconvened. As the Board moves forward into 2017/18 issues with recurring savings moving out to an unsustainable level would be continue to be a concern.
- 31.1.7 The Committee accepted the significant assurance that the Corporate Risk Register contains all appropriate risks, which were set out in section 3.2 and set Appendix 1 of the report.
- 31.1.8 The Committee acknowledged that as part of the system of control, the other Board committees will be asked to assess the level of assurance provided to them with respects to plans in place to mitigate the risks pertinent to their remit, as set out in the Quality and Performance Report and other associated committee reports.
- 31.2 Update on Risk Appetite – Stroke – The Committee received the update on the recent performance against the nation Scottish Stroke Care Standard.

Ms Jacqui Campbell provided clarity surrounding the predicted compliance outlined in the report. The Chair welcomed her comments and anticipated that the target would be achieved well within the predicted timescale.

- 31.2.1 Members were advised that the Healthcare Governance Committee had taken moderate assurance from the report and that the Acute Hospitals Committee monitors compliance against the stroke bundle through the Quality and Performance Report.
- 31.2.2 Members sought clarity on the reported concern that rehabilitation was difficult to deliver within a pressured site such as the Royal Infirmary of Edinburgh. Ms Campbell explained that I this comment referred to the management of services out with the stroke unit, changes to admission policies and the increased number of patients presenting at the RIE.
- 31.2.3 The Committee accepted moderate assurance that the different approach locally to measure, present and ultimately improve performance based on the national standards, along with projected timescales, will result in meeting national stroke bundle compliance by October 2017.

Ms Campbell left the meeting.

- 31.3 Risk Appetite – Patient Experience – Professor McMahon introduced the report which aimed to provide assurance that there were plans in place to improve patient experience and bring patient feedback within tolerance. He went on to highlight that the Healthcare Governance Committees has oversight of patient experience and the recent discussions with the SPSO.
 - 31.3.1 The Committee discussed the validity and reliability of the data relating to patient experience. Prof. McMahon explained that the sample sizes have been small and the quality of the information is dependant on what respondents say. There are currently problems with the underlying processes in that there are two vacancies, and the IT system that had been used has crashed. The management team are currently working with eHealth to correct this.
 - 31.3.2 Prof McMahon advised that the sample sizes are improving but more needs to be done. More wards need to improve their level of returns, as the overall return rate has been achieved by a small number of wards achieving a high level of returns. Prof. McMahon advised that the support from wards is critical and the organisation needs to explore the use of technology to make the whole process easier, and continue with the improvement work. There has been some success in introducing electronic feedback at the Royal Hospital for Sick Children, making use of a re-designed Tell Us Ten Things questionnaire.
 - 31.3.3 Ms Hirst commented that the Audit & Risk Committee currently cannot take assurance on the reliability of data at individual ward level, and highlighted that it is the role of the Healthcare Governance Committee to oversee this overall topic.

- 31.3.4 Mr Crombie drew the Committee's attention to the 90 day programme lead by Dr Watson which will consider how feedback is gathered. He anticipated that this process will commence within the next couple of weeks with recommendations expected in March. He highlighted his concerns over some comments arising from the annual review where it was suggested that the Board isn't listening to patients. Mr Crombie advised that the Board requires a more explicit strategic approach.
- 31.3.5 The Committee accepted limited assurance that the root causes that are driving the patient experience score are adequately understood. The Committee acknowledged that the Healthcare Governance Committee and the Board have adequate oversight on the key areas of work.
- 31.3.6 The Committee agreed to propose a change in the measure for overall patient experience from 9.5 to 9 in line with the national target and the agreement in principle made by the Healthcare Governance Committee in May 2016. It was acknowledged that this was further supported by the Feedback and Improvement Quality Assurance Working Group in October 2016.
- 31.3.7 The Committee agreed that it should be recommended to the Board that the risk tolerance measure for patient experience should be reduced to 8.5. **JB**

Ms Morrison left the meeting.

32. Internal Audit (assurance)

32.1 Internal Audit – Progress Report (December 2016)

- 32.1.1 Ms Brown noted that following her appointment to the role of Chief Internal Auditor she had reviewed the scope of the Organisational Culture Review and with management made some amendments to the draft report. She expected that the report would be brought forward to the February 2017 meeting.
- 32.1.2 Ms Brown advised the committee that she had reassessed the audit plan in light of some long term absence within the team, and remained confident that the team could deliver all the planned audits as set out in the approved plan.
- 32.1.3 Ms Brown reported that a total of 120 days had been allocated to the IJB audit function for the period of January to March 2017. Each IJB would get the same number of days. Ms Brown and the Chief Internal Auditors for each IJB will meet in February 2017 at which point draft plans would be presented for 2017/18.
- 32.1.4 It was highlighted that a meeting with the IJB audit committee chairs in early 2017, as agreed in the workshop held in August 2016, is still to be scheduled. **JBr/AP**
- 32.1.5 Ms Brown advised the Committee that the chief internal auditors are developing a controls assurance map which should assist the efficient conduct of business.
- 32.1.6 The Committee accepted the progress report.

- 32.2 Internal Audit – Reports with Green Ratings – Waiting times (August 2016; Research and Development (September 2016) – The Committee accepted the report.
- 32.3 Internal Audit -Absence Management (October 2016) – Mr Murray expressed concerns that there was no mandatory training outline for Managers, the management responses placed reliance on local Partnerships Forums and the approach to addressing the problems was too weak. ~Ms Butler that she took the view that a more effective approach to this subject is to take the work through the 12 local partnership fora, each of which are jointly chaired by management and staff partnership representatives. These fora are responsible for the local staff governance improvement plans, and Ms Butler had asked them to come back with local action plans to this audit.
- 32.3.1 Ms Butler advised the Committee that management teams are proactive in addressing absences, and there is a lot of review and checks as part of normal management practice. She advised that some management teams have established absence review panels. HR online was the recognised training vehicle for management and staff alike. Mr Murray thanked for Ms Brown for her overview however he highlighted a remaining concern with regard to the uptake on training in relation to the management of sickness absence.
- 32.3.2 Mr Ash enquired as to how integration joint boards have oversight of staff governance matters as they relate to their integration functions. Ms Butler explained that the management teams in health & social care partnerships monitor staff governance issues, and additionally the NHS Lothian Staff Governance Committee is currently reviewing its role.
- 32.3.3 Mr Ash explained that there does need to be a mechanism so that each integration joint board has oversight on staff governance matters. There was further discussion on this point, which highlighted that integration joint boards do not employ anyone, and that health and local authority employees are employed on different terms & conditions and in line with the policies of their employer. It was suggested that there needed to be a pragmatic solution to this, and that the subject should be explored further. Ms McDowell concluded that this matter shall be referred to the Staff Governance Committee for it to determine how this will be addressed. JMCD
- 32.3.3 The Committee accepted the report on Absence Management (October 2016).

Ms Butler left the meeting.

33. Internal Audit (Continued)

- 33.1 Draft Internal Audit Plan 2016/17 – 2018/19 – Ms Brown gave a brief overview of the key points in the three year plan that reflected the risk register, audit universe and the needs of the Corporate Management Team, and had made explicit links to the Board's values. She highlighted that she had built in a 10% efficiency saving into the development of the plan.

- 33.1.1 Mr Murray highlighted that it may be helpful to carry out IJB reviews earlier in the year in order to link in with the review that Audit Scotland will be performing. JBr
- 33.1.2 Mr Ash highlighted that it would be good to get assurance that the actions within the integration schemes have been done. Ms Brown said this could be linked into the work on the IJB controls assurance map and review of IJB Directions scheduled for February 2017. JBr
- 33.1.3 Ms Hirst highlighted that the new complaints systems is to be implemented in April 2017, and suggested that it would be better for this subject to be audited at a later point in the year. Ms Brown agreed to this. JBr
- 34.1.4 The Committee approved the internal audit plan subject to the requested changes.
- 33.2 Follow-Up of Management Actions Report (December 2016) – Mr Murray asked for further information on the the critical issue relating to the bank and agency audit. Prof McMahon explained that although the use of agency staff had generally been stopped, there were exceptions in some areas, particularly paediatrics.
- 33.2.1 The Committee accepted the report.
- 34. Counter Fraud (Assurance)**
- 34.1 Counter Fraud Activity – the Committee accepted the report as a briefing on the current status of counter fraud activity.
- 34.1.1 The Committee agreed that the report provides a significant level of assurance that all cases of suspected fraud were accounted for and an appropriate action had been taken.
- 35. External Audit (Assurance)**
- 35.1 External Audit Update and Outline Plan 2016/17 - Mr Brown gave a brief overview of the report that provided an update on the latest developments and initial outcome of the planning for Scott Moncrieff's 2016/17 external audit. It was expected that a final external audit plan would be presented at the February 2017 meeting.
- 35.1.1 The committee was advised that the external auditors consider the system of governance every year and evaluate any changes. The auditors will consider the impact of integration joint boards as part of this process. .
- 35.1.2 The Committee agreed to accept the report.
- 36. General Corporate Governance (assurance)**
- 36.1 Review of the Standing Financial Instructions – Mr Payne gave a brief overview of the changes made to the standing financial instructions and drew member's attention to the the new definition for a local authority employee.

The proposed changes are to facilitate the implementation of integrated working.

36.1.1 The Chair questioned whether the Audit & Risk Committee did cover all the matters raised in the section on external audit, particularly the annual appraisal of the performance of the external auditor. Mr Payne advised that historically the appraisal had been conducted through the questionnaire issued by Audit Scotland, however it was agreed this is not the same as the process described in the SFIs. Ms Goldsmith and Mr Payne agreed to examine what the SFIs require the committee to do and provide a report back.

AP/SG

36.1.2 The Committee reviewed the attached Standing Financial Instructions and advised that no further changes were required.

36.1.3 The Committee agreed to recommend that the Board approves the Standing Financial Instructions.

36.2 Review of the Scheme of Delegation – Mr Payne gave a brief overview of the report that brought the members up to date with the revisions of the scheme of delegation.

36.2.1 The Committee agreed to recommend to the Board that they adopt the revisions to the scheme of delegation and the new principle that the Director of Finance was authorised to approve any amendments to the scheme of delegation which may be required to keep it in line with the management structure.

AP

36.3 Update on Information Commissioner's Audit –.

36.3.1 The Committee agreed to accept the report as a moderate source of assurance that actions in the ICO action plan will be completed by the end of December whilst recognising that there was an action plan in place to address outstanding points.

36.3.2 The Committee noted that the Information Commissioner's office will return in December 2016 to review NHS Lothian's progress towards implementing its recommended actions.

36.4 Update on the Summary of Losses as at 31 October 2016 – The Committee agreed to take a significant level of assurance on the system of control within the credit control process and that the board were continually reviewing and evaluating changes to improve the internal credit control functions.

36.4.1 Professor McCallum made a general point that it is important for transparency and scrutiny that the Committee receives detailed information. However in the event that there is a request for information to be published, care should be taken to redact details so as to protect confidentiality where it is possible that the information would allow individuals or individual cases to be identified. .

36.5 Write-Off of Overseas Debts –

36.5.1 Members noted that Lothian was currently best in class in respect of recovering payments from non-UK resident patients, but nevertheless there remains a high number of cases which have to be pursued through debt recovery processes..

36.5.2 The Committee reviewed the information on the proposed debts to be written off and confirmed that the Director of Finance may approach the Scottish Government Health Department for its approval to write-off the losses.

36.6 Audit Scotland – National Performance Reports – Members noted the report that provided assurance that management were aware of and reviewed relevant Audit Scotland reports.

36.6.1 The Committee accepted:

- The report as a source of significant assurance that Board members and management were aware of relevant Audit Scotland reports.
- The report as a moderate source of assurance that the organisation has had a systematic approach to consider relevant Audit Scotland Reports.
- The report as a source of significant assurance that the organisation has considered and had made use of the NHS in Scotland (October 2016) Report.

36.7 Alternative Committee Annual Reports to Inform the Review of the Governance Statement –Members discussed the proposal and whether it would meet requirements for the purpose of reviewing the governance statement.

36.7.1 The Committee generally welcomed the proposal and the Chair agreed to discuss the proposal with the Chairs of the other committees which were required to produce a report.

JMcD

37. **Any Other Competent Business**

37.1 There were no other items of business for consideration. The Committee agreed to meet in private with the external auditors after the meeting.

38. **Date of Next Meeting**

38.1 The next meeting of the Audit and Risk Committee would take place at **9.00** on **Monday 27 February 2017** in **Meeting Room 7, Second Floor, Waverley Gate**.

NHS Lothian

Audit & Risk Committee

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 27 February 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms J. McDowell (chair), Non-Executive Board Member; Mr M. Ash, Non-Executive Board Member; Cllr. D. Grant, Non-Executive Board Member; Ms C. Hirst, Non-Executive Board Member; and Mr P. Murray, Non-Executive Board Member.

In Attendance: Mr C Brown, Scott Moncrieff; Ms J Brown, Chief Internal Auditor; Ms M Cuthbert (Associate Director of Pharmacy)); Mr D Eardley, Scott Moncrieff; Miss S Gibbs (Deputising for Ms Bennett); Ms S Goldsmith, Director of Finance; Mr C. Marriott, Deputy Director of Finance; Professor A McMahon, Executive Director for Nursing, Midwifery and AHPs. Mr A. Payne, Corporate Governance Manager; Ms L Baird, Committee Administrator.

Apologies: there were no apologies for absence.

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.

Welcomes and Introductions

The Chair welcomed everyone to the meeting.

39. Minutes from the Previous Meeting (12 December 2016)

39.1 The minutes from the meeting held on 12 December 2016 were approved as a correct record.

40. Matters Arising

40.1 Matters arising from the Meeting of 12 December 2016 – The Committee accepted the update on the actions detailed within the Running Action Note.

40.2 The Chair advised that a meeting to follow up matters with the Chairs of the Integration Joint Boards (IJBs) Audit Committees had been scheduled for Monday 6 March 2017. .

41. Risk Management (assurance)

41.1 NHS Lothian Corporate Risk Register

41.1.1 Ms Gibbs updated on the Committee on the changes to the risk register as at quarter 3. She advised that the Patient Experience and General Practice Sustainability risks had been to Healthcare Governance Committee in January 2017 and both items would remain on their agenda. Work on delayed discharges, financial sustainability and achieving the 4 hour emergency target remained ongoing.

- 41.1.2 It was noted that the Nursing Workforce Safe Staffing levels risk had been reduced from high 16 to Medium 9 following various initiatives including a recruitment plan.
- 41.1.3 With regard to the risk on the financial challenge (risk ID:3600), Mr Murray highlighted that waste and variation should be explicitly considered as part of the efforts to mitigate the risk. He referred to the work of Don Berwick and suggested that the Board should increase its efforts in this area. Mrs Goldsmith advised that examining variation is a component of the Board's quality work. Mr Marriott advised that the organisation is looking at variation in clinical practice and there is also work in prescribing. He advised that the Scottish Government has recently introduced a benchmarking tool, DISCOVERY, which should assist with identifying variation and waste.
- 41.1.4 Mr Ash suggested that some work could be undertaken to assess the impact of the investment in the quality initiative. Members agreed that waste and variation was a key issue and should be highlighted and explored in light of the financial challenges that NHS Lothian was facing.
- 41.1.3.1 The Chair requested three actions in light of the discussions surrounding waste and variation:
- Ms Brown to consider the potential for internal audit to perform a review in 2017/18 on the quality programme, with a particular focus on variation and waste.. JBr
 - Ms Brown to review the 2017/18 internal audit plan in general, to identify opportunities for the issue of variation and waste to be considered as part of the delivery of the internal audit plan. JBr
- Mrs Goldsmith to review the actions/ controls in place for risk 3600, to determine if there is a specific line of enquiry or programme of action focussed on tackling waste. SG
- 41.1.4 Ms Hirst commented that it would be helpful if the ARC report on the Corporate Risk Register highlighted what had changed from the previous report. It would be helpful if there was a consistent approach to changes in the update column in the risk register itself, as well as any changes being highlighted in the covering report. . The Chair requested that Ms Gibbs take this matter forward with Ms Bennett. JBe
- 41.1.5 With regard to the risk on delayed discharges (Risk ID: 3726), Mr Murray highlighted that there was nothing within the actions to express the role of integration joint boards and whatever actions they are taking. The discussion highlighted that delayed discharges is being taken forward as a shared responsibility. The effect of integration is that the role of the NHS Board has changed, and the Board has different risks with regard to complying with IJB directions. The title of the risk (Achieving the delayed discharges targets of 2 weeks) is no longer appropriate. It was agreed that the delayed discharge risk should be reviewed, and also following the same principle, the risks relating to primary care should be examined.. JBe/AP
- 41.1.6 The Committee agreed to accept the significant assurance that the Corporate Risk Register contains all appropriate risks, which were contained in section 3.2 and set out in appendix 1 of the report.

41.1.7 The report invited the Committee to acknowledge that the governance committees of the Board had been asked to assess the level of assurance provided to the committee with the respect to put plans in place to mitigate the risks pertinent to each committee. Mr Payne advised that the governance committees were scrutinising performance however he was not in a position to confirm if they were all examining the relevant risks from the corporate risk register and agreeing a level of assurance on the same. He agreed to clarify what the committees have been asked to do.

AP

41.1.8 The Committee acknowledged the findings of the Internal Audit report on Risk Management which was concluded that the control objectives were adequate with no major weakness in the controls.

42. Internal Audit (assurance)

42.1 Internal Audit – Progress Report (February 2017)

42.1.1 Ms Brown noted that the progress of the Internal Audit plan had been delayed following a period of sickness absence however the member of staff concerned would return to work in March bring the team back to full capacity. She was confident that even with the delays the team would fulfil the requirements of the audit plan on schedule.

42.1.2 Mr Murray questioned whether Key Performance Indicator No 4 (Draft reports are issued within 15 working days of completing field work) was relevant and or achievable, given that the performance over the years had been consistently graded as red. Ms Brown advised that she considered that the KPI is an appropriate one, and that it is for internal audit to deliver that level of performance. Ms McDowell said that given the changeover in internal audit provider and the recent sickness absence within the small team, it was reasonable to give the team a bit more time to improve the performance. It was agreed that the KPI should continue to be used for the next 6 months, and if no improvement was shown, then the Committee will revisit the matter.

JBr

42.1.3 Ms Hirst asked whether the KPIs could have more focus on quality, rather than just time-measured processes. Ms Brown advised that the current audit feedback form does have some qualitative aspects, and that she would examine this to see if they can inform the development of a KPI on quality.

JBr

42.1.4 Mr Brown explained that the external auditors carry out a review of internal audit so that they may place reliance on specific pieces of internal audit work. The external auditors will not wholly rely on the work of internal audit and may undertake further audit work themselves. The external audit process cannot be taken as a source of assurance of the overall quality of the internal audit function and their work.

42.1.5 The Committee accepted the progress report.

42.2 Internal Audit – Reports with Green Ratings – Risk Management; Treasury and Cash Management; Patient Records (February 2017) – The Committee accepted the report.

42.3 Healthcare Governance – Prison Services (September 2016) – Ms Brown advised that the audit looked at the arrangements in place for healthcare governance, roles, responsibilities, reporting frameworks and governance oversight for prison healthcare. In addition a review of the revised prisons complaint and process was carried out to deem whether current arrangements were operating effectively. All but one of the control objectives were given a GREEN rating, the exception being the one relating to the complaints feedback aspect which was rated AMBER.

42.3.1 Professor McMahon highlighted ongoing work with Ms Morrison and Ms McKinley. He advised that NHS Lothian consistently achieved 90% against the 21 day target however further work in respect of the 3 day target and early resolution was required. He also advised that the new model complaints handling procedure would not come into effect until 1 April 2017.

42.3.2 The Chair highlighted that the implementation date for some of the actions had already passed and asked if the actions had been completed. Professor McMahon advised that the dates look incorrect and that he would review them with Ms Brown.

AMcC/ JBr

42.3.4 The Committee accepted the report.

42.4 Follow-up of Management Actions Report (February 2017) – Professor McMahon provided an update on the outstanding RED action from the audit on bank & agency staffing. He advised that t he and the Medical Director are seeking to tighten the controls relating to the use of Medical Locums. .

42.4.1 Members noted it was not clear from the report when Internal Audit had received the last update from management on specific points. Ms Brown advised the Committee that internal audit automatically email management when an agreed implementation date passes. She assured the Committee that there has been an improvement in the engagement by management in the follow-up process. She explained that in many cases what internal audit are looking for is evidence of completion, and the internal audit team has started to provide more information to management to explain what they are looking for. Ms Brown agreed that the follow-up report could be more explicit as to the dates when updates were provided and that this will be addressed for the next version of the report.

JBr

42.4.2 The Committee accepted the report.

42.5 Internal Audit Plan 2017/18 – Ms Brown advised that the only changes to the plan were those discussed at the December meeting.

42.5.1 The Committee agreed to approve the Internal Audit Plan 2017/18 subject to the inclusion of waste and variance in the scope of the plan and the correction of the typographical errors identified in respect of the 15 day KPI.

JBr

Mr Davison entered the meeting

42.6 Referral of Internal Audit Reports to the IJB Audit and Risk Committees – Members noted the report would be a standing item on future agendas however the onus of identifying audit reports to be referred to the IJB Audit Committees would lie with management rather than the Chair and or Members of the Audit and Risk Committee. The Chair requested that Mr Payne amend the recommendations within this and future reports accordingly.

AP

It was also agreed that there should be an indication on the face of internal audit reports whether the report is relevant to integration joint boards.

JBr

43. Counter Fraud (Assurance)

43.1 Counter Fraud Activity – the Committee accepted the report as a briefing on the current status of counter fraud activity.

43.1.1 The Committee agreed that the report provides a significant level of assurance that all cases of suspected fraud were accounted for and an appropriate action had been taken.

44. External Audit (Assurance)

44.1 The Audit and Risk Committee's Responsibilities for External Audit (Standing financial Instructions) – Mr Payne gave a brief overview of the report and sought the Committee's views on the appraisal process for the external auditors and whether a policy for the provision of non-audit services was required.

44.1.1 Members agreed that a policy on the provision of non-audit services was required, and the addition of a paragraph in the SFIs would suffice. It was agreed that Mr Payne would develop a proposal for the next meeting.

AP

44.1.2 The Committee accepted that the report as a source of significant assurance that there were arrangements in place for the Committee to discharge its role as described in the Standing Financial Instructions, with the exception of the points relating to the appraisal of the external auditor and the provision of non-audit services.

44.1.3 The Committee accepted the report as an update that the issue of appraisal was currently being investigated and a further update will be provided.

AP

44.2 External Audit Plan 2016/17 - Mr Brown gave a brief overview of the report that provided an update on the developments since December 2016. He advised that the four areas risks were:

- The timetable for the completion of accounts, recognising that there are four integration joint boards with separate accounting regimes and timescales.
- PFI /PPP schemes
- Standard audit matters such as risks relating to revenue recognition and management override.
- Financial sustainability.

- 44.2.1 Mr Brown advised that he was still to discuss the issues of materiality and the audit fees with the Director of Finance.

Mr Murray asked if the PFI/PPP arrangements will have an impact on the ability of the Board to move services out of hospitals. Mrs Goldsmith advised that this is an issue that management are looking at.

Ms Goldsmith advised that her initial view is that the proposed fee within the plan was reasonable..

- 44.2.2 With regard to materiality Ms Goldsmith reported that it was reasonable for the External Auditors to report on adjustments over £230k made to the annual accounts. Members supported the decision following advice from the Director of Finance.
- 44.2.3 The Committee agreed to delegate authority to the Director of Finance to agree the final fee with the external auditors.
- 44.2.5 The Committee accepted the report.

SG

Ms Goldsmith left the meeting.

45. General Corporate Governance (assurance)

- 45.1 Litigation Annual Report 2015/16 – Ms Gibbs gave a brief overview of the report drawing the Committees attention to the changes to the administration process, new pre-action protocols for clinical and non-clinical claims. She highlighted that the level of non-clinical claims had returned to normal after the spike in 2014/15.
- 45.1.1 The Committee accepted the report provided a significant level of assurance on the processes in place to manage litigation in NHS Lothian.
- 45.1.2 The Committee noted the annual update on litigation activity in terms of numbers, financial impact and recurring themes.
- 45.1.3 Members noted the programme in place to reduce the likelihood of adverse events taking place that may result in settles claims.

46. Internal Audit – Organisation Culture – Follow-Up of PwC and Bowels Report Action Plans (January 2017)

- 46.1 Ms Brown introduced the report highlighting that all 20 actions from the PwC recommendations had been completed and 29 out of 31 actions from the Bowles report had been completed. She advised that there had been a significant improvement in the culture of NHS Lothian. The continuing actions are by their nature “ongoing”, and internal audit had found no evidence to suggest that the previously reported oppressive management/ leadership style referred to in both reviews was still in place.
- 46.2 It was unclear whether the Staff Governance Committee had received and considered this report. The Committee agreed this should be checked as it would welcome the views of the Staff Governance Committee. .

AP

- 46.3 The Chair requested clarity on which Non-Executive Members had been appointed as champions. Mr Davison advised that they were in the midst of reviewing this. He did highlight as an example that Alison Mitchell is the whistleblowing champion, and there are tiered arrangements to support whistleblowing with the Chief Executive, Director of Nursing and the Medical Director available to discuss matters of concern. Mr Davison advised that corporate objectives will be re-introduced for 2017/18.
- 46.4 Ms McDowell highlighted that it was disappointing that only 2 % of staff received an exit interview. Mr Davison agreed that this was something that has to be promoted.
- 46.5 Mr Davison reflected on his 5 years as the Chief Executive of NHS Lothian, and recognised the power of the Chief Executive to influence the culture through exemplar behaviour. There has been a shift from an aim to be one of the e Top 25 healthcare providers in the world , towards an approach drawing on the NHS Scotland 2020 Vision, the Triple Aim mission, and NHS Lothian values . He explained that the organisation is focussed on continuous quality improvement, and “developing” the culture rather than trying to “change” it.
- 46.6 Mr Davison explained that iMatter is a key tool, and consequently there is perhaps limited value in continuing with 360 degree reviews for the Chief Executive and the Corporate Management Team.
- 46.7 Mr Murray said that it was right to acknowledge that there has been an improvement in culture, and agreed that the uptake of exit interviews needs to be improved. He enquired whether Investors in People is still relevant. Mr Davison agreed that it is worth re-assessing whether to continue with Investors in People as accreditation does come at a cost, and there are other arrangements in place.
- 46.8 Ms Hirst commented that positive developments in culture when the issues of communication and how to address conflicts are addressed. Mr Davison explained that the key challenges are in the acute sector where pressure is greater. The system is under more pressure than before but nevertheless the culture seems to be getting better. More work can be done to have greater assurance that the desired model behaviours are in place at every level of the organisation.
- 46.7 The Committee accepted the report.

47. Any Other Competent Business

- 47.1 There were no other items of business for consideration. .

48. Date of Next Meeting

- 48.1 The next meeting of the Audit and Risk Committee would take place at **9.00** on **Monday 24 April 2017** in **Meeting Room 7, Second Floor, Waverley Gate**.

MINUTE of MEETING of the WEST Lothian INTEGRATION JOINT BOARD of WEST Lothian COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 31 JANUARY 2017.

Present –

Voting Members – Danny Logue (Chair), Martin Hill, Susan Goldsmith, Alex Joyce, John McGinty, George Paul (substitute for Anne McMillan) Frank Toner, Lynsay Williams.

Non-Voting Members – Ian Buchanan (Stakeholder Representative), Jim Forrest (Director), Jane Houston (Staff Representative), Jane Kellock (Chief Social Work Officer), Mary-Denise McKernan (Stakeholder Representative), Martin Murray (Staff Representative), Patrick Welsh (Chief Finance Officer).

Apologies – Anne McMillan, Elaine Duncan, Mairead Hughes and Marion Barton

In Attendance – Alan Bell (Senior Manager, Communities and Information, WLC), James Millar (Standards Officer), Steve Field (Head of Service, WLC).

1. DECLARATIONS OF INTEREST

There were no declarations of interest made.

2. MINUTES

(a) The West Lothian Integration Joint Board approved the minute of its meeting held on 29 November 2016.

(b) The West Lothian Integration Joint Board noted the correspondence arising from its previous meeting.

The Board further noted that, to date, there had been no response to the letter concerning Alcohol and Drug Partnership Funding.

The Board agreed to re-send the letter to the Cabinet Minister and to provide a copy to the Chair of NHS Lothian.

(c) The West Lothian Integration Joint Board noted the minute of the meeting of the Strategic Planning Group held on 6 October 2016.

(d) The West Lothian Integration Joint Board noted the minute of meeting of the Audit Risk and Governance Committee held on 23 September 2016.

3. IJB FINANCE UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the budget forecast position for 2016/17 and an update in relation to the 2017/18 Scottish Draft Budget, including an initial assessment of the implications for health and social care services.

The Chief Finance Officer informed the Board that, as previously reported, it was anticipated by NHS Lothian and West Lothian Council that a break even position would be achieved for 2016/17. There remained a degree of uncertainty around a number of aspects of the 2017/18 budget but an initial estimate of high level implications for both partner bodies and health and social care functions was set out in the report. This would be subject to further work over the coming weeks and months.

The report provided a table showing the most recent 2016/17 monitoring exercise undertaken by NHS Lothian and West Lothian Council.

Appendix 1 to the report provided further detail on the forecast position. An overspend of £2.095 million was forecast on the payment to the IJB and an overspend of £913,000 was forecast against the notional share of acute set aside resources attributed to West Lothian. A breakeven position was forecast for Adult Social Care services.

The Chief Finance Officer went on to explain that the updated position represented an improved outturn position of £336,000 on NHS Lothian delegated functions compared to the position previously reported to the Board on 29 November 2016. The previously highlighted key pressure areas were largely unchanged, and the improved position was largely due to reduced spend forecast in prescribing, although this area remained the most significant IJB budget pressure. Taking account of the overall breakeven position anticipated by NHS Lothian, the overspend on IJB functions would be managed and a breakeven position would effectively be achieved for 2016/17.

In relation to the draft Scottish Budget 2017/18, it was reported that Scotland's total proposed spending plans, as set out in the Draft Budget 2017/18, amounted to £38,048 million, an increase of £923.8 million compared to the 2016/17 Scottish budget. In terms of IJB delegated services, the relevant portfolio movements were shown in a table within the report. The two Scottish Government portfolios which included funding for NHS Boards and Local Government were Health and Sport (Health) and Communities, Social Security and Equalities (Local Government). These made up £22,995 million (60.4%) of the £38,048 million total 2017/18 Draft Budget. Taking account of the movement in SG funding across both portfolios, there was a cash reduction compared to 2016/17 funding levels of over £40 million.

The report went on to examine the position in relation to:- Initial NHS Lothian 2017./19 Funding Position, Initial West Lothian Council 2017/18 Funding Position, Health and Social Care Fund, Scottish Government

Priorities for IJBs – Draft Budget 2017/18.

The Chief Finance Officer reported that it was clear from the draft 2017/18 Scottish Budget that the 2017/18 budget process would be extremely challenging for NHS Boards, Local Authorities and Integration Authorities. Compared to the very significant growth in West Lothian expenditure demands evident in 2016/17 across areas such as elderly care at home (20%), elderly care homes (11%), learning disability care (24%) and prescribing (6%), the overall cash reduction highlighted in Section C.3 of the report in Scottish Government revenue funding for portfolios including health and social care funding was clearly of concern.

At this stage there remained a number of uncertainties including confirmation still required on funding streams and work was currently progressing with NHS Lothian and the council to prepare a 2017/18 budget position for IJB delegated functions.

In terms of future year budgets, it was clear from Treasury public spending plans in place that future year funding would continue to be very constrained. Taken in conjunction with increasing demands within health and social care, it was considered important going forward that medium term financial strategy and planning was developed during 2017. Discussions were taking place with the council's Head of Finance and Property Services and the NHS Lothian Director of Finance to consider this for 2018/19 onward.

It was recommended that the IJB:-

1. Note the updated forecast outturn for 2016/17 in respect of IJB Delegated functions taking account of saving assumptions.
2. Note the provisional impact assumed on NHS Lothian and West Lothian Council funding taking account of the 2017/18 Scottish Draft Budget.
3. Note the 2017/18 Health and Social care funding included in the 2017/18 settlement and the breakdown of the funding.
4. Note the Scottish Government letter to Lothian IJBs in respect of expectations around the 2017/18 budget settlement.
5. Note that a report on the financial assurance of IJB 2017/18 budget contributions from NHS Lothian and West Lothian Council, along with proposed Directions, would be presented to the Board on 14 March 2017.

Decision

To note the terms of the report and the recommendations by the Chief Finance Officer.

DRAFT

The Board considered a report (copies of which had been circulated) by the Director informing the Board of the comments received on the consultative draft of the Participation and Engagement Strategy and recommending responses to comment received, including changes to the strategy.

The Director recalled that, at its meeting on 11 August 2016, the IJB Strategic Planning Group had noted the terms of a draft strategy and action plan for 2016/17 that had been prepared by officers. The group agreed to put these out to consultation prior to approval by the IJB.

The report advised that consultation took place over a 26 day period extending from 16 September to 12 October. The consultation was based on a Survey Monkey questionnaire and the questions and responses were attached as Appendix 1 to the report.

The Board was informed that the number of respondents via Survey Monkey was 15. 85% of responses were from individuals and 15% were from organisations. Three email responses were also received from organisations.

Question 1 asked if the respondents agreed or disagreed with the 17 core commitments in the strategy. There was a high level of endorsement for the proposed commitments with all receiving 80% - 100% strongly agree/agree responses except PES12 (development of the website) which received 79% in the category strongly agree/agree.

Question 2 asked consultees to explain if they disagreed with any of the proposed commitments and why that was the case.

Question 3 invited additional comments on the proposed commitments.

Question 4 invited suggestions for any additional actions to be added to the action plan.

Question 5 invited any additional comments not covered by previous answers.

Responses received to questions 2-5 and the three sets of comments received by email were summarised in Appendix 2 to the report along with a recommended response.

The Board noted that the majority of comments received were positive or asked for clarification on various points. A small number had suggested revisions to the strategy, and these suggestions were summarised in the report.

A finalised strategy document showing the recommended changes was attached as Appendix 3 to the report. A finalised action plan showing recommended changes was attached as Appendix 4 to the report. Appendix 5 to the report was an integrated impact assessment of the

strategy.

The Integration Joint Board was asked to:-

1. note the comments received on the consultative draft;
2. agree the proposed responses to the comments received;
3. agree the resulting changes to the strategy and action plan for 2016/17;
4. approve the revised strategy as IJB policy; and
5. endorse the action plan for 2016/17.

Questions raised by IJB members were then dealt with by the Head of Service. In particular, the Board was informed of the development of a Plain English version and an easy-read version of the strategy.

Decision

1. To note the terms of the report.
2. To agree the proposed responses to the comments received and to agree the resulting changes to the strategy and action plan for 2016/17.
3. To approve the revised strategy as IJB policy.
4. To endorse the action plan for 2016/17

5. ADULT SUPPORT AND PROTECTION BIENNIAL REPORT

The Board considered a report (copies of which had been circulated) by the Head of Social Policy informing members about the submission of the West Lothian Public Protection Committee's 2014-2016 Adult Support and Protection Biennial report to the Scottish Government on 31 October 2016.

The Head of Social Policy informed the Board that the West Lothian Public Protection Committee's 2014-2016 Adult Support and Protection Biennial report addressed the two years of activity and of action on adult protection; confirming that the local Adult Support and Protection multi-agency practice arrangements were operating well.

The report outlined the strong practice links that had been developed by the Public Protection Committee with those agencies providing a service to members of the public. The Public Protection Committee's commitment to developing both Intra-agency and multi-agency practice enabled it to continually strive to achieve the right support and protection for adults at risk within a public protection focus. The approach ensured it continued to routinely audit practice examples, its performance indicators and engaged with service users and carers to enable it to respond flexibly to

opportunities whilst strategically planning for the future.

The Board was asked to note the submission of the report for information.

Decision

To note the terms of the report.

6. CONSULTATION RESPONSE TO NEW NATIONAL HEALTH AND SOCIAL CARE STANDARDS

The Board considered a report (copies of which had been circulated) by the Head of Social Policy attaching a proposed response to the public consultation in relation to the proposed new National Health and Social Care Standards.

The Head of Social Policy informed the Board that a public consultation exercise had taken place on proposed new standards with all responses requiring to be submitted no later than 22 January 2017. The Board noted, however, that it had been agreed by Scottish Government because of the timescales involved, West Lothian IJB could submit their response after the close of the consultation period. Thus enabling their views to be taken into consideration however they would not be included in the final report produced following the closure of the consultation period.

The Scottish Government consultation was seeking comments as to whether anything was missing or required to be added to the standards. The consensus of opinion expressed by all at the consultation meeting was the standards were felt to be comprehensive overall with a few benefiting from some additional text predominantly to clarify meaning or context. No significant omissions were identified which was deemed to be reassuring by those participating in the consultation exercise.

The Head of Social Policy concluded that the new proposed standards should enable services to deliver and demonstrate how those who used health and social care services were able to receive a personalised service of their choice throughout their care journey in order to best improve their quality of life.

The Board was asked to approve the proposed response from the IJB, a copy of which was attached as Appendix 1 to the report.

Decision

To approve the proposed response as recommended by the Head of Social Policy.

7. SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DELIVERY PLAN

The Board considered a report (copies of which had been circulated) by the Director advising the Board of the recently published Scottish

Government's Health and Social Care Delivery Plan.

The Board was informed that, in December, the Scottish Government had published its Health and Social Care Delivery Plan outlining the plan for delivering the Scottish Government's Vision for improving health and social care.

The Plan set out the government's programme to further enhance health and social care services so that the people of Scotland could live longer, healthier lives at home or in a homely setting and that Scotland had a health and social care system that:

- was integrated
- focused on prevention, anticipation and supported self-management
- would make day-case treatment the norm, where hospital treatment was required and could not be provided in a community setting
- focused on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions.
- ensured people got back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The plan addressed challenges which were recognised in the Audit Scotland report, NHS in Scotland 2016.

Finally, the Board was informed that the IJB Strategic Plan was due to be reviewed in March 2017. It would be appropriate to take account of the Health and Social care Delivery Plan within the review.

The Board was asked to note the Scottish Government's Health and Social Care Delivery Plan and to agree to take account of the plan within the annual review of the IJB Strategic Plan.

Questions raised by Board members were then dealt with by the Director and by the Senior Manager Community Care Support and Services.

Decision

To note the Scottish Government's Health and Social Care Delivery Plan and to agree to take account of the plan within the annual review of the IJB Strategic Plan.

8. SCHEME OF DELEGATION FOR IJB OFFICERS

The Board considered a report (copies of which had been circulated) by the Standards Officer seeking approval of a list of powers and

responsibilities to be delegated by the Board to its officers, as part of the Board's governance arrangements.

Currently, the Board only had one member of staff – the Chief Officer, known locally as the Director. It had other officers who were not members of its staff but who carried out duties for it (for example, the Chief Finance Officer, the Standards Officer). It also received support from officers and employees of the council and the health board. They were not employed by the Board and they were managed by the Director in his complementary roles in the management structures of those two organisations.

The Standards Officer informed the Board that one part of the Board's decision-making structures which still required to be approved was a document setting out the scope and rules for decisions being taken by officers on behalf of the Board. That document would be known as the Scheme of Delegation to Officers.

Each of the posts covered by the Scheme had its own role description used by the Board's Appointments Committee and the Board itself when the posts were first filled. It was not the Scheme's purpose to replace those or duplicate them or repeat them. The Scheme was part of a governance framework for efficient, effective and accountable decision-making amongst the Board, its committees and its officers. It was noted that the Scheme was not designed to be an exhaustive list of things that officers could do on behalf of the Board. It recorded the most significant and standing delegations of powers and responsibility to officers. There was no need for it to record temporary or one-off instructions or delegations to officers. Those were recorded in minutes of Board and committee meetings. As a general rule, it was suggested that delegations which would last for more than six months would be included.

The proposed Scheme was attached as Appendix 1 to the report.

The Board was invited to:-

1. approve the Scheme of Delegations in the appendix
2. delegate to the Standards Officer the powers to make administrative changes to the Scheme as required from time to time, and to amend and re-publish the Scheme as and when required by further delegations authorised by the Board.
3. agree that the Scheme should be comprehensively reviewed every three years.
4. note that the approved Scheme would be published alongside the Board's Standing Orders and committee and working group remits to provide an open and transparent set of decision-making rule ad procedures.

Decision

1. To approve the Scheme of Delegations as recommended by the

Standards Officer.

2. To delegate to the Standards Officer the powers to make administrative changes to the Scheme as required from time to time, and to amend and re-publish the Scheme as and when required by further delegations authorised by the Board.
3. To agree that the Scheme should be comprehensively reviewed every three years.
4. To note that the approved Scheme would be published alongside the Board's Standing Orders and committee and working group remits to provide an open and transparent set of decision-making rules and procedures.

9. ETHICAL STANDARDS IN PUBLIC LIFE

The Board considered a report (copies of which had been circulated) by the Standards Officer informing the Board of duties arising under statute and guidance in relation to the ethical standards in public life regime, and inviting the Board to agree a process to ensure compliance by the Board and its members and officers.

The Standards Officer advised that the Integration Joint Board was a devolved public bodies (public body) for the purposes of the Ethical Standards in Public Life etc (Scotland) Act 2000 (the Act). The regime was built around a code of conduct.

The duties which applied to the IJB itself as a corporate body were as follows:-

- To adopt a Code of Conduct and have it approved by the Scottish Ministers
- To promote the observance by members of high standards of conduct in accordance with statutory guidance
- To assist them to observe the code in accordance with statutory guidance
- To set up a register of members' interests, and then to maintain it and make it available for public inspection, again in accordance with statutory guidance
- To appoint a Standards Officer to ensure that it met its statutory duties

The report went on to list the statutory duties relating to Board members.

It was noted that the Board and its members and officers had already made significant progress towards meeting their statutory duties. However, there were some statutory duties which still had to be met.

Those were the more general duties about promoting high standards of conduct and observance of the code in accordance with guidance. Steps had to be taken by the Boards, its members and officers to meet those promotion and observance duties, and these were examined in the report.

The steps which were proposed to ensure compliance with the statutory duties were:-

- Immediately on their appointment, the Standards Officer to provide a form for registration of interests with explanatory information and the opportunity for a meeting with the Standards Officer to explain.
- Once the entries in the form were clarified and finalised, the Standards Officer to make it publicly available as part of the Board's overall register of members' interests.
- The register and the code to be published on the internet with an explanation about the legal requirements.
- The Standards Officer to send bi-annual reminders to members to check the accuracy of their register and notify any changes within one month of them happening.
- The Standards Officer to record any notified changes and amend the register accordingly.
- The Standards Officer to inform members of any significant developments in an appropriate way, for example, by email, depending on how significant and complex they were.
- The Standard Officer to provide (at least) an annual briefing and training session each autumn for members, outwith Board meetings, on the ethical standards regime for the preceding financial year and about their duties and compliance.
- The Standards Officer to submit an annual report to the Board at its last meeting of the calendar year about the ethical standards regime.
- The current process to continue whereby there is a standing item on the agenda for Board meetings to remind members to consider their position in relation to declarations of interest and withdrawal from meetings.
- The Code and these compliance procedures to be formally reviewed by the Audit Risk and Governance Committee every three years from the date of establishment of the Board (September 2015).
- The committee's recommendations to be reported to the Board for noting and approval.

The Standards Officer recommended that members of the IJB:-

1. Note the statutory duties incumbent on the Board and its members and officers in relation to ethical standards in public life.
2. Note that the audit Risk and Governance Committee had considered the proposals in the report at its meeting on 6 January 2017 and recommended that they be adopted by the Board.
3. Agree the proposals in paragraph 5.1 of the report.

Decision

1. To note the terms of the report and;
2. To agree the proposals in paragraph 5.1 of the report.

10. WORKPLAN

A copy of the Workplan had been circulated for information.

Decision

To note the Workplan.

To note the intention to bring a paper to the March IJB meeting concerning Lothian Hospitals Strategic Plan.



MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

WEDNESDAY 21 DECEMBER 2016
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:

Councillor S Akhtar
Councillor S Currie
Councillor Goodfellow
Councillor D Grant
Ms F Ireland
Mr A Joyce
Mr P Murray

Non-voting Members Present:

Ms F Duncan
Dr A Flapan
Mr D King
Mrs M McKay
Ms S Saunders
Mr D Small
Mr E Stark
Dr J Turvill
Mr A Wilson

ELC/NHS Officers Present:

Mr C Briggs
Mr P Currie

Visitors Present:

Mr M Bonnar (MELDAP)

Clerk:

Ms F Currie

Apologies:

Mr M Ash
Dr R Fairclough
Mr D Harvie
Ms A MacDonald
Ms M McNeill

Declarations of Interest:

None

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 24 NOVEMBER 2016

The minutes of the East Lothian Integration Joint Board meeting of 24 November 2016 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 24 NOVEMBER 2016

The following matters arising from the minutes of the meeting held on 24 November were discussed:

Cockenzie Medical Centre – David Small advised members that the standard business case had been presented to the Lothian Capital Investment Group and, following some refinement, would be considered at the NHS Lothian Finance & Resources Committee meeting in February 2017.

3. CHAIR'S REPORT

The Chair thanked members for attending what had been a very interesting and worthwhile Primary Care workshop on 24 November 2016. Mr Small explained that the key propositions from this meeting would be used to formulate some of the Directions for 2017/18 and to influence the Lothian-wide discussions on Primary Care. A follow up event would be hosted by Edinburgh in February 2017.

In response to questions, Mr Small indicated that for 2017/18 it would be for IJBs to decide how to spend their share of Primary Care budgets. He added that a workshop on financial matters was being arranged for East Lothian IJB members and that this would take place in January 2017.

4. NHS HEALTHCARE GOVERNANCE COMMITTEE

Fiona Ireland reported back on two meetings of the NHS Healthcare Governance Committee which took place on 27 September and 29 November 2016.

Ms Ireland advised that the East Lothian IJB had presented its proposals for comprehensive reporting arrangements at the September meeting. These were accepted by the Committee with the suggestion that they be used as a template for other IJBs to follow. At the meeting in November, the Committee considered a range of topics including GP sustainability and Child and Adolescent Mental Health Services (CAMHS). The discussion on CAMHS had centred on access to psychological therapies. Ms Ireland advised members that there was huge pressure on this service and an action plan had recently been put in place to reduce waiting times for psychological therapies.

In response to questions, Ms Ireland and Mr Small agreed to look into the possibility of IJB members receiving a copy of the action plan and having access to other papers submitted to the NHS Healthcare Governance Committee.

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

Councillor Jim Goodfellow gave members a brief outline of the remits and membership of the Council's scrutiny committees. He advised that the Audit & Governance Committee had recently considered the Children and Adult Services Risk Register and the Policy & Performance Review Committee received performance reports on social work complaints processes and Delayed Discharges.

Councillor Goodfellow added that two reports of relevance to the IJB would be presented at the January meeting of the Audit & Governance Committee: 'Social Work in Scotland (Audit Scotland) and a report from the Council's Internal Audit Manager containing proposals for the sharing of audit reports and information between the Council and the IJB.

6. FINANCIAL ASSURANCE 2016/17

The Chief Finance Officer had submitted a report updating the IJB on financial assurance work for the IJB for 2016/17.

David King presented the report summarising the background and decisions taken to date in respect of financial assurance for 2016/17. He advised that NHS Lothian were predicting a breakeven position for 2016/17 and, if this proved to be the case, they had agreed to underwrite the projected overspend in the health element of the IJB's budgets. He added that East Lothian Council had recently agreed to put an additional £1million into the Adult Wellbeing budget which meant that this budget was also likely to breakeven, although the position remained challenging.

Mr King also referred to the use of Social Care Fund (SCF) monies to fund other budget pressures, including the increased cost of the Living wage, and to provide additionality, some of which had already been done through funding of additional care packages. He suggested that the IJB should continue to move forward with its Partners and avoid placing additional pressures on them during the current financial year.

Mr Small added that the additionality monies given to address delayed discharges were already having an impact with an increase in weekly care hours available to over 65s, a substantial increase in Self Directed Support packages and a continued improvement in the delayed discharge figures.

In response to questions from members, Mr Small said that it was his intention to prepare a review of the impact of additionality monies during the period April 2016 to January 2017 and present this to the IJB in the New Year. He said that this would also tie-in with the planned workshop on finance which was being arranged for January.

Margaret McKay said that it was important for the IJB to be clear about what it meant by 'additionality'. At the moment it seemed to be doing more of the same for good purpose whereas it should really be about change and transforming the way services are provided.

Peter Murray observed that there was often an expectation that such change will generate efficiency savings and when setting budgets for future years the IJB would need to be confident that any proposals were achievable. He also said that significant public engagement was required to ensure that service users understood how they might be affected by any proposed changes.

Councillor Currie agreed, adding that meeting targets for efficiency savings was crucial if the IJB was to deliver on its longer term goal of investing in real additionality and service redesign. He said that the IJB must also be realistic about setting these targets and ensure that appropriate measures are in place to monitor performance and mitigate against the risk of failure, which would not only impact on the current budget year but on future years as well.

Alex Joyce said that the IJB needed to adopt a pragmatic approach. Much of what was being dealt with this year had been inherited from the previous system and it was important now to focus on planning for future years. He welcomed the opportunity to debate financial matters at the workshop in January and also to consider further what the IJB means by 'additionality'.

Councillor Akhtar agreed that the IJB needed to be realistic and to support its Partners. She said that the additional money provided by the Council was hugely significant and that budgets were likely to become even more challenging in future years.

The Chair thanked members for their contributions and acknowledged the challenges ahead. He said that strong financial planning was key and he hoped that the workshop in January would allow members to debate all of the issues and agree a way forward.

Decision

The IJB agreed to:

- (i) Note that NHS Lothian will underwrite the projected overspend in the health element of the IJB's budgets on the basis that NHSiL can break even in 2016/17; and
- (ii) Recognise the financial pressures within the Adult Wellbeing operational budgets and support them as necessary in 2016/17. This on the basis that:
 - a. East Lothian Council underwrite any overspend in the social care element of the IJB budget.
 - b. That in 2017/18 an appropriate element of additionality is delivered from the recurrency of the 2016/17 SCF investments.

7. DELAYED DISCHARGES

The Chief Officer had submitted a report updating the IJB on performance on delayed discharges in East Lothian.

Mr Small presented the report drawing members' attention to the reduction in the number of patients awaiting discharge during the period October – November 2016 and outlining the key factors which supported this improvement. He indicated that the improvement had continued during December but that a spike in numbers was expected during January/February 2017. The situation would continue to be monitored closely and a further update provided to the IJB.

In response to questions from members Mr Small expanded on the reasons for fluctuations in the figures during the census period and the current provision of step down facilities. Dr John Turvill provided background on the Hospital at Home service and its impact on delayed discharges.

Mrs McKay observed that those patients who were moved to step down facilities were still in a hospital setting and the length of time they remained there should also be monitored. She added that often the distinction between care homes and nursing homes could seem quite artificial and it was more important to focus on the provision of comprehensive care.

Councillor Akhtar welcomed the improvement in the figures and said that increasing the numbers of available step down beds would help to continue this positive progress.

Councillor Currie suggested that future reports might include a breakdown of private and public care provision and explanations as to why some facilities were full and others not. He added that only by having facilities which were flexible enough to adapt to changing levels of demand could the IJB hope to fully address the problem of patients remaining in hospital longer than necessary.

Decision

The IJB agreed to note the recent improving trend on performance.

8. DRUGS AND ALCOHOL FUNDING IN EAST LoTHIAN 2016/17

The Chief Officer had submitted a report explaining the work being undertaken to deliver a redesign of drug and alcohol services for East Lothian driven by the 23% reduction in funding ADPs received from the Scottish Government for the financial year 2016/17. The government's position was that as additional funding had been provided to NHS Boards any shortfall should be made up by NHS Boards.

Martin Bonnar presented the report outlining the background and the key issues contained in the report. He responded to a number of questions on the range of facilities available and the consultation taking place with services users and carers.

A lengthy discussion followed in which the members debated the impact of the reduction in funding, the allocation of budgets for different aspects of the service, the implications for future Directions issued by the IJB and how to ensure that the fullest range of support and treatment options remained available to service users within East Lothian.

Councillor Akhtar expressed her concern that this 23% reduction would affect services for some of the most vulnerable people in the county and asked for this to be noted in the minutes.

Decision

The IJB agreed to:

- (i) Note the process agreed by the MELDAP Strategic Group to manage the loss of 23% of the available income for Drugs and Alcohol Services in East Lothian;
- (ii) Note the intention to use MELDAP reserves for East Lothian where appropriate to smooth the transition in making the agreed changes for financial year 2017-18; and
- (iii) Support the redesign process by directing NHS Lothian to:
 - Make available East Lothian's full share of the drug and alcohol funding available to the IJB

- Ask MELDAP to propose a redesigned drug and alcohol service for East Lothian within the available financial envelope designed on a community based, recovery based model for agreement
- Deliver the agreed model.

9. PROGRESS AGAINST 2016-17 DIRECTIONS AND PROPOSED DIRECTIONS FOR 2017-18

The Chief Officer had submitted a report informing the IJB of progress made against the suite of Directions issued to NHS Lothian and East Lothian Council in April 2016 and seeking agreement to the development of 2017-18 Directions for NHS Lothian and East Lothian Council.

Paul Currie presented the report. He advised that the summary of progress covered the period up to the end of the third quarter and he referred members to the table within the report which outlined the achievement against each Direction. He highlighted the Directions that were yet to be achieved and advised that a further progress report would be provided in the New Year. He also referred members to the outline proposals for Directions to be issued in 2017/18. He said that his intention was to prepare more detailed Directions for consideration by the IJB in February and each of these would include the appropriate budgetary information.

Mr King added that the Directions were linked to the budget and the budget must balance at the end of the year. It was therefore important to prepare specific Directions which clearly showed the resources available to achieve the expected outcomes.

Responding to questions from members, Mr King and Mr Currie confirmed that the Directions and reporting on their progress were key aspects of the IJB's wider Performance Management Framework. They also acknowledged the need to build on the current year and consider where things could be done better and how to begin achieving transformational change through redesign of services.

Mrs McKay raised a concern that there appeared to be no proposals for a specific Direction in relation to carers. She noted the current Direction which focused on development of the Strategy for Carers but she said that a further Direction should be added to those for 2017/18 to focus on support for carers. She stated that carers provided more care than all of the health and social care staff put together and it was crucial to recognise their contribution and address their needs. She proposed an amendment to the report recommendations to include an additional Direction focussing on carers.

Mr Small pointed out that the proposals within the report were in the early stages and the detail was yet to be agreed.

Fiona Duncan suggested that community justice might be another addition and she advised members that a presentation was planned for the IJB's January meeting.

Sharon Saunders suggested that future discussions on Directions should also consider that services for the adult population did not just cover the elderly and that there were a wide range of services for vulnerable adults which had a significant impact on budgets. She added that to not do so would be a missed opportunity, particularly in relation to the potential for service redesign.

There was further discussion about how best to address these proposed amendments and additions. Members wanted to ensure that the comments would be reflected not only in the minutes but also in the development of the detailed Directions.

The Chair acknowledged these views and gave a commitment that officers would take into account the proposals put forward by members when drafting the Directions for 2017/18 and reminded members that the IJB would have a further opportunity to debate the detail of the Directions at its February meeting.

Decision

The IJB agreed to:

- (i) Note the progress made against many of the 2016/17 Directions, to note that a number of Directions remain to be delivered and that some of these may not be achieved before the financial year end;
- (ii) Approve the development of new Directions for 2017/18 as proposed in the report; and
- (iii) Agree that those partners delivering the Directions should be required to report on progress as required by the IJB for the purposes of monitoring achievement.

SUMMARY OF PROCEEDINGS – EXEMPT INFORMATION

The Integration Joint Board agreed to exclude the public from the following business containing exempt information by virtue of paragraph 5.9.1 of its Standing Orders (the Integration Joint Board is still in the process of developing proposals or its position on certain matters).

NHS Lothian Hospitals Plan

A report was submitted to update the IJB on the NHS Lothian Hospitals Plan to provide the opportunity for members to discuss the way forward. The IJB agreed to note the contents of the report and that updated proposals would be presented to the IJB in the first quarter of 2017.

East Lothian
Integration Joint Board



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

**THURSDAY 26 JANUARY 2017
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON**

Voting Members Present:

Mr A Ash
Councillor S Currie (Items 1 – 6)
Councillor J Gillies (*substitute)
Councillor Goodfellow
Councillor D Grant
Ms F Ireland
Mr A Joyce
Mr P Murray

Non-voting Members Present:

Mr D Harvie
Mr D King
Ms A MacDonald
Mrs M McKay
Ms M McNeill
Mr D Small
Dr J Turvill

ELC/NHS Officers Present:

Ms J Ogden-Smith
Mr B Davies
Mr I Rogan
Mr P Conalglan
Mr P Currie

Visitors Present:

Councillor P MacKenzie

Clerk:

Ms F Currie

Apologies:

Councillor S Akhtar*
Dr R Fairclough
Mr T Miller
Ms S Saunders
Mr E Stark
Mr A Wilson

Declarations of Interest:

None

1. MINUTES OF THE MEETING OF THE EAST LoTHIAN INTEGRATION JOINT BOARD OF 21 DECEMBER 2016

The minutes of the East Lothian Integration Joint Board meeting of 21 December 2016 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 21 DECEMBER 2016

The following matters arising from the minutes of the meeting held on 21 December were discussed:

Delayed Discharges – David Small updated members on the census figures for December 2016 and January 2017 and the progress required to meet the target set for March 2017.

Drugs & Alcohol Services – Mr Small advised that work was underway and a further update would be provided to the IJB as part of the financial report in March 2017.

3. CHAIR'S REPORT

The Chair reported that on 19 January 2017 he and Mr Small had joined the Health Secretary, Shona Robison MSP, in marking the official commencement of work on the new East Lothian Community Hospital. He had been encouraged by the progress made on the site and he looked forward to following the development of the new facility over the next two years.

4. NHS HEALTHCARE GOVERNANCE COMMITTEE

Fiona Ireland reported back on the January meeting of the NHS Healthcare Governance Committee. The Committee had considered updates on community nursing, GP sustainability, the Royal Edinburgh Hospital bed base reduction and performance against complaints and feedback. She advised that a paper on Delayed Discharges had also been presented and had shown that East Lothian was the only area whose figures were exceeding expectations.

Ms Ireland added that arrangements would be put in place to provide members with copies of Committee papers which were relevant to the East Lothian IJB.

5. EAST LoTHIAN COUNCIL POLICY & PERFORMANCE REVIEW COMMITTEE AND AUDIT & GOVERNANCE COMMITTEE

Councillor Jim Goodfellow advised members that there had been no reports of relevance to the IJB presented at the January meetings of the Policy & Performance Review Committee and the Audit & Governance Committee.

Councillor Currie referred to the agenda of the Audit & Governance Committee meeting on 24 January 2017 which had included a report by the Internal Audit Manager on a Data Sharing Protocol for the IJB Audit & Risk Committee. The Clerk advised members that this report had been withdrawn from the agenda and would be presented at a future meeting of the Committee.

Mike Ash asked whether the issue of delayed discharges was discussed at the Council's scrutiny committees. Councillor Goodfellow explained that while this was not a standing item, the Policy and Performance Review Committee could request reports at any time and the Committee had considered two previous reports on this issue.

6. OLDER PEOPLE'S DAY CENTRES

The Chief Officer had submitted a report seeking the IJB's agreement to support the development of older people's day centres in line with the commitment in the East Lothian Health and Social Care Partnership Strategic Plan 2016-18.

Bryan Davies presented the report. He stated that, following registration with the Care Commission, day centres would in future focus on early intervention, prevention and outreach as well as direct care and support. He outlined the proposed redesign programme which included equitable distribution of funding across the day centre network, based on an agreed daily rate, addressing geographical inequalities in current provision and developing dementia care provision and improving links with social work and health services.

The members of the IJB debated the matter at length and Mr Davies provided further details of the timescale for increasing the service provision across the day centre network, the proposed funding framework, how improvements in data gathering would help to inform the capacity and service requirements for each day centre and the importance of staff development and training. Mr Davies also reminded members that this proposal was a medium term strategy and would be reviewed after three years.

Responding to further questions from members, Mr Davies expanded on the issue of geographical inequality with particular reference to services in the west of the county. He also outlined the consultation process undertaken with day centre staff and acknowledged that transportation had to be a key part of the proposals. On funding, Mr Davies confirmed that the proposed funding level, although requiring a modest level of additional investment from the Council, would bring the services into line with those of other local authorities.

Margaret McKay stated that while she could see the future benefits such a service would bring to carers, and that the day centre staff were to be congratulated on their willingness and ability to embrace change. However, she pointed out that the proposals could not work without a reliable transport network and this must be a crucial part of the programme. She also raised the question of whose responsibility it would be to ensure that at the end of the three years the funding level would be sustained.

Mr Small advised that although the Integration Fund was a recurring budget it was not committed on a recurrent basis. The proposals were part of a three year strategy and the IJB would want to review progress at the end of this period.

Mr Ash said he had found the discussion very helpful and he could see the sense in phasing in the proposals and to allow each day centre to build its capacity before

coming on stream. He emphasised the importance ensuring that the budget was in place but otherwise he strongly supported the principle of the report.

Peter Murray observed that the overall intent and outcomes for the project needed to be clearly identified and detailed performance data would be required to assess whether these outcomes had been met.

Councillor Currie welcomed the aspiration of the proposals but expressed concern that the level of funding proposed may be too optimistic. He said that the report had shown the variety and quality of existing services provided by day centres in east Lothian and he cautioned against adopting too much of a standardised approach. He said he looked forward to seeing further details on the proposals including how to address issues such as deprivation and the proposals for development of services in Musselburgh.

Councillor Goodfellow commented on the phenomenal change in day centre services over the past 35 years and the acknowledgment now that they are a key resource in older people's services. He said he welcomed the proposals for two reasons: the levelling up of all day centre provision to the highest quality provision and that the proposals themselves had been developed in discussion with day centre staff and the Association of Day Centres. He also welcomed the increase in budget provision.

Marilyn McNeill referred to the proposal for development of a community hub to provide support for older people and to a similar project which was underway in Fife. She expressed the hope that such a hub would link closely with the network of day centres.

The Chair thanked members for their contributions. He stated that day centres had been in existence for nearly 40 years and had matured and diverged over that period. The recent introduction of registration through the Care Inspectorate had placed additional responsibilities on day centres and additional investment was now required. He acknowledged that this was a significant investment but worthwhile to maintain and develop such a valuable service.

Decision

The IJB agreed:

- (i) To support the development of an improvement programme approach to older people's day services in line with the strategic priorities as set by East Lothian's Health and Social Care Partnership and Integration Joint Board.
- (ii) That the additional investment need in order to achieve the improvement programme, as detailed in the resources framework, should be funded from the Integrated Care Fund subject to final budget decisions by the IJB in March 2017.

7. COMMUNITY JUSTICE TRANSITION

The Chief Officer had submitted a report informing the IJB of progress with the community justice transition and highlighting the need for further dialogue.

Ian Rogan and Philip Conaglen gave a presentation on the process of change towards a new model of community justice. They outlined the background to the new legislation and the national Strategy, the governance structure, the key health and social

challenges facing those leaving prison and the next steps in the process of raising awareness and improving services.

In response to questions from members Mr Rogan and Mr Conaglen explained the arrangements for access to services following release from prison, both statutory and voluntary, and the challenges involved in improving engagement levels.

Mr Conaglen confirmed that rates of learning disability within the prison population were significant but there was an absence of detailed statistics.

Mr Small responded to a question on funding indicating that community justice was a delegated function of the IJB and any proposals for improvement to services could be reflected in the Strategic Plan and future Directions issued by the IJB.

In response to further questions, Mr Rogan clarified the position in relation to services for victims and the role of third sector organisations. He also acknowledged the effect which shorter sentences had on reoffending rates and how this was being tackled. Mr Conaglen agreed that lack of literacy posed barriers to engagement with services and organisations needed to be mindful of how they communicated with these individuals.

The Chair thanked Mr Rogan and Mr Conaglen for their presentation and said he looked forward to the IJB working more close with them in future.

Decision

The IJB agreed to:

- (i) Note its role as a statutory partner in Scotland's new community justice arrangements, with a duty to co-operate and actively contribute to reducing offending.
- (ii) Develop dialogue with the reducing reoffending Board around how assessments of need and strategic approaches are shared and aligned between partners.

SUMMARY OF PROCEEDINGS – EXEMPT INFORMATION

The Integration Joint Board agreed to exclude the public from the following business containing exempt information by virtue of paragraph 5.9.1 of its Standing Orders (the Integration Joint Board is still in the process of developing proposals or its position on certain matters).

Finance/Directions for 2017/18

A briefing was provided on the proposed 2017/18 Financial Settlement and the outcome of the recent financial workshop for members of the IJB. The IJB agreed that further reports would be presented at their meeting on 23 February and 30 March 2017 with a view to discussion and agreement of a final financial settlement and Directions for 2017/18.

Signed

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Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

Item 4.1 Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 20 January 2017

Waverley Gate, Edinburgh

1.12

Present:

Board Members: George Walker (Chair), Councillor Elaine Aitken, Colin Beck, Carl Bickler, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Councillor Joan Griffiths, Councillor Ricky Henderson, Kirsten Hey, Councillor Sandy Howat, Alex Joyce, Angus McCann, Rob McCulloch-Graham, Maria McLgorm, Moira Pringle, Ella Simpson, Richard Williams, and Councillor Norman Work.

Officers: Eleanor Cunningham, Wendy Dale, Marna Green, Gavin King, Tim Montgomery, Allan McCartney, Katie McWilliam, Ross Murray and David White.

Apologies: Ian McKay and Michelle Miller.

1. Chair's Comments

George Walker noted this would be his last meeting as chair, following his term as a non-executive director of NHS Lothian concluding. He thanked members and officers for their support during this period as Chair, paying particular tribute to the strong teamwork and good working relationships shown by all the Joint Board members.

2. Minutes

Decision

To approve the minute of the Edinburgh Integration Joint Board of 18 November 2016 as a correct record.

3. Sub-Group Minutes

Decision

- 1) To note that the matter of audit capacity would be raised with NHS Lothian and CEC Chief Executives
- 2) To otherwise note the Sub-Group minutes.

4. Rolling Actions Log

The Rolling Actions Log for 20 January 2017 was presented.

Decision

- 1) To approve the closure of actions 4, 5, 6, 8, 9, 10, 11, 14, 15 and 16.
- 2) To note that the programme of visits (item 2) would be reviewed at the Joint Board Development Session on 17 February 2017.
- 3) To otherwise note the outstanding actions.

(Reference – Rolling Actions Log – 20 January 2017, submitted.)

5. Standing Orders – Annual Review

The current version of the Joint Board's Standing Orders was approved in July 2015, with further amendments approved in January 2016 and May 2016. An initial annual review of Standing Orders was submitted which sought approval of amendments to the Standing Orders to ensure that substitutes on the Joint Board were aware of their duties with regard to the Code of Conduct, to establish urgency provisions and to incorporate the pre-existing deputations process.

Decision

- 1) To repeal the existing Standing Orders of the Joint Board and approve in its place appendix 1 to the report by the IJB Chief Officer, such repeal and approval to take effect from 21 January 2017.
- 2) To note that the next annual review of Standing Orders would be presented to the Joint Board in January 2018.

(References – minutes of the Integration Joint Board 13 May 2016 (item 3) and 18 November 2016 (item 10); report by the IJB Chief Officer, submitted.)

6. Whole System Delays – Recent Trends

An overview was provided of performance in managing hospital discharge against Scottish Government targets. Key reasons for delay were explained, and a number of workstreams aimed at reducing delays were outlined.

It was advised that work was underway to develop a whole-system overview on a phased basis to assist with identifying the causes of delayed discharge. A target to reduce the number of individuals awaiting discharge to 50 by the April 2017 census was stated.

Decision

- 1) To note that there had been a significant increase in delayed discharge since June 2016 with the increase only partly explained by the changes in reporting which were introduced across Scotland in July 2016.
- 2) To note that given the complexity of the issue, a self assessment of the current approach in Edinburgh to tackling delays in transfer of care was carried out utilising the best practice guidance contained within the Joint Improvement Team "Self Assessment Tool for Partnerships" (updated 2015) and The National Institute for Health and Care Excellence guidelines (December 2015) for "Transition between inpatient hospital settings and community or care home settings for adults with social care needs".

- 3) To note that a comprehensive range of actions was in place to secure a reduction in the number of people delayed. These focussed on: admission avoidance, rehabilitation and recovery and supporting discharge.
- 4) That in future update reports include more specific detail about the acute sites.

(References – minute of the Integration Joint Board 18 November 2016 (item 6); report by the IJB Chief Officer, submitted.)

7. Financial Planning Update

An update on the financial process for 2017/18 was detailed.

Decision

- 1) To note the impact of the 2017/18 draft Scottish Budget on the financial plans for the City of Edinburgh Council, NHS Lothian and the Integration Joint Board.
- 2) To note the current status of the financial plans for the City of Edinburgh Council and NHS Lothian and the impact on delegated budgets for the Integration Joint Board.
- 3) To agree to receive a financial plan for the Joint Board for 2017/18 in March 2017.
- 4) To refer the proposed social care fund investments to the Strategic Planning Group for prioritisation.

(References – minute of the Integration Joint Board 18 November 2016 (item 8); report by the IJB Chief Officer, submitted.)

8. Financial Position to November 2016

The forecast year end position for the Joint Board and an overview of the financial position for the eight months to November 2016 was detailed. This showed an eight-month overspend at £5.4m, equivalent to a year-end overspend of £12.3m.

The forecast of a breakeven position was reliant on reaching an agreed position with NHS Lothian.

Decision

- 1) To note the financial position at the end of November 2016 – a cumulative overspend of £5.4m.
- 2) To note that a combination of social care fund monies identified by the Joint Board and provisions made by the City of Edinburgh Council reduced the forecast overspend in the Council element of the Joint Board's budget to £0.9m.
- 3) To note that NHS Lothian would underwrite the projected overspend in the health element of the Joint Board's budgets on the basis that NHS Lothian could break-even in 16/17.

- 4) To request that NHS Lothian undertake a detailed review of prescribing in Edinburgh at a locality level.

(References – minute of the Integration Joint Board 18 November 2016 (item 7); report by the IJB Chief Officer, submitted.)

9. Workforce Update: District Nursing

An update on the pressures and challenges facing District Nursing across the area covered by the Edinburgh and three Lothian Joint Boards was submitted. The service was experiencing a vacancy rate of 20% amongst band six employees. 57% of band six and seven employees were aged over 50, with the option to retire on full pension aged 55. Additional succession planning measures had been implemented to help deal with the ageing workforce and high level of existing vacancy.

Decision

- 1) To accept the report as assurance that the Edinburgh Health & Social Care Partnership (EHSCP) was taking a whole system approach to ensure the pressures within district nursing in Edinburgh were being addressed, and that a Lothian-wide approach was being taken to deal with current and future service needs. This was being overseen by the Executive Nurse Director and the NHS Lothian Board.
- 2) To acknowledge current and future District Nurse supply and demand issues and the need to urgently train additional District Nurses as well as attempt to recruit nationally to vacant posts.
- 3) In conjunction with the three Lothian Joint Board's, to support the recommendations from the Lothian Review of District Nursing 2016 and to support a collective Lothian-wide approach to taking forward the recommendations and key priorities within this report as detailed in Appendix 1 of the Chief Officer's report.
- 4) To support the current actions being taken to address the pressures within the District Nursing service in Edinburgh and across all four Joint Board's, and to receive regular updates from the Partnership in relation to progress against the actions.

(References – minute of the Integration Joint Board 18 November 2016 (item 9); report by the IJB Chief Officer, submitted.)

10. Joint Inspection of Older People

An update on the joint inspection of services for older people by the Care Inspectorate and Healthcare Improvement Scotland, which occurred between August and December 2016, was provided.

Decision

- 1) To note the key areas associated with early consideration for improvement from the professional discussion with Inspectors, the staff survey and file reading processes.

- 2) To accept the report as assurance that the Edinburgh Health & Social Care partnership (EHSCP) was taking a whole system approach to improve on the significant elements identified throughout the year, and during the inspection itself.
- 3) To support the EHSCP outline Action Plan, which had provided a strong foundation for improvement moving forward.
- 4) That the assurance statement be discussed at a future development session.

(References – minute of the Integration Joint Board 16 September 2016 (item 11); report by the IJB Chief Officer, submitted.)

11. Mental Health and Wellbeing in Edinburgh

An update was provided on the actions being taken to ensure that on opening in January 2017, Phase 1 of the Royal Edinburgh Hospital (REH) re-provision was able to manage admissions and discharges in equilibrium with the reduced bed capacity and for this to be sustained.

It was advised that without delays to discharge, the planned capacity of the REH would be in line with the accepted business case for Phase 1 which saw a reduction of 10 older people's mental health beds and seven adult mental health beds.

Decision

- 1) To note the decision made by the Strategic Planning Group on 10 January as set out in section 24 of the report by the Chief Officer.
- 2) To delegate authority to the Chief Officer and Chief Finance Officer to progress a one year agreement with the Cyrenians based on an indicative cost of £140k to provide four grade 4 places utilising funding from the Social Care Fund.
- 3) To note the intention to issue a Public Information Notice to develop interest and shape the market for a longer term plan to provide accommodation and support.
- 4) To note that regular, comprehensive, updates would be routinely presented to the Strategic Planning Group. These would be shared with all Joint Board members, with monitoring reports to the Joint Board as appropriate.

(References – minute of the Integration Joint Board 18 November 2016 (item 12); report by the IJB Chief Officer, submitted.)

12. Chair

Councillor Ricky Henderson took the Chair for item 13 below. George Walker resumed the Chair for the remaining items of business thereafter.

13. Joint Board Membership - Appointment

Following the resignation of Kay Blair from the Joint Board and the Audit and Risk Committee on 18 November 2016 there had been a vacancy on both bodies. An additional vacancy would be created when George Walker's term as non-executive director on NHS Lothian came to an end on 31 January 2017. As both individuals

were appointed as voting members by NHS Lothian it fell to that body to nominate appropriate replacements. The Joint Board was asked to note NHS Lothian's Board appointments and appoint an individual to the Audit and Risk Committee as required under section 14 of its Standing Orders.

Decision

- 1) To note that NHS Lothian had agreed to appoint Michael Ash to the Edinburgh Integration Joint Board as a voting member in place of Kay Blair.
- 2) To note that NHS Lothian had agreed to appoint Carolyn Hirst to the Edinburgh Integration Joint Board as a voting member in place of George Walker from 1 February 2017.
- 3) To agree that George Walker be appointed to the Edinburgh Integration Joint Board as a non-voting member from 1 February 2017.
- 4) To agree that Michael Ash be appointed to the membership of the Audit and Risk Committee.
- 5) That a short biography of the new Joint Board members be circulated.

(References – minute of the Integration Joint Board 18 November 2016 (items 1 and 10); report by the IJB Chief Officer, submitted.)

Declaration of Interests

George Walker declared a non-financial interest in the foregoing item in relation to a proposed appointment and left the meeting room during consideration.

14. Urgent Business

14.1 Audit and Risk Committee

It was noted that the Audit and Risk Committee continued to seek to co-opt an individual with financial experience and members were invited to recommend any suitable candidates.

14.2 Chief Officer for Policy and Strategy

It was advised that Maria McILgorn had been appointed to the position of Chief Officer for Policy and Strategy.

14.3 George Walker

Those present thanked George Walker for his work in chairing and helping to develop the Joint Board from its inception. The Chief Officer in particular paid tribute to his effective chairing, promoting high quality debate, and encouraging partnership working.

Decision

To note the additional items of business.

15. Resolution to consider in private

Decision

The Joint Board resolved that the public be excluded from the meeting during consideration of the following items of business on the grounds that they involved the disclosure of exempt information as defined under standing order 5.9.

16. Care at Home Contract

One of the Joint Board's partner providers for the delivery of home care to people over 65 in Edinburgh, had been suspended from taking on new packages of care in November 2016 and later served an improvement notice on 6 March 2017. The Chief Officer provided further details on the action taken to address this matter.

Decision

To note the report, and the mitigating actions taken by the Chief Officer, as detailed in the Confidential Schedule, signed by the Chair, with reference to this minute.

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

17. Southside Practice Update

Proposals for an interim solution for patients currently registered to Southside Practice were submitted.

Decision

- 1) To note the actions taken in response and to support the interim solution proposed, both as detailed in the Confidential Schedule, signed by the Chair, with reference to this minute.
- 2) To agree to receive a further report at the Joint Board's February 2017 meeting.

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

Item 4.1 Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 17 February 2017

Waverley Gate, Edinburgh

Present:

Board Members: Councillor Ricky Henderson (In the Chair), Councillor Elaine Aitken, Shulah Allan, Mike Ash, Colin Beck, Carl Bickler, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Councillor Joan Griffiths, Carolyn Hirst, Alex Joyce, Rob McCulloch-Graham and Ella Simpson.

Officers: Wendy Dale, Allan McCartney, Ross Murray, Julie Tickle and David White.

Apologies: Kirsten Hey, Sandy Howat, Angus McCann, Ian McKay, Alex McMahon, Michelle Miller, George Walker and Richard Williams,

1. New Board Members

Councillor Ricky Henderson welcomed Carolyn Hirst and Michael Ash to their first meeting of the Joint Board in their capacity as NHS appointed voting members.

2. Resolution to consider in private

Decision

The Joint Board resolved that the public be excluded from the meeting during consideration of the following item of business on the grounds that it involved the disclosure of exempt information as defined under standing order 5.9.

3. Southside Practice Update

At its last meeting, the Joint Board heard details of the decision of the current partners of the Southside Practice to sell the property on the open market, and considered proposals for an interim solution for patients currently registered to Southside Practice and a governance route required to enable the presentation of a business case for a longer term solution to the NHS Lothian Finance and Resources Committee on 15 March 2017. The Joint Board agreed to support the interim solution proposed by the Chief Officer, and to receive the business case for the medium/longer term solution at this meeting.

The Chief Officer now reported that it had not been possible to reach agreement on the interim solution. In the circumstances, the alternative interim solutions set out in his report to the January 2017 Joint Board were being investigated.

Decision

- 1) To note that it had not been possible to put into effect the interim proposal agreed at the last Joint Board meeting.
- 2) To note the ongoing action to identify an alternative interim solution, and authorise the Chief Officer, in consultation with the Vice-Chair to respond to any interim and longer term proposals that were brought forward, on the basis that an update would be provided at the next Joint Board meeting.
- 3) To note the intention to keep patients and local politicians fully advised of progress.
- 4) To agree that Joint Board members also be kept fully updated on any progress, or otherwise.

(Reference – minute of the Integration Joint Board 20 January 2017 (item 17).)

Minute of Meeting



1.13

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 1 December 2016	2.00pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Peter Johnston (Vice Chair)
Cllr Bryan Pottinger	Alex Joyce
Cllr Joe Wallace (substitute for Cllr Bob Constable)	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)
Marlene Gill (User/Carer)	Ruth McCabe (Third Sector)

In attendance:

Keith Chapman	Nicky Hood (Alzheimer Scotland)
Jamie Megaw (Strategic Programme Manager)	Mike Broadway (Clerk)

Apologies:

Cllr Bob Constable	Cllr Derek Milligan
Margaret Kane (User/Carer)	

Midlothian Integration Joint Board

Thursday 1 December 2016

1. Welcome and introductions

The Chair, Catherine Johnstone, welcomed everyone to the Meeting of the Midlothian Integration Joint Board, in particular Keith Chapman and Nicky Hood (Alzheimer Scotland).

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of interest

No declarations of interest were received.

4. Minutes of Previous Meetings

- 4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 27 October 2016 was submitted and approved.
- 4.2 Arising from the minutes, the Board noted that in terms of the membership of MIJB, it was proposed that Keith Chapman be appointed to the vacant user/carer representative position. The Board agreed to approve the appointment and joined with the Chair in welcoming Keith to the meeting.

5. Public Reports

Report No.	Report Title	Presented by:
5.1	IJB Directions 2017-18	Jamie Megaw

Executive Summary of Report

This report summarised the key issues which required to be addressed in setting the 2017/18 Directions to be issued to Midlothian Council and NHS Lothian by the MIJB prior to April 2017.

The report highlighted that the Directions were intended to provide greater clarity about the key changes which need to be made during 2017-18 in the delivery of health and care services in Midlothian, and that they required to be considered alongside the MIJB Strategic Plan 2016-19.

Summary of discussion

Having heard from the Strategic Programme Manager and the Chief Officer, the Board in considering the emerging principles which should inform the redesign of services, discussed the need for a balanced approach between what could be achieved in the community; through the Community Hospital; and via acute hospital provision, as each was seen as having a role to play. Whilst it was evident that changes were required, it was important that they were proportionate and maximised outcomes within the resources available.

Midlothian Integration Joint Board

Thursday 1 December 2016

Decision

After further discussion, the Board:-

- **Approved the key requirements to be included in the IJBs Directions for 2017-18; and**
- **Agreed to receive a further report in March 2017 outlining the formal Directions and approving them for issue to NHS Lothian and Midlothian Council.**

Report No.	Report Title	Presented by:
5.2	Financial Update - 2016/17 Out-turn and 2016/17 Directions	David King

Executive Summary of Report

This report reflected on three issues :-

1. An update on the projected financial position of the IJB for 2016/17. The projections show an overspend position for the IJB but the IJB had now reached agreements with both NHS Lothian and Midlothian Council for non-recurrent support to underpin this position – the IJB was therefore projecting a break-even position for 2016/17;
2. That the financial values contained in the IJB's 2016/17 directions required to be updated to reflect the current budgets. This was to ensure a clean audit trail and would not affect the delivery of the delegated functions in 2016/17; and
3. A further consideration of the financial challenges facing the IJB in 2017/18 following from the projected financial out-turn in 2016/17 and a reflection of any additional financial pressures and any proposed investments.

Summary of discussion

The Chief Finance Officer in presenting the report highlighted that the real challenge for the MIJB was to continue to deliver high quality services for its population within the financial resources available given that these resources were reducing in real terms and that the demand for the MIJB's functions were likely to increase.

The Board, in discussing the budgetary and demographic pressures that they were likely to be faced in the coming years, acknowledged the importance going forward of the Directions issued to NHS Lothian and Midlothian Council.

Decision

The Board:

- **Noted the projected out-turn position for 2016/17;**
- **Agreed the financial revisions to the 2016/17 directions; and**
- **Noted the potential financial pressures/investments for 2017/18.**

Midlothian Integration Joint Board

Thursday 1 December 2016

Report No.	Report Title	Presented by:
5.3	Adult Social Care and Health Budget Pressures	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to provide Members with the background to the current financial pressures in Adult Social Care and Health, together with a summary of actions being taken to address these pressures. The report also highlighted the key challenges facing social care in seeking to remodel services to meet increasing demand in the context of reducing public finance and a finite social care workforce.

Summary of discussion

The Board, having heard from the Chief Officer, welcomed the recovery plans that had been put in place and acknowledged that in order to successfully deliver these plans there would require to be a shift in public expectations. In this regard, staff would be working with individuals and their families to find best solutions which maximised outcomes within available resources. This approach mirrored the shift in thinking about health as outlined in the recently published report by Scotland's Chief Medical Officer "Realistic Medicine".

Decision

The Board:

- **Noted the work being undertaken to reduce/manage a major projected overspend in Adult Social Care and Health; and**
- **Agreed that further consideration be given to the implications of the current financial position when decisions about the financial offer to be made to the IJB by the Council for 2017-18 were being made.**

Report No.	Report Title	Presented by:
5.4	Chief Officer's Report	Eibhlin McHugh

Executive Summary of Report

This report provided a summary of the key issues which had arisen over the past two months in health and social care, highlighting in particular service pressures as well as some recent service developments.

The report also described the work that was being progressed to address the anticipated increased pressures on services in both acute hospital and community services over the winter period.

Midlothian Integration Joint Board

Thursday 1 December 2016

Decision

The Board, having heard from the Chief Officer:

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

Report No.	Report Title	Presented by:
5.5	MELDAP Care Inspectorate – Validated Self-Evaluation Report	Alison White

Executive Summary of Report

This report provided a summary of the Care Inspectorate's Report on the work of MELDAP (Mid and East Lothian Drug and Alcohol Partnership) with regards to the progress made in the implementation of The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services (2014).

Summary of discussion

Having heard from the Chief Social Work Officer, the Board in discussing the report complimented MELDAP on the excellent services that they provided. MELDAP's ability to maintain these standards in the wake of the reduction in funding of substance misuse services was again raised, with serious concerns being expressed that this would have implications not just for the services provided directly by MELDAP but on other related services as well. It was noted that the MIJB's concerns had been highlighted in a response to the Minister's letter, and that whilst the dialogue was ongoing, there was nothing concrete to report as of yet.

Decision

The Board:

- **Noted the significant strengths highlighted in the report in the areas of *Policy, Service Development and Planning, Partnership Working and Resources and Leadership and Direction* as well as the area for continuing improvement;**
- **Noted the progress made by MELDAP and its services in implementing The Quality Principles;**
- **Noted that the Midlothian Peer Support Project was identified as an example of good practice; and**
- **Recognised the challenges from 2017 onwards in sustaining the very high level of service performance against a backdrop of reduced funding.**

6. Any other business

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

Midlothian Integration Joint Board

Thursday 1 December 2016

7. Date of next meeting

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

- Thursday 12th January 2017 2pm Development Workshop – Substance Misuse/MELDAP
- Thursday 9th February 2017 2pm **Midlothian Integration Joint Board**

The meeting terminated at 4.27 pm.

HEALTH AND SOCIAL CARE DELIVERY PLAN (HSCDP)

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

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

<ul style="list-style-type: none">• Note the publication of the Scottish Government HSCDP in December 2016 and associated actions.	2.1, Appendices 1 and 2
<ul style="list-style-type: none">• NHS Lothian's response to address the actions outlined in the HSCDP are incorporated within the 2017-18 Local Delivery Plan (LDP) which is also presented to NHS Lothian Board on 5 April 2017	2.2, 3.19
<ul style="list-style-type: none">• NHS Lothian require to work in collaboration with NHS Boards in South East Scotland to develop a Regional HSCDP for submission to the Scottish Government in September 2017. NHS Lothian's Chief Executive has been appointed to lead this work.	2.3,2.4,2.5,,2.6,3.19, 3.21
<ul style="list-style-type: none">• Risk associated with the HSCDP aspirations relating to:<ul style="list-style-type: none">- Reduction in unscheduled care bed use by 10%- Organisational and cultural risk associated with the need to closely align NHS Boards through development of the Regional HSCDP	4.2

Name Alyson Cumming
Title Strategic Programme Manager
Date 27 March 2017
Email alyson.cumming@nhslothian.scot.nhs.uk

HEALTH AND SOCIAL CARE DELIVERY PLAN

1 Purpose of the Report

- 1.1 The purpose of this report is to brief the Board on the Health and Social Care Delivery Plan (HSCDP)

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

2 Recommendations

The Board is recommended to;

- 2.1 Note the publication of the HSCDP and the analysis provided of its contents;
- 2.2 Note the expectation that the Local Delivery Plan (LDP) will be the response of NHS Lothian to the objectives laid out in the HSCDP;
- 2.3 Note the expectation that Boards will work more closely together to deliver Regional Health and Social Care Delivery Plans (RHSCDP) and the work undertaken and being undertaken by NHS Lothian in this respect.
- 2.4 As part of this work a new regional governance framework is being developed and will be issued in due course.
- 2.5 That an initial regional plan will be developed and submitted to Scottish Government by the end of September.
- 2.6 Note that NHS Lothian's Chief Executive has been appointed to lead the delivery of the RHSCDP for the region.

3 Discussion of Key Issues

- 3.1 The HSCDP was published in December 2016, building on the previous publication of the National Clinical Strategy (NCS), on announcements regarding the future development of Elective/Diagnostic and Treatment Centres (DTCs), on the new GP contract, and on the integration of Health and Social Care. The document is attached at appendix 1. A summary of HSCDP actions is attached as Appendix 2.
- 3.2 HSCDP covers a very broad canvas, which is appropriately reflective of the nature of the health and social care system. It includes aspirations regarding integration authorities, the acute and primary care elements of the system, public health, and workforce planning as a key enabler of change.
- 3.3 HSCDP is described as focussed on delivering the triple aim of better health, better care, and better value, which is of course in line with NHSL's approach. The scope of HSCDP perhaps prevents providing real clarity on the detail of measurement and actions to be taken, but the following points can be identified.
- 3.4 In terms of **Integration**, there is a clear desire to ensure that integration authorities act as the engines of a transformed health and social care system. There is a clear expectation that by 2018, these authorities (known within NHSL as Integration Joint Boards, "IJBs") will deliver a

10% reduction in unscheduled care bed-days, removing, in Lothian, up to 60,000 bed days, or in the region of 175 beds released from the system.

- 3.5 IJBs are also expected to facilitate the shifting of the balance of care, but also the balance of spend from the acute sector to the community, with an expectation that by 2021 11% of the “frontline NHS Scotland budget” is spent in primary care. HSCDP also outlines the expectation that primary care will be redesigned to incorporate new workforce models, with less of a reliance on general practitioners.
- 3.6 There are further aims for the roll-out of the Family Nurse Partnership, expanded Health Visiting roles and pathways, and other elements broadly in line with the current NHSL direction of travel.
- 3.7 For **acute care**, HSCDP affirms the expectation that all Boards will deliver the six essential actions for unscheduled care, and will learn from national work on improving acute flow.
- 3.8 There is an expectation that by 2020 400,000 outpatient appointments will have been removed from the system – again, for NHSL, this approximately 60,000, and the Outpatients Programme Board is already taking this forward.
- 3.9 There is a reaffirmation of the investment of up to £200m in DTCs, and NHSL has already established a regional programme board, as identified in the Lothian Hospitals Plan, to take this forward, with input from partner Health Boards in Fife, Borders, Forth Valley, Tayside, and Lanarkshire.
- 3.10 HSCDP also makes explicit reference to strengthening regional planning arrangements for scheduled acute care, in particular.
- 3.11 HSCDP restates many of the actions underway with **realistic medicine**.
- 3.12 In terms of **public health**, HSCDP outlines that by 2017 public health priorities will be agreed with SOLACE and COSLA, ensuring closer alignment with the work of local government, with a new single body to drive public health improvement established in 2018. There is no detail included in the plan as to how this would be configured.
- 3.13 There are also various commitments regarding smoking, alcohol, obesity, and physical health. There are restatements of commitments on maternal and infant nutrition. Mental health improvement commitments appear to be broadly restatements of work already in train.
- 3.14 Sections of the plan also touch on Board configuration and governance. There is a commitment to look at how “special” Health Boards work together, which may signal a desire to amalgamate these in some way. There is a commitment to ensure that “form follows function”.
- 3.15 There does not appear to be any new money associated with the plan, with the exception of £25m of “transformation” monies made available nationally.
- 3.16 There is a promising appendix to the plan which covers workforce and signals a consultation with stakeholders regarding the workforce planning activity which needs to be undertaken to support the plan and its delivery.
- 3.17 The plan is not clear on how delivery will be tracked, beyond the promise of a new integrated performance framework in 2017.
- 3.18 HSCDP also raises the issue of more effective regional planning, and the expectation from the Scottish Government now is that Boards will submit a Health Board LDP to the normal timescale but also describe the regional elements which could be achieved, with a further stage of submission of a Regional Health and Social Care Delivery Plan (HSCDP) by September 2017.

- 3.19 The Scottish Government 2017-18 LDP guidance also refers to the need for NHS Boards to work in collaboration to develop a Regional Health and Social Care Delivery Plan (RHSCDP) by September 2017.

NHS Lothian's management team have interpreted this latter ask as an opportunity to develop a regional "sustainability and transformation plan", along the lines of those developed in England. Here, 44 territorial groupings have been established across organisational lines and these have been tasked with identifying the major changes and challenges to be met in that territory. The STPs have been produced at pace and contain some interesting ideas, but also clearly need considerable additional work to make them truly transformative.

NHS Lothian's management team are therefore working closely with partner Boards from the East of Scotland (Fife, Borders, Tayside, and Forth Valley) on how the RHSCDP can be produced. The South-East and Tayside planning group has been refocused as an "HSCDP Board" and has agreed to a two-stage process for delivering a RHSCDP with a draft "statement of intent" by the end of March and a final version by September 2017.

The sections of the RHSCDP are;

- **Context** – outlining the demographic needs of the regional population and how these are likely to change, including disease patterns, the age structure of the population, inequality and inequity;
- **Prevention** – outlining how disease and care requirements could be mitigated by increased focus on prevention and health promotion;
- **Integrated Services** – outlining the priorities and actions for Integrated Joint Boards within the planning area and how these will deliver on the HSCDP aims, as well as how these will interdigitate with acute services in order to deliver a sustainable model of acute care, operating at 85% bed occupancy;
- **Workforce** – outlining how the workforce profile looks currently, and how this needs to change to support the aims and requirements of clinical services. This section will also outline the "HR services" elements of Board operations where alignment could be productive and efficient;
- **Finance** – covering the financial position across the involved Health Boards, savings and efficiency plans, capital plans, and the "finance services" elements of Board operations where, again, alignment could be productive and efficient;
- **Acute services** – outlining which 5-7 specialty areas within acute services where services could be planned regionally, focussing on a high-performing standard model across the region, with workforce, facilities, demand and capacity, and modernisation of models at the forefront of considerations. It is anticipated that over the next few years a rolling approach will be taken of dealing with 5-7 specialty areas in each planning cycle.

- 3.20 These chapters will have a focus initially on a short-term timescale of the period up until 2020, but will also be expected to have sensible consideration of the medium (up to 2025) and long-term (up to 2032).

- 3.21 NHS Lothian's Chief Executive, Tim Davison, has been appointed to the role of lead Chief Executive for the East region, with a seat on the National Delivery Board for the HSCDP. The expectations on this role include;

(a) lead the overall design and planning of services at regional level, taking into account the particular features of the region, its assets, resources and infrastructure

(b) take a lead role in the implementation of the Health and Social Care Delivery Plan within the region and nationally

(c) be a member of the Health and Social Care Delivery Plan Programme Board

(d) report to the Director General for Health and Social Care on matters concerning the planning and delivery of services in the region

(e) work with Scottish Government colleagues to shape the overall approach to implementation, governance and assurance as the work evolves

4 Key Risks

4.1 The documents described in this paper are intended to assist in risk management.

4.2 However, there is a challenge associated with the aspirations in the HSCDP, and two points in particular;

- There is a risk that the aspiration to reduce unscheduled care bed use by 10% - removing upwards of 175 beds from the Lothian system – is unachievable;
- There is a significant organisational development and cultural risk associated with more closely aligning disparate Boards through the regionalisation work.

5 Impact on Inequality, Including Health Inequalities

5.1 All risks described in these documents are on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 Successful delivery of these plans would significantly reduce inequality and health inequality.

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

7.1 The HSCDP is being consulted upon nationally.

7.2 The LDP has drawn on input from every part of the organisation, and is for discussion at the Board, in public session, on 5th April.

7.3 The Regional Delivery Plan will, when complete, be the subject of public engagement.

8. Resource implications

8.1 Members of the NHSL management team are spending increasing portions of their time working in a regionalised way, and this is likely to continue. This is under review.

Alyson Cumming
Strategic Programme Manager
27th March 2017

Colin Briggs
Associate Director

List of Appendices

Appendix 1: Scottish Government HSCDP, December 2016

Appendix 2: Summary of Actions - HSCDP



Health and Social Care Delivery Plan

December 2016



**Healthier
Scotland**
Scottish
Government

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Introduction

1. Our aim¹ is a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so.
2. This delivery plan sets out our programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
 - is integrated;
 - focuses on prevention, anticipation and supported self-management;
 - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
 - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
 - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
3. To realise these aims, we will continue to evolve our health and care services to meet new patterns of care, demand, and opportunities from new treatments and technologies. Since 2007 we have ensured that NHS funding has not only been protected but has increase to record high levels, supporting NHS frontline staffing to substantially increase. There have also been significant improvements in treatment times, reductions in mortality rates, and reductions in healthcare associated infections. As a consequence of these improvements, delivered by committed health and care staff across the country, patient satisfaction has also increased to record highs.
4. To meet the changing needs of our nation, investment, while necessary, must be matched with reform to drive further improvements in our services. Our services will increasingly face demands from more people with long-term conditions needing support from health and social care. These challenges were recognised in the Audit Scotland report², NHS in Scotland 2016, and underline the importance of bringing together the different programmes of work to improve health and social care services.

1 <http://www.gov.scot/Topics/Health/Policy/2020-Vision>.

2 <http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2016>.

5. This plan is not an exhaustive list of all the actions being taken to improve our health and our health and social care system. While it concentrates on health services, our aspirations will only be delivered through a wider focus on the support provided by a range of services. It acknowledges that change must take place at pace and in collaboration with partners across and outside of the public sector, and that partnership working is essential for the planning that will deliver the actions described here.

How Will We Deliver Our Plan?

6. This plan will help our health and social care system evolve, building on the excellence of NHS Scotland, recognising the critical role that services beyond the health sector must play and is ultimately fit for the challenges facing us. What that will look like for individuals is described in more detail in **Appendix 1**. We must prioritise the actions which will have the greatest impact on delivery. We will focus on three areas, often referred to as the 'triple aim':
 - we will improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all (**'better care'**);
 - we will improve everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management (**'better health'**); and
 - we will increase the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention (**'better value'**).

Better care

7. We need to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. That requires a change in our approach to medicine and in how and where the services that support our health are delivered. First, we need to move away from services 'doing things' to people to working with them on all aspects of their care and support. People should be regularly involved in, and responsible for, their own health and wellbeing.

8. Ultimately, individuals and where appropriate, their families – should be at the centre of decisions that affect them. They should be given more freedom, choice, dignity and control over their care. Care planning should anticipate individuals' health and care needs – both by helping those with chronic and other complex conditions to manage their needs more proactively, and by focusing on a prevention and early intervention approach to supporting health throughout people's lives. This is not always a question of 'more' medicine, but making sure that support fits with, and is informed by, individual needs. Success should be measured by better outcomes for individuals, not simply on whether processes and systems have been followed. As set out in the Healthcare Quality Strategy for Scotland³, it is an approach to health rooted in the principles of care that is person-centred, safe and effective.
9. We need services that have the capacity, focus and workforce to continue to address the increasing pressures of a changing society. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces, not least with respect to an ageing population. For our Community Health Service, that will mean everyone should be able to see a wider range of professionals more quickly, working in teams. For acute and hospital services, it will mean thinking differently about how some health and care services are delivered if we are to ensure people receive high-quality, timely and sustainable support for their needs throughout their lives.

Better health

10. To improve the health of Scotland, we need a fundamental move away from a 'fix and treat' approach to our health and care to one based on anticipation, prevention and self-management. The key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health.
11. This can only be done by health and other key public sector services (such as social care and education) working together systematically. All services must be sensitive to individual health and care needs, with a clear focus on early intervention. Moreover, it will not just be what services can provide, but what individuals themselves want and what those around them – not least families and carers – can provide with support. Services need to be designed around how best to support individuals, families and their communities and promote and maintain health and healthy living.

³ <http://www.gov.scot/Resource/Doc/311667/0098354.pdf>.

Better value

12. Better value means more than just living within our means; it means improving outcomes by delivering value from all our resources. It is not just about increasing the efficiency of what we currently do, but doing the right things in different ways. This will demand an integrated approach to the components of the delivery plan so that the whole approach and its constituent parts are understood and joined up.
13. Critical to this will be shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment.
14. Taking full account of the current pressures on primary and community services, we need to redesign those services around communities and ensure that they have the right capacity, resources and workforce. At the same time, people should look to improved and sustainable services from hospitals.
15. We need to free up capacity in hospitals and acute care, allowing for specialist diagnostic and elective centres to provide better-quality services to people and potentially changes to be made to the location of some services. Services should be organised and delivered at the level where they can provide the best, most effective service for individuals. Regional – and in some case, national – centres of expertise and planning should develop for some acute services to improve patient care. The governance structures of all our NHS Boards should support these changes and maximise ‘Once for Scotland’ efficiencies for the kind of functions all health services need to deliver. That doesn’t mean structural change to NHS Boards responsible for the delivery of services to our patients but it does mean that they must work more collaboratively and across boundaries.
16. Evolving our services must also be rooted in a widespread culture of improvement. Sustainable improvements in care, health and value will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.
17. Our health and care system has achieved a great deal in the last ten years using improvement methods which are data rich, engaging of leaders and frontline staff, and outcome driven. The Scottish Patient Safety Programme⁴ is a good example of what this approach can deliver. While work in safety, efficiency and person-centred care has been planned and led centrally, the improvement has been local. The NHS Scotland workforce is crucial to this, and teams released to test and measure have already produced globally recognised improvements for Scotland’s patients, families and carers.

⁴ <http://www.gov.scot/Resource/Doc/311667/0098354.pdf>.

18. We will build on the extensive investment in improvement skills and capacity across the health service to continue testing and measuring changes to improve care, supported by the dedicated expertise of Healthcare Improvement Scotland.
19. In meeting the triple aim, our ambition is not about a single strand of work or necessarily about commissioning a new series of projects. Indeed, much of the work is already underway. It is about making sure the different components of change work together to achieve the interlinked aims of better care, better health and better value at pace. Across those different aims, our actions are being driven by four major programmes of activity:
 - health and social care integration;
 - the National Clinical Strategy⁵;
 - public health improvement; and
 - NHS Board reform.
20. Taken together, these changes in health and social care will bring long-term sustainability of our services and the continuing improvement of the nation's health and wellbeing. They are underpinned by a series of cross-cutting, thematic programmes of activity, which are also set out below.

Health and social care integration

21. Optimising and joining up balanced health and care services, whether provided by NHS Scotland, local government or the third and independent sectors, is critical to realising our ambitions. Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. The people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs.

⁵ <http://www.gov.scot/Resource/0049/00494144.pdf>.

22. For better integrated care to become a reality, the new Health and Social Care Partnerships must plan and deliver well-coordinated care that is timely and appropriate to people’s needs. We are integrating health and social care in Scotland to ensure people get the right care, at the right time and in the right place, and are supported to live well and as independently as possible. An important aspect of this will be ensuring that people’s care needs are better anticipated, so that fewer people are inappropriately admitted to hospital or long-term care. Consequently, we are focusing actions around three key areas: **reducing inappropriate use of hospital services; shifting resources to primary and community care;** and **supporting capacity of community care.**

Health and social care integration: actions

Reducing inappropriate use of hospital services

In **2017**, we will:

- Ensure Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. This will be a key lever in shifting the focus of care across health and social care services.
- Agree with partners how to deliver an ambition of raising the performance of the whole of Scotland on delayed discharges from hospitals to the performance of the top quartile of local areas. This will be done as a step to achieving our wider commitments of eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care.
- By **2018**, we aim to: Reduce unscheduled bed-days in hospital care by up to 10 percent (ie. by as many as 400,000 bed-days) by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. A range of actions will be taken to achieve this, including improving links between secondary, primary and community care under integration, supported by further work to understand better and take action on the extent to which emergency admissions are currently inappropriate and avoidable. As a result, people should only stay in hospital for as long as necessary and get more appropriate care in a more homely setting. It will reduce growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by **2021** (as set out below). The annual reports produced by Health and Social Care Partnerships and regular monitoring data will enable progress to be tracked.

Health and social care integration: actions – continued

- By **2021**, we aim to: Ensure that everyone who needs palliative care will get hospice, palliative or end of life care. All who would benefit from a ‘Key Information Summary’ will receive one – these summaries bring together important information to support those with complex care needs or long-term conditions, such as future care plans and end of life preferences. More people will have the opportunity to develop their own personalised care and support plan. The availability of care options will be improved by doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting.

Shifting resources to the community

- By **2021**, we will: Ensure Health and Social Care Partnerships increase spending on primary care services, so that spending on primary care increases to 11 percent of the frontline NHS Scotland budget. Again, the annual reports produced by Health and Social Care Partnerships and regular monitoring data will be used to assess progress.

Supporting the capacity of community care

- In **2017**, we will: Continue to take forward a programme of work to deliver change in the adult social care sector, together with COSLA and other partners. This has begun with work to reform the National Care Home Contract, social care workforce issues and new models of care and support in home care. Reform of the National Care Home Contract will maintain the continuity, stability and sustainability of residential care provision while embedding greater local flexibility, maximising efficiency, improving quality, enhancing personalisation and promoting innovation. This national, consensus-based approach to improving social care will reinforce the ability of Health and Social Care Partnerships to match care and health support for individuals more quickly and more appropriately.

National Clinical Strategy

23. The National Clinical Strategy sets out a framework for developing health services across Scotland for the next 10-20 years. It envisages a range of reforms so that health care across the country can become a more coherent, comprehensive and sustainable high-quality service – one that is fit to tackle the challenges we face. At its heart is a fundamental change in the respective work of acute and hospital services and primary and community care, and a change in the way that medicine is approached. As a result, the Strategy aims to:

- strengthen primary and community care;
- improve secondary and acute care; and
- focus on realistic medicine.

Primary and community care

24. Community and hospital-based care needs to be integrated and rebalanced to ensure that local health services are more responsive and supportive to the needs of individuals, not least those with chronic conditions who would be better supported in primary and community care. That requires reforming the latter to deliver a stronger, better resourced and more flexible service for people. We are also working to address the current workload pressures and recruitment challenges facing many GP practices and cannot simply result in a crude redistribution of pressures between different parts of the health service. To do this, we must:

- support individuals, families and carers to understand fully and manage their health and wellbeing, with a sharper focus on prevention, rehabilitation and independence;
- expand the multi-disciplinary community care team with extended roles for a range of professionals and a clearer leadership role for GPs;
- develop and roll out new models of care that are person- and relationship-centred and not focused on conditions alone;
- enable those waiting for routine check-up or test results to be seen closer to home by a team of community health care professionals, in line with the work of the Modern Outpatient Programme⁶ in hospitals (as detailed later);
- ensure the problems of multiple longer-term conditions are addressed by social rather than medical responses, where that support is more appropriate; and
- reduce the risk of admission to hospital through evidence-based interventions, particularly for older people and those with longer-term conditions.

We will achieve this by **building up capacity in primary and community care** and **supporting development of new models of care**.

⁶ <http://www.gov.scot/Publications/2016/12/2376>.

Primary and community care: actions

Building up capacity in primary and community care

- In **2017**, we will: Continue the investment in recruitment and expansion of the primary care workforce which began in 2016, and which will mean that, by **2022**, there will be more GPs, every GP practice will have access to a pharmacist with advanced clinical skills and 1,000 new paramedics will be in post. This will reinforce the workforce and the capacity of primary and community care to support our services for the future and will be done in line with our National Health and Social Care Workforce Plan (as discussed later).

By **2018**, we aim to:

- Have increased health visitor numbers with a continued focus on early intervention for children through addressing needs identified through the Universal Health Visiting Pathway⁷, which started in 2016. As a result of this, every family will be offered a minimum of 11 home visits including three child health reviews by **2020**, ensuring that children and their families are given the support they need for a healthier start in life.
- Have commenced Scotland's first graduate entry programme for medicine. This will focus on increasing the supply of doctors to rural areas and general practices more generally.
- By **2020**, we aim to: Have implemented the recommendations of the Improving Practice Sustainability Short Life Working Group, the GP Premises Short Life Working Group and the GP Cluster Advisory Group. These actions will support more sustainable GP practices over the long term and build stronger links to Health and Social Care Partnerships, ensuring that the changes in primary care are both effective and sustainable.

By **2021**, we aim to:

- Have strengthened the multi-disciplinary workforce across health services. We will agree a refreshed role for district nurses by **2017**, train an additional 500 advanced nurse practitioners by **2021** and create an additional 1,000 training places for nurses and midwives by **2021**. This will build on four successive increases in student nursing and midwifery intakes to meet additional demand, especially in primary and community settings.
- Have increased the number of undergraduates studying medicine by 250 as a result of the 50 additional places in Scotland's medical schools introduced in **2016**.
- Have increased spending on primary care and GP services by £500 million by the end of the current parliament so that it represents 11 percent of the frontline budget. This is a fundamental change in how health resources are directed and will enable the critical shift in balance to primary and community care.

⁷ <http://www.gov.scot/Resource/0048/00487884.pdf>.

Primary and community care: actions – continued

Supporting new models of care

In **2017**, we will:

- Negotiate a new landmark General Medical Services contract, as a foundation for developing multi-disciplinary teams and a clearer leadership role for GPs.
- Test and evaluate the new models of primary care in every NHS Board, which will be funded by £23 million, and disseminate good practice with support from the Scottish School of Primary Care. These new models of care will include developing new, effective approaches to out-of-hours services and mental health support, and are essential for moving to a more person- and relationship-centred approach to individual care across the whole of Scotland.
- Taken forward the recommendations from the Review of Maternity and Neonatal Services⁸ and progress actions across all aspects of maternity and neonatal care.
- Launch Scotland's Oral Health Plan, following consultation, as part of a comprehensive approach to modernise dentistry and improve the oral health of the population through a prevention and early intervention approach.

By **2018**, we will:

- Have rolled out the Family Nurse Partnership programme nationally to provide targeted support for all eligible first-time teenage mothers. This will give intensive support to mothers and their children and give their health and wellbeing a strong start.

Secondary and acute care

25. People should only be in hospital when they cannot be treated in the community and should not stay in hospital any longer than necessary for their care. This will mean reducing inappropriate referral, attendance and admission to hospital, better signposting to ensure the right treatment in a timely fashion, and reducing unnecessary delay in individuals leaving hospital. Addressing admission to, and discharge from, hospitals will be the responsibility of Health and Social Care Partnerships; but all partners will need to work together to reduce the levels of delayed discharges, ensure services are in place to facilitate early discharge and avoid preventable admissions in the first place.
26. At the same time, within hospitals, more needs to be done to ensure better outcomes for people, while making a more effective use of resources. There is increasing evidence that better outcomes are achieved for people when complex operations are undertaken by specialist teams and some services are planned and delivered on a population basis. This might mean some services currently delivered at a local level would produce better outcomes for people if delivered on a wider basis. This kind of service change needs to be accompanied by investment in new, dedicated facilities to ensure that the capacity for high-quality, sustainable services can be delivered at the appropriate level.

⁸ <http://www.gov.scot/Topics/People/Young-People/child-maternal-health/neonatal-maternity-review>.

27. To achieve this we will take intensive and coordinated action in several key areas of secondary and acute care: **reducing unscheduled care**; **improving scheduled care**; and **improving outpatients**.

Secondary and acute care: actions

Reducing unscheduled care

In **2017**, we will:

- Complete the roll out of the Unscheduled Care Six Essential Actions⁹ across the whole of acute care. Through improving the time-of-day of discharge, increasing weekend emergency discharges and a more effective use of electronic information in hospitals, we will enhance a patient's journey at each stage through the hospital system and back into the community without delay.
- Undertake a survey on admission and referral avoidance opportunities. This will give a strong evidence base to target modelling for how to reduce unscheduled care through integrated primary and secondary care services.

Improving scheduled care

In **2017**, we will:

- Put in place new arrangements for the regional planning of services. The National Clinical Strategy sets out an initial analysis of which clinical services might best be planned and delivered nationally and regionally, based on evidence supporting best outcomes for the populations those services will serve. This is a critical first step towards strengthening population-based planning arrangements for hospital services, working across Scotland. NHS boards will work together through three regional groups. In **2018**, the appropriate national and regional groups will set out how services will evolve over the next 15 to 20 years, in line with the National Clinical Strategy.
- Reduce cancellations and private care spend in scheduled care by rolling out the Patient Flow Programme from the current pilots across all NHS Boards. The Programme builds on the success of previous programmes – such as Day Surgery, Enhanced Recovery for Orthopaedics and Fracture Redesign – by increasing national and local capacity to use operations management techniques to improve care for patients. Four pilot boards are implementing improvement projects covering emergency and elective theatre operations, elective surgery planning and emergency medical patient flow. As this is expanded, it will introduce more responsive and efficient secondary care and reduce wastage and the unnecessary use of resources.

⁹ <http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care>.

Secondary and acute care: actions – continued

By **2021**, we will:

- Complete investment of £200 million in new elective treatment capacity and expanding the Golden Jubilee National Hospital. Overall, this investment will ensure that there is high-quality and adequate provision of elective care services to meet the needs of an ageing population.
- Complete investment of £100 million in cancer care to ensure: earlier detection with more rapid diagnosis and treatment; more and better care during and after treatment, taking account of what matters most to people with cancer; increased entry to clinical trials/research; and an evidence driven cancer intelligence system for clinicians and patients with access to near-to-real time information through care pathways. Addressing cancer in such a comprehensive way will target one of the critical health issues facing the population.

Improving outpatients

- By **2020**, we aim to: Have reduced unnecessary attendances and referrals to outpatient services through the recently-published Modern Outpatient Programme. The aim is to reduce the number of hospital-delivered outpatient appointments by 400,000, reversing the year-on-year increase of new appointments. It will draw on the existing Delivering Outpatient Integration Together (DOIT) Programme and other activities such as the Technology Enabled Care Programme to:
 - give GPs greater access to specialist advice to reduce the time people wait to get appropriate treatment;
 - use clinical decision support tools to reduce the amount of time people wait to get the right treatment;
 - reduce the number of attendances for people with multiple issues through a holistic approach to their support and care;
 - enable GPs to have more access to hospital-based tests so that people can be referred to the right clinician first time; and
 - facilitate more return or follow-up appointments in non-hospital settings through virtual consultation from their own home.

Realistic medicine

28. We need to change our long-term approach to the role of medicine and medical interventions in our health and wellbeing. A new clinical paradigm, based on a 'realistic medicine' approach and backed by clinical leadership, will support people through informed, shared decision-making that better reflects their preferences and what matters most to them. There needs to a greater focus on the discussions that medical practitioners have with people about their care, and what different types of medical intervention can entail. Relationships between individuals and practitioners should be based on helping people understand options about their care and choose treatment according to their preferences.
29. At the same time, we must get better value out of medicine and medical interventions and find ways to reduce any unnecessary cost. Waste and variation in clinical practice need to be addressed, and we should also support the reliable implementation of effective interventions that are not currently being made available to people.
30. Consequently, we need to take forward actions that will strengthen **relationships between professionals and individuals** as well as **reduce the unnecessary cost of medical action**.

Realistic medicine: actions

Strengthening relationships between professionals and individuals

In **2017**, we will:

- Refresh our Health Literacy Plan, Making It Easy¹⁰, to support everyone in Scotland to have the confidence, knowledge, understanding and skills we need to live well with any health condition we have.
- Review the consent process for patients in Scotland with the General Medical Council and Academy of Medical Royal Colleges and make recommendations for implementation from **2018** onwards. This is a key element in transforming the relationship between individuals and medical professionals.

¹⁰ <http://www.gov.scot/Topics/Health/Support-Social-Care/Health-Literacy>.

Realistic medicine: actions – continued

By **2019**, we aim to:

- Commission a collaborative training programme for clinicians to help them to reduce unwarranted variation. This will support a workforce that can find more effective and valued ways of delivering medicine.
- Refresh the Professionalism and Excellence in Medicine Action Plan¹¹ and align high-impact actions to realistic medicine.

Reducing the unnecessary cost of medical action

By **2018**, we aim to:

- Incorporate the principles of realistic medicine as a core component of lifelong learning in medical education and mainstream the principles of realistic medicine into medical professionals' working lives at an early stage.

By **2019**, we aim to:

- Develop a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost and reduce the overall cost of medicine.

Public health improvement

31. Scotland's ability to respond to infectious diseases and other risks to health matches and, in some cases, exceeds that of much of the developed world. But in common with many developed societies, we face greater challenges to public health arising from lifestyle behaviours, wider social-cultural factors that prevent positive health choices being made and a modern environment that impacts on the health and wellbeing of individuals, families and communities. There are many social determinants which impact on health and wellbeing, including those that can affect us from our earliest years throughout our lives, such as Adverse Childhood Experiences. We need to increase public and service knowledge and awareness of where avoidable harm can be reduced, including a wider understanding of both physical and mental health and the right actions to promote and strengthen healthy lifestyles.

¹¹ <http://www.gov.scot/Publications/2014/01/8967>.

32. This requires a concerted, sustained and comprehensive approach to improving population health through targeting particular health behaviours, acting to reduce avoidable harm and illnesses and taking a population- and lifetime-wide approach to prevention and early intervention treatment. We will:
- create a clear set of **national public health priorities** for Scotland as a whole and streamline the currently cluttered **public health landscape**;
 - develop and build on our sustained approach to addressing the **key public health issues** of alcohol and tobacco misuse and diet and obesity;
 - drive forward a new approach to **mental health** that ensures support and treatment are mainstreamed across all parts of the health service – and beyond – and is not simply the responsibility of specialist services, working within the framework of a new 10-year mental health strategy to be published in early 2017; and
 - support a **More Active Scotland**¹².

Public health improvement: actions

Supporting national priorities

- In **2017**, we aim to: Set national public health priorities with SOLACE and COSLA, that will direct public health improvement across the whole of Scotland. This will establish the national consensus around public health direction that will inform local, regional and national action.
- By **2019**, we aim to: Support a new, single, national body to strengthen national leadership, visibility and critical mass to public health in Scotland. Such a body will have a powerful role in driving these national priorities and providing the evidence base to underpin immediate and future action.
- By **2020**, we aim to: Have set up local joint public health partnerships between local authorities, NHS Scotland and others to drive national public health priorities and adopt them to local contexts across the whole of Scotland. This will mainstream a joined-up approach to public health at a local level.

¹² <http://www.gov.scot/Resource/0044/00444577.pdf>.

Public health improvement: actions - continued

Supporting key public health issues

In **2017**, we will:

- Continue delivery of the ambitious targets set out in our 2013 Strategy, Creating a Tobacco Free Generation¹³, including reducing smoking rates to less than 5 percent by 2034. We will implement legislation to protect more children from secondhand smoke and reduce smoking in hospital grounds.
- Refresh the Alcohol Framework¹⁴, building on the progress made so far across the key areas of: reducing the harms of consumption; supporting families and communities; encouraging positive attitudes and choices; and supporting effective treatment. A key part of the Framework is the introduction of a minimum unit price for alcohol and we will work towards its implementation at the earliest opportunity, subject to the current legal proceedings. This will combine into a highly ambitious approach to reducing alcohol harm in Scotland.
- Consult on a new strategy on diet and obesity. There are huge preventable costs to NHS Scotland and society associated with poor diet, as one of the critical health issues we are facing, and it requires a different approach to diet and obesity.
- Introduce the Active and Independent Living Improvement Programme which will support people of all ages and abilities to live well, be physically active, manage their own health conditions, remain in or return to employment, and live independently at home or in a homely setting.
- By **2021**, we will: Deliver the Maternal and Infant Nutrition Framework with a focus on improving early diet choices and driving improvements in the health of children from the earliest years. This will include: by **2017**, rolling out universal vitamins to all pregnant women; by **2019**, consolidating best practice and evidence on nutritional guidance for pregnancy up to when children are aged 3, and developing a competency framework to promote and support breastfeeding; and by **2020**, have integrated material into training packages for core education and continuing professional development.

13 <http://www.gov.scot/resource/0041/00417331.pdf>.

14 <http://www.gov.scot/Publications/2009/03/04144703/14>.

Public health improvement: actions – continued

Supporting mental health

- By **2018**, we will: Improve access to mental health support by rolling out computerised cognitive behavioural therapy services nationally.

By **2019**, we will:

- Have evaluated the most effective and sustainable models of supporting mental health in primary care, and roll these out nationally by **2020**.
- Have rolled out nationally targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder.

By **2020**, we will:

- Have improved access to mental health services across Scotland, increased capacity and reduced waiting times by improving support for greater efficiency and effectiveness of services, including Child and Adolescent Mental Health Services and psychological therapies. This will be accompanied by a workforce development programme and direct investment to increase capacity of local services.
- Have delivered new programmes promoting better mental health among children and young people across the whole of Scotland.
- By **2021**, we will: Have invested £150 million to improve services supporting mental health through the actions set out in the 10-year strategy.

Supporting a More Active Scotland

- In **2017**, we will: Publish a new delivery plan to support the Active Scotland Outcomes Framework and the Vision for a More Active Scotland, with greater action to address inequalities in physical activity across Scotland and a refocusing of resources.
- By **2019**, we will: Have embedded the National Physical Activity Pathway in all appropriate clinical settings across the health care system, ensuring that:
 - hospitals routinely support patients and staff to be more physically active;
 - we build on our success in schools, creating a culture of being active within children and young people. This will include rolling out the Daily Mile, extending the number of school sports awards, strengthening the Active Schools network creating more quality opportunities and supporting more active travel to and from school;
 - all partners stay on track for delivering 200 Community Sports Hubs, providing local places for communities to be active designed by themselves around their own needs; and
 - we continue to build on the legacy of the 2014 Commonwealth Games using the European Championships in Glasgow in 2018 to encourage more Scots to be active.

NHS Board reform

33. As the NHS moves into this new and changing delivery environment, we need our health bodies and governance models to reflect those changes and support the delivery for the people of Scotland. Our reform focus will continue to be on providing quality care for people, a shift towards prevention and early intervention, and making best use of our resources, rather than on structures and bureaucracy. Governance arrangements will only adjust to support this shift if required – i.e. the ‘form’ of governance would follow the ‘function’ of service planning and delivery. Any such changes would have to meet two tests. Firstly, that the changes were better able to respond to the needs of local communities. Secondly, that the changes would have to ensure better collaboration between NHS boards and, additionally, improve how our NHS works with providers of other public services to secure better outcomes for people.
34. We will also build on the work that has already taken place through a ‘Once for Scotland’ approach to provide efficient and consistent delivery of functions and prioritise those non-patient facing services which make sense to be delivered on a national basis. The approach will consider the differing needs across Scotland, and will be, for example, ‘island-proofed’ as part of the Scottish Government’s wider commitment on recognising the distinct nature of island communities. Our territorial and patient facing national boards such as the Ambulance Service and NHS 24 must be allowed to focus on delivery of the “triple aim” of better care, better health and better value.

NHS Board reform: actions

In **2017**, we will:

- Review the functions of existing national NHS Boards to explore the scope for more effective and consistent **delivery of national services** and the support provided to local health and social care system for service delivery at regional level. As part of this, clear guidance will be put in place to NHS Boards that their Local Delivery Plans for 2017/18 must show their contributions to driving the work of this delivery plan, not least their contributions in support of the regional planning of clinical services.
- Ensure that NHS Boards expand the **‘Once for Scotland’ approach** to support functions – potentially including human resources, financial administration, procurement, transport and others. A review will be completed in **2017**, and new national arrangements put in place from **2019**.
- Start a comprehensive programme to look at **leadership and talent management** development within NHS Scotland. This will ensure that current leaders are equipped to drive the changes required in health and social care, but it will also ensure sustainability of approach by identifying the next cohort of future leaders of NHS Scotland.

Cross-cutting actions

35. Improvements will be driven by the key components set out above, but they will need to be supported by a series of cross-cutting sets of actions. These are the key programmes of work which will inform all the change set out here:

- our approach to improving the services for children and young people through Getting It Right For Every Child;
- the National Health and Social Care Workforce Plan;
- the review of health and social care targets.
- a focus on research and development, innovation and digital health; and
- a robust approach to engagement.

Getting It Right For Every Child

36. The principles of our Getting It Right For Every Child¹⁵ approach to improving services for children and young people are simple: more effective and widespread prevention and early intervention; better cooperation amongst professionals and between them, the child or young person, and their family; and a holistic approach to addressing a child's wellbeing. In addition to actions included in the main components of work above, we will drive this agenda through: continued implementation of Children and Young People (Scotland) Act 2014¹⁶, in particular, the Named Person and the Child's Plan; and developing a new Child and Adolescent Health and Wellbeing Strategy in **2017**. This will form the cornerstone for a comprehensive approach to ensuring that all the factors affecting a child's or young person's health are regularly identified and supported with the individual, their family and, where appropriate, services.

15 <http://www.gov.scot/Topics/People/Young-People/gettingitright/what-is-girfec/foundations>.

16 <http://www.legislation.gov.uk/asp/2014/8/contents/enacted>.

National Health and Social Care Workforce Plan

37. Reform that delivers improved outcomes for patients can only happen with a committed, supported workforce that has the right skills, flexibility and support. Everyone Matters: 2020 Workforce Vision¹⁷ sets out the health and social care workforce policy for Scotland, and a vision and values. The National Health and Social Care Workforce Plan will take forward the commitment to a sustainable workforce by establishing the priorities for action, assess current resources, and detail the actions to close the gap between what we have and what we will need to deliver high-quality, integrated and transformed services to those who need them. To be published in Spring **2017**, the Plan will:

- align workforce planning more effectively with the different components of the delivery plan so that capacity challenges are identified at an early stage; and
- improve workforce planning practice to make clearer what should be planned at national, regional and local levels.

A short discussion paper outlining these arrangements, produced in consultation with key stakeholders, is attached at **Appendix 2**.

Review of health and social care targets

38. Targets can be instrumental in driving improvements in performance, but we need to ensure that performance is focused on improving outcomes for individuals and communities. Chaired by Sir Harry Burns, a national review is being conducted into the present suite of targets and indicators for health and social care. The review will work with service users, staff, professional bodies, and providers to ensure targets and performance indicators lead to the best outcomes for people being cared for, whether in hospital, primary care, community care or social care services. The interim report is expected in the Spring and the final report later in **2017**.

Research and development, innovation and digital health

39. Research is central to all high-performing health systems, leading to better targeted and more personalised treatment and improved patient outcomes. Scotland has a solid track record as a health research nation and in winning competitively awarded research funds. Research and development (R&D) and innovation are core activities for our health and social care services in Scotland and development in health and social care will depend on the science and discovery that underpins it. Through NHS Research Scotland (NRS), there is already a firm foundation of collaborative R&D partnership working successfully across NHS Scotland, academia and life-science industries. We will continue to invest in NRS to support health-related R&D, building on its model to drive a renewed effort in health innovation, as well as in Scottish Health Innovations Ltd to encourage, develop and appropriately commercialise innovative ideas and new technologies arising from within the health services. By **2018**, we will also:

¹⁷ <http://www.workforcevision.scot.nhs.uk>.

- create governance structures to support a new, coherent and concerted effort on the promotion and exploitation of health-related innovation and new technologies for the benefit of the whole health service;
 - develop regional innovation clusters to translate cutting-edge research and innovation into excellent individual health care; and
 - support innovation and technology capacity-building at national, regional and local levels by facilitating, encouraging and empowering those who work in health and care to identify innovation challenges and develop partnerships to deliver solutions.
40. Digital technology is key to transforming health and social care services so that care can become more person-centred. Empowering people to more actively manage their own health means changing and investing in new technologies and services, by, for example enabling everyone in Scotland to have online access to a summary of their Electronic Patient Record. The time is right to develop a fresh, broad vision of how health and social care service processes in Scotland should be further transformed making better use of digital technology and data. There is an opportunity to bring together all IT, digital services, tele-health and tele-care, business and clinical intelligence, predictive analytics, digital innovation and data use interests in health and social care. This will be taken forward through:
- a review led by international experts of our approach to digital health, use of data and intelligence, to be completed in **2017**, which will support the development of world-leading, digitally-enabled health and social care services; and
 - a new Digital Health and Social Care Strategy for Scotland, to be published in **2017**, that will support a digitally-active population, a digitally-enabled workforce, health and social care integration, whole-system intelligence and sustainable care delivery.

Engagement

41. Engagement with patients, service users, staff and their representatives, key stakeholders and volunteers is vital in delivering our plans. The public and all stakeholders must not only be aware of the broader context within which decisions about any service changes are taken over the coming years, but inform how those decisions are taken from a position of understanding both the challenges and opportunities facing us.

42. There has already been huge engagement in developing health and social care integration, realistic medicine and through the National Conversation on Creating a Healthier Scotland¹⁸. The latter alone reached over 9,000 people through 240 events and engagements and with over 360,000 inputs through digital and social channels. Building on this work, the Our Voice framework¹⁹ has been developed in partnership with NHS Scotland, COSLA, the ALLIANCE and other third sector partners to support people to engage, with purpose, in improving health and social care. The framework builds on much of the good work already underway at individual and local level to hear the voices of patients, their families, carers and unpaid carers, and involve them in improvement. We will explore ways in which Our Voice can support engagement on the work of this delivery plan through use of methods such as the national citizens' panel and citizens' juries.
43. Key to this will also be building on existing engagement mechanisms to ensure that all those who will be critical in delivering this change are fully involved in planning how it will take place. Work will continue with delivery partners across the public sector on how to take forward the different existing components of the delivery plan's activity, and this will be accelerated in the context of ensuring that the links between different activities are identified and opportunities for joint working maximised.
44. At the same time, it will be essential that engagement with the NHS Scotland workforce around this agenda is robust and makes full use of the potential of the workforce to drive this change. Through developing the National Health and Social Care Workforce Plan and as part of wider professional engagement, we will work with relevant organisations and bodies to ensure that the workforce needs of the future are identified early and fully and the contributions of the workforce to these workstreams are properly supported. In recognition of the established partnership working model in NHS Scotland, we will develop this work further in collaboration with trade union and professional organisations.

18 <https://healthier.scot/>.

19 http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice_framework.aspx#.WEk5e7IDTEo.

How Will Delivery Of Our Plan Be Funded?

45. Achieving long-term financial sustainability of our health and care system and making the best use of our total resources is critical to this delivery plan. We will need to deliver transformational change while managing increasing demand for services, inflationary pressures and the growing needs of an ageing population. This will require a short-, medium- and long-term focus on sustainability and value of services alongside reform.
46. Over the next five years, we will invest £70 billion of resources in our health and social care system. At the same time the impact of our demographics and inflation in pay and in prices means that we must increase our overall productivity. Health funding is expected to grow in resource terms by the end of this Parliament, with significant planned investment in areas such as primary care, mental health, social care, cancer and new elective capacity. Spending on primary care services is set to increase by £500 million so that it accounts for 11 percent of the frontline NHS Scotland budget by May 2021.
47. A financial plan will support this delivery plan, creating the environment and incentives for change, and supporting transition. This will ensure stability to maintain the quality of care, health of the population and best value from resources through:
 - providing dedicated funding to invest in the levers of change;
 - putting in place arrangements to support sustainable financial balance across the whole of NHS Scotland;
 - creating short-term financial capacity to allow time to deliver change through efficiencies in current ways of working;
 - supporting clinicians to make best use of resources through investment in costing and value tools to support shared decision making on clinical and financial evidence;
 - driving an early intervention and prevention approach across services; and
 - developing an approach to infrastructure and digital that supports the shift from hospital to community and primary care and works across the public sector estate.
48. The components within the delivery plan will be financially and economically assessed at key stages in their development, from initial scoping through to implementation, to create a comprehensive assessment of affordability and sustainability.

How Will Delivery Be Tracked?

49. It is crucial that the delivery plan does not remain a simple statement of intent, but a continuing process of monitoring, challenge and review. Every component of the delivery plan will continue to be tested for its fit with our strategic aims and how it supports shifting the balance of care towards community settings, managing demand, reducing waste, harm and variation, and delivering value from our total resources. We will challenge the expected levels of investment and levels of efficiencies in local, regional and national plans to ensure delivery of the aims of the delivery plan.
50. As part of this, a robust, integrated performance framework for the different components of the delivery plan will be developed for early **2017**. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated outcomes can be fully realised, but that the delivery plan is updated with new measures as appropriate. It cannot remain a static document, but a way of continually assessing whether the measures and approach being taken are appropriate and sufficient to secure our Vision.

Appendix 1: What Will Be Different in a Transformed Health and Social Care System in Scotland?

What will be different for individuals

- People will be equal partners with their clinicians, working with them to arrive at decisions about their care that are right for them. They will be supported to reflect on and express their preferences, based on their own unique circumstances, expectations and values. This might mean less medical intervention, if simpler options would deliver the results that matter to them.
- People will be supported to have the confidence, knowledge, understanding and skills to live well, on their own terms, with whatever conditions they have. They will have access to greater support from a range of services beyond health, with a view to increasing their resilience and reinforcing their whole wellbeing.
- Health and social care professionals will work together to help older people and those with more complex needs receive the right support at the right time, and where possible, live well and independently by managing their conditions themselves.
- Hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter. Individuals will benefit from more care being delivered in the community, and where possible, at home.
- Everyone will have online access to a summary of their Electronic Patient Record and digital technology will underpin and transform the delivery of services across the health and social care system.
- Children, young people and their families will benefit from services across the public sector – including health, education, social care and other services – working together to support prevention and early intervention of any emerging health issues.
- The diet and health of children from the earliest years will improve from coordinated and comprehensive nutritional support for children and families.
- There will be a significant reduction in the harmful impact on health of alcohol, tobacco and obesity, and our approach to oral health will be founded on prevention.
- People will have access to more and more effective services across the health system to support mental health, including the specialist services for children and young people. Mental health will be considered as important as physical health.
- People will lead more active, and as a result, healthier lifestyles.
- People will receive more sensitive, end of life support that will aim to support them in the setting that they wish. All those who need hospice, palliative or end of life care will receive it and benefit from individual care and support plans. Fewer people will die in hospitals.

What will be different for communities

- Most care will be provided locally through an expanded Community Health Service, avoiding the need to go into hospital.
- People will benefit from local practices and other community care with a wider range of available support. Practices will typically consist of complementary teams of professionals, bringing together clusters of health support and expertise. Communities will have access to quicker and joined-up treatment – this might be the GP, but supported by a team including highly-trained nurses, physiotherapists, pharmacists, mental health workers and social workers. GPs will take on a greater leadership role.
- Local practices will be able to provide more information and secure better advice for people locally without the need to attend hospitals to get specialist consultancy advice. That advice will be increasingly delivered locally.
- Families will receive more integrated and extended primary and community care for their children. There will be more home visits from health care professionals, including three child health reviews, and teenage mothers will receive more intensive and dedicated maternal support.

What will be different regionally

- Some clinical services will be planned and delivered on a regional basis so that specialist expertise can deliver better outcomes for individuals, services can be provided quicker and stays will be shorter. This will ensure that the services provided to people are high quality and the expertise remains as effective as possible.
- More centres will be provided to help NHS Scotland handle the growing demand for planned surgery, particularly from an ageing population. Such centres will allow medical professionals to become extremely skilled and have facilities to the highest standards. This will take pressure off other hospitals so there are fewer delays when urgent or emergency care is needed.

What will be different nationally

- There will be a national set of health priorities giving clear, consistent direction for how to improve public health across the whole of Scotland and a single national body to drive the priorities.
- Services and functions of the health service which can be delivered more efficiently at national level will be done on a 'Once for Scotland' basis.

Appendix 2: National Health and Social Care Workforce Plan: Outline Discussion Paper

Introduction

1. This document sets out the initial arrangements for the production, in early 2017, of a National Discussion Document on workforce planning in health and social care. A consultation exercise undertaken at this stage will report back and a final version of a National Health and Social Care Workforce Plan will be published in Spring 2017. There are three distinct stages:
 - **Outline Discussion Paper:** setting out initial arrangements prior to –
 - the **National Discussion Document:** to be published in early 2017, leading to –
 - the **National Health and Social Care Workforce Plan**, to be published by Spring 2017.
2. This is a complex area which will need time for all relevant stakeholders to have an opportunity for real engagement in order fully scope the landscape, issues and levers in order to 'get it right'. The production of the Workforce Plan by Spring 2017 should be seen as an **intermediate** step and part of a developing and iterative approach, not an end in itself. The Workforce Plan will be the first in an **annual series** aimed at improving workforce planning practice, as well as developing more effective and informed intelligence.
3. The Workforce Plan will present an opportunity to: a) refresh guidance for production of NHS Scotland workforce plans; and b) introduce workforce planning to which provides an overall picture for health and social care staff. The current position is different for NHS Scotland and Health and Social Care Partnerships, but the two will become increasingly interdependent in delivering care across Scotland, linking back to the recent Audit Scotland report recommendations. This outline discussion paper, the forthcoming National Discussion Document and the Workforce Plan, therefore, seek to achieve a balance in referring to working planning as it applies across NHS Scotland, and social work and social care interests.
4. Health and Social Care Partnerships are expected to develop integrated workforce plans to ensure people get the right support at the right time from staff who not only have the skills but are working in the most appropriate setting. The Workforce Plan should, therefore, look to support this agenda.

5. The need for the Workforce Plan derives from the national and international context within which workforce planning in health and social care needs to take place. The incremental approach reflects the timelines required to deliver a changed workforce and the effects of changing demand, demography and generational perspectives on work/life balance and careers. While the Workforce Plan and subsequent annual Plans will be practically focused and useable, they must also read across to and be able to adjust to strategic areas of health and social care reform.
6. This paper describes outline arrangements, processes around engagement, and some of the context for this work.

Aim of the Outline Discussion Paper

7. The aim of this paper is to set out the intended actions reflecting the Scottish Government's Programme for Government commitment on workforce planning and to assure organisations within health and social care – including NHS Boards and the full range of employers in the social service sector – of their full involvement in the work being undertaken to realise this commitment.

Objectives

8. We are working to develop national and regional workforce planning through a Workforce Plan which helps deliver the direction set out in a range of strategic developments – among them this delivery plan as well as the National Clinical Strategy – while also reflecting progress in key areas of health and social care such as integration and self-directed support. To do this, we must ensure that all key stakeholders are able to contribute to and help to shape the Workforce Plan, so that it addresses their interests and issues.
9. As we work towards a Workforce Plan in 2017, we want to ensure a clear view for those responsible for workforce planning within health and social care services, on:
 - roles and responsibilities with regards to workforce planning, and in the production of the Workforce Plan itself, as well as current arrangements already in place;
 - Ministers' intentions to ensure better coordination of national, regional and local workforce planning against a complex and shifting health and social care background; and
 - how more consistent and coordinated workforce planning can help deliver better services and outcomes for Scotland's people.

The Workforce Plan will also provide an opportunity to consider integrated workforce planning arrangements, recognising differences in workforce planning practice between NHS Scotland, local authorities and other social service employers.

Context

10. The need for a Workforce Plan stems from the Programme for Scotland commitments in relation to health and social care, as well as from Audit Scotland recommendations on workforce planning in relation to its recent findings on the public sector workforce²⁰, health and social care integration²¹ and on the NHS in 2016²².
11. It is important that the Workforce Plan should apply in an integrated context, covering the social care services sector, comprising a wide range of support and services and employing 130,000 NHS Scotland staff and over 200,000 staff across the third, independent and public sectors²³. There is a statutory duty on NHS Boards to undertake workforce planning and this will continue to apply. We, therefore, expect the Workforce Plan to be:
- **a strategic document**, setting out the workforce vision for health and social care services, the priorities to be taken forward, the assessment of current resources to deliver the vision, and actions to close the gap between what we have and what we will need;
 - **apply at a national level**, linking, as appropriate, to regional and local levels; and
 - **active and useable**, making coherent workforce planning links between national and regional activity and offering frameworks for practical workforce planning in both the NHS Scotland and social services sectors.
12. The Workforce Plan will consider how workforce planning is influenced by the following developments in health and social care:
- public service reform and integration of health and social care, allowing space for NHS Boards, local authorities and Health and Social Care Partnerships to plan for the workforce for the health and social care system that Scotland needs, now and in future;
 - Progr.5ng plans for elective centres;
 - recommendations on workforce planning from Audit Scotland²⁴;
 - the NHS Scotland Workforce 2020 Vision, Everyone Matters; and
 - approaches and methodologies in use which support development of services delivered by multi-disciplinary teams – for example, the Workforce Planning Guide by the Scottish Social Services Council, the NHS Scotland 6 Step Model, and local authority tools and guidance.

20 <http://www.audit-scotland.gov.uk/report/scotlands-public-sector-workforce>.

21 <http://www.audit-scotland.gov.uk/report/health-and-social-care-integration>.

22 http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_161027_nhs_overview.pdf.

23 <http://data.sssc.uk.com/data-publications/22-workforce-data-report/128-scottish-social-service-sector-report-on-2015-workforce-data>.

24 “The Scottish Government, in partnership with NHS Boards and integration authorities, should share good practice about health and social care integration, including effective governance arrangements, budget-setting and strategic and workforce planning”. [Audit Scotland – NHS in Scotland 2016-17].

13. In relation to meeting the challenging health and social care needs required, the Workforce Plan will:
- set out a useable framework to improve current workforce planning practice;
 - clarify how workforce planning should take place nationally, regionally and locally across health and social care;
 - map and coordinate similarities and differences in workforce planning practice; and
 - harmonise, reconcile and share approaches where appropriate, while preserving what works well.

Intended outcomes

14. The Workforce Plan will help to bring about:
- clearer understanding about respective roles and responsibilities on workforce planning;
 - clearer understanding about the changes and improvements which need to be made and why;
 - improved consistency, allowing for sharing of best workforce planning practice across Scotland;
 - clearer evidence that robust workforce planning helps to deliver effective, efficient delivery of services and better patient/ service user/ client outcomes; and
 - a longer-term view of the challenges in regard to capacity and capability of this workforce and the solutions we need to design now in response to these.

Process for developing the Workforce Plan

15. An important first step will be to define and articulate the scale of the challenge and the scope of the Workforce Plan. Though NHS Boards are required to follow a single methodology, workforce planning practice can vary significantly. There is also considerable diversity in workforce planning practice between NHS Boards and employers in the social services sector. However, there are indications that workforce challenges are common to both, including: an ageing workforce and the need to provide care for a larger proportion of the population; increasing activity and demand on services; difficulties in recruitment for some hard-to-fill posts; the need to design multi-professional approaches to service challenges; and the availability and suitability of training and career pathways. Starting to be clearer about what can/should be dealt with nationally, regionally and locally will help.
16. Some workforce planning issues will require more pressing action. For the short to medium term, the Workforce Plan will need to:
 - for NHS Scotland, align workforce planning objectives with strategic policies, enabling capacity challenges to be identified before they become an issue;
 - improve workforce planning practice and issue more useable guidance to assist employers. This will apply across health and social care and, for NHS Scotland, will be specific about how this can be done at national, regional and local levels, recognising the key interest of Health and Social Care Partnerships in this development; and
 - examine how collecting, reporting and triangulating workforce planning information might be undertaken more efficiently, so we ensure it embeds with strategic and financial planning issues and translates into planned rather than reactive action. This might also be explored in an integrated context, given the range of different tools and resources available.
17. For the longer term, the Workforce Plan will need to develop a series of actions, perhaps set within a framework of tools accessible by different employers, allowing them to use these to build sufficient numbers of appropriately trained and qualified staff. This will involve exploring how to develop better intelligence through workforce analysis – being clear how a range of demand factors impact on supply. We will want to describe this in more detail as we move to publish the National Discussion Document in early 2017.

Timescale

18. Designing a framework for workforce planning which can apply successfully to different sectors will take time. The arrangements for publishing the National Discussion Document and the Workforce Plan are:
- in **December 2016**, issue this Outline Discussion Paper, seeking input in parallel from key stakeholders and consulting with COSLA and other key local government partners, NHS Management Steering Group, the Scottish Partnership Forum, the Human Resources Working Group on Integration and employer representative bodies such as Scottish Care and the Coalition of Care and Support Providers in Scotland. There will also be discussions with NHS Scotland and Health and Social Care Partnerships, professional bodies, representatives from the primary care sector and other professional stakeholders;
 - in **early 2017**, publish the National Discussion Document, aligning with other relevant publications/releases at that time; and
 - in **Spring 2017**, publish the National Health and Social Care Workforce Plan, which NHS Boards and employers in the social care sector can use to support development of their local plans, working with Health and Social Care Partnerships as appropriate.

Approach

19. The proposed new approach in the Workforce Plan will require roles and responsibilities in respect of workforce planning activity to be clarified and will involve:
- i. forging closer links between and among:
 - senior managers in NHS Boards, local government and the social services sector responsible for strategic planning;
 - planners in NHS Boards, local government and the social services sector involved with implementing robust, progressive workforce plans, and aligning them with those for financial and service planning;
 - service managers, in a unique position to know the strengths and weaknesses of services to patients, service users and clients provided locally;
 - groups of health and social care professionals, whose views on achieving an optimum workforce balance will help build a workforce which will meet the future needs of health and social care;
 - trade unions across health and social care, whose input is key to creating the right working conditions for those professionals; and
 - ii. equipping NHS Boards, local government and the social care sector with the means to plan ahead effectively to ensure they have the right staff in the right place at the right time to provide safe, high-quality health and social care services for Scotland's people.

Next steps

20. We want as far as possible to use the **existing** infrastructure to work towards a Workforce Plan by:
- using this Discussion Paper and the National Discussion Document to invite constructive input, views and comment; and
 - visiting NHS Boards, Health and Social Care Partnerships, COSLA, local authorities and other social services employers to seek views, intelligence and support; and consulting the full range of stakeholders across the health, social care sectors, independent sector, trade unions and professional/regulatory organisations, educational institutions and other interested parties.
21. Arrangements covering governance, data and risks are currently being put in place to underpin the development of the Workforce Plan. These will ensure priority issues faced by the health and social care sector are addressed in a fully inclusive way. Once agreed, these arrangements will be shared with relevant parties.

Challenges

22. Some of the workforce planning challenges specific to NHS Boards and social services sector are outlined below.

NHS Boards

23. Building a more effective workforce planning network with NHS managers, including HR Directors and workforce planners in NHS Boards, is urgently required.
- **Nationally:** we will hold early discussions with HR Directors about the establishment of a national workforce planning group, to be taken forward in partnership between Scottish Government and the service, to ensure there is clarity of responsibility, governance and expectation. Dialogue to facilitate and establish this will involve membership from the wider medical and non-medical professions. This group will also need to consider how best to involve Health and Social Care Partnerships and social care representatives on practical workforce planning issues. The group will require a work programme that is solution-driven, and will need an active and dynamic agenda that prioritises workforce planning challenges, linked clearly to national priorities.
 - **Regionally:** regional workforce planning already takes place in the North, West and South East/Tayside – but it is variable in scope. A more inclusive approach is needed to allow solutions to be designed across individual NHS Board boundaries. The discussions above could also consider how work should be grouped at regional level, to evolve regional approaches to particular capacity challenges.

- **Locally:** we need to maintain links with individual NHS Boards, local authorities and Health and Social Care Partnerships to ensure they are aware of and able to respond to the challenges in the Workforce Plan.

Social care employers

24. The Workforce Plan will need to recognise and address the challenges faced by the social services sector in recruiting and retaining the staff needed to deliver social care services. It will need to be relevant in different contexts, and achieve a 'fit' between existing workforce plans within health and social care (including NHS Boards, Health and Social Care Partnerships and local authorities).
25. Opportunities for joint working on this topic should be explored to minimise duplication of effort. It may be possible in future, for example, to consider the scope of Health and Social Care Partnership and NHS Board workforce plans so that they apply in more focused ways to different parts of the workforce – for example, the workforce delivering community health and social care services, and the workforce which delivers acute sector services. There will be opportunities to look at these issues in the National Discussion Document in early 2017.
26. It may be appropriate for the social care services sector to consider: whether it might build national and regional approaches into its workforce planning; and how local flexibility can best operate (particularly in the context of local government). Discussion on this will require further engagement within the social care sector, specifically involving local government and its representative organisations. In the social services sector it is understood that most, if not all, organisations take decisions about workforce planning at senior level and collect data on current:
 - staff numbers and costs;
 - vacancies; and
 - training activity.

Most organisations use this data for budget setting, day to day management and planning for short term needs. However relatively few use workforce planning tools – the most widely used being the Scottish Social Services Council Workforce Planning Guide²⁵.

25 <http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=25>.

27. There is acknowledgement within the social service sector²⁶ about the urgency of workforce planning issues in light of demographic effects (such as ageing workforce) which influence the ability to plan ahead, the reliance of forecasting on available budgets and the daily effects of service changes (with consequences in planning for workforce). There are strong interconnections between workforce planning and pay, recruitment and retention and a range of other factors. It is clear that this will require an integrated approach not only to planning for services but also to workforce planning. This will require a systematic approach informed by accurate, coordinated and relevant data, allowing available capacity to be deployed flexibly.

Health and Social Care Partnerships

28. Although Health and Social Care Partnerships are required to complete integrated workforce development plans, not all have yet been completed and there is some variance in their contents. The position of Health and Social Care Partnerships is relevant here too. Although Health and Social Care Partnerships are not employers themselves, they are tasked with managing joint budgets to provide integrated health and community care services in the most effective way possible. They will play a key role in shaping workforce demand and in supporting 'intelligent forecasting', which should be reflected in both NHS Scotland and social care services workforce planning.

Discussion

29. We plan to contact all NHS Boards, COSLA and Health and Social Care Partnerships as we engage on developing the National Discussion Document. While aims and expectations depend on effective communication, we are realistic about the audience we can achieve in the limited time available. All are important and will need good reason to invest in facilitated time.

26 "Recruitment and Retention in the Social Service Workforce in Scotland" – Shona Mulholland, Jo Fawcett and Sue Granville (Why Research).

30. We will aim to involve the following professional staff groupings, principally through their existing representative bodies but also, where possible, individually:
- staff side representatives – including Scottish Partnership Forum, the Society for Personnel and Development Scotland, Unison, Unite, GMB, the Royal College of Nursing, the Royal College of Midwives, and the British Medical Association;
 - the HR Working Group on Integration;
 - COSLA;
 - NHS Boards and local government (through SOLACE);
 - Health and Social Care Partnerships;
 - HR and SP Directors;
 - Medical Directors;
 - Nursing Directors;
 - Chief Social Work Officers;
 - Finance Directors;
 - service managers;
 - workforce Planners in NHS Boards – regional and local – and in local authorities;
 - recruitment managers;
 - service planners, including for acute and elective services, as well as representatives from local cancer planning groups and other condition-specific groups (such as the National Advisory Committee on Stroke);
 - clinicians and health and social care professionals;
 - NHS Education in Scotland, Scottish Social Services Council and other regulatory and educational interests;
 - the Royal Colleges; and
 - social care employer representatives bodies – the Coalition of Care Providers in Scotland, Scottish Care and others.
31. We will communicate with the groups outlined above in various ways, including:
- tapping into planned meetings of existing committees, boards and other gatherings as appropriate, rather than setting up new structures;
 - assessing whether ‘roadshow’-type events – with regional/board variations taking account of local issues – may be useful;
 - holding specific small events or workshops – informal and flexible, with few attendees but lively discussion;
 - organising more formal meetings, with presentations followed by discussion; and
 - facilitated discussion, at events such as Strengthening the Links.



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2.3.

Work Plan of Actions from the Health and Social Care Delivery Plan

	HSC Delivery Plan Action	By	By Who	Ties to Existing Work	Triple Aim
	Health and Social Care Integration: Reducing inappropriate use of hospital services				
1	Ensure Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. This will be a key lever in shifting the focus of care across health and social care services.	2017	<u>HSCPs</u>	Transformational Change	Better Value
2	Agree with partners how to deliver an ambition of raising the performance of the whole of Scotland on delayed discharges from hospitals to the performance of the top quartile of local areas. This will be done as a step to achieving our wider commitments of eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care.	2017	<u>NHS Boards</u>	Transformational Change and Unscheduled Care 6 essential actions	Better Health Better care
3	Reduce unscheduled bed-days in hospital care by up to 10 percent (ie. by as many as 400,000 bed-days) by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. A range of actions will be taken to achieve this, including improving links between secondary, primary and community care under integration, supported by further work to understand better and take action on the extent to which emergency admissions are currently inappropriate and avoidable. As a result, people should only stay in hospital for as long as necessary and get more appropriate care in a more homely setting. It will reduce growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by 2021 (as set out below). The annual reports produced by Health and Social Care Partnerships and regular monitoring data will enable progress to be tracked.	2018	<u>NHS Boards and HSCPs</u>	Transformational Change and Unscheduled care 6 essential actions	Better Care
4	Ensure that everyone who needs palliative care will get hospice, palliative or end of life care. All who would benefit from a 'Key Information Summary' will receive one – these summaries bring together important information to support those with complex care needs or long-term conditions, such as future care plans and end of life preferences. More people will have the opportunity to develop their own personalised care and support plan. The availability of care options will be improved by doubling the palliative and end of life provision in the community,	2021	<u>Medical Directors</u>	End of life care and Realistic Medicine	Better Care

	which will result in fewer people dying in a hospital setting.					
	Shifting resources to the community					
5	Ensure Health and Social Care Partnerships increase spending on primary care services, so that spending on primary care increases to 11 percent of the frontline NHS Scotland budget. Again, the annual reports produced by Health and Social Care Partnerships and regular monitoring data will be used to assess progress.	2021	<u>NHS Boards and HSCPs</u>	Transformational Change and Primary Care Transformation	Better Value	
	Supporting the capacity of community care					
6	Continue to take forward a programme of work to deliver change in the adult social care sector, together with COSLA and other partners. This has begun with work to reform the National Care Home Contract, social care workforce issues and new models of care and support in home care. Reform of the National Care Home Contract will maintain the continuity, stability and sustainability of residential care provision while embedding greater local flexibility, maximising efficiency, improving quality, enhancing personalisation and promoting innovation. This national, consensus-based approach to improving social care will reinforce the ability of Health and Social Care Partnerships to match care and health support for individuals more quickly and more appropriately.	2017	<u>SG and HSCPs</u>	Transformational Change	Better value Better Care	
	Primary and community care: Building up capacity in primary and community care					
7	Continue the investment in recruitment and expansion of the primary care workforce which began in 2016, and which will mean that, by 2022, there will be more GPs, every GP practice will have access to a pharmacist with advanced clinical skills and 1,000 new paramedics will be in post. This will reinforce the workforce and the capacity of primary and community care to support our services for the future and will be done in line with our National Health and Social Care Workforce Plan	2017	<u>SG, NES, SAS, HSCPs</u>	GMS Contract	Better Value Better Care	
8	Increased health visitor numbers with a continued focus on early intervention for children through addressing needs identified through the Universal Health Visiting Pathway, which started in 2016. As a result of this, every family will be offered a minimum of 11 home visits including three child health reviews by 2020, ensuring that children and their families are given the support they need for a healthier start in life.	2018	<u>HSCPs</u>	GIRFEC / Early Years	Better Health Better Care	
9	Commenced Scotland's first graduate entry programme for medicine. This will focus on increasing the supply of doctors to rural areas and general practices more	2018	<u>NES</u>	Graduate Programme	Better Care	

	generally.				NES	
10	Implemented the recommendations of the Improving Practice Sustainability Short Life Working Group, the GP Premises Short Life Working Group and the GP Cluster Advisory Group. These actions will support more sustainable GP practices over the long term and build stronger links to Health and Social Care Partnerships, ensuring that the changes in primary care are both effective and sustainable.	2020	SG, HSCPs		Primary Care Transformation	Better Care
11	Strengthened the multi-disciplinary workforce across health services. We will agree a refreshed role for district nurses by 2017, train an additional 500 advanced nurse practitioners by 2021 and create an additional 1,000 training places for nurses and midwives by 2021. This will build on four successive increases in student nursing and midwifery intakes to meet additional demand, especially in primary and community settings.	2021	SG, NES, NHS Boards		Workforce development/planning	Better Value Better Care
12	Increased the number of undergraduates studying medicine by 250 as a result of the 50 additional places in Scotland's medical schools introduced in 2016.	2021	SG and NES		Junior Doctors NES	Better Care
13	Increased spending on primary care and GP services by £500 million by the end of the current parliament so that it represents 11 percent of the frontline budget. This is a fundamental change in how health resources are directed and will enable the critical shift in balance to primary and community care.	2021	SG and HSCPs		Shifting the Balance	Better Health Better Care
	Supporting new models of care					
14	Negotiate a new landmark General Medical Services contract, as a foundation for developing multi-disciplinary teams and a clearer leadership role for GPs	2017	SG		GMS	Better Value Better care
15	Test and evaluate the new models of primary care in every NHS Board, which will be funded by £23 million, and disseminate good practice with support from the Scottish School of Primary Care. These new models of care will include developing new, effective approaches to out-of-hours services and mental health support, and are essential for moving to a more person- and relationship-centred approach to individual care across the whole of Scotland.	2017	HSCPs and NHS Boards		Transformational Change and Primary Care Transformation	Better Health Better Care
16	Take forward the recommendations from the Review of Maternity and Neonatal Services and progress actions across all aspects of maternity and neonatal care.	2017	NHS Boards		Maternity Strategy	Better Care
17	Launch Scotland's Oral Health Plan, following consultation, as part of a comprehensive approach to modernise dentistry and improve the oral health of the population through a prevention and early intervention approach.	2017	SG and Primary Care		?	Better Health Better Care
18	Roll out the Family Nurse Partnership programme nationally to provide targeted support for all eligible first-time teenage mothers. This will give intensive support to mothers and their children and give their health and wellbeing a strong start.	2018	HSCPs		?	Better Care

Secondary and acute care: Reducing unscheduled care					
19	Complete the roll out of the Unscheduled Care Six Essential Actions across the whole of acute care. Through improving the time-of-day of discharge, increasing weekend emergency discharges and a more effective use of electronic information in hospitals, we will enhance a patient's journey at each stage through the hospital system and back into the community without delay.	2017	NHS Boards	Unscheduled Care Programme	Better Health Better Care
20	Undertake a survey on admission and referral avoidance opportunities. This will give a strong evidence base to target modelling for how to reduce unscheduled care through integrated primary and secondary care services.	2017	SG	Unscheduled Care Programme	Better Value Better Care
Improving scheduled care					
21	Put in place new arrangements for the regional planning of services. The National Clinical Strategy sets out an initial analysis of which clinical services might best be planned and delivered nationally and regionally, based on evidence supporting best outcomes for the populations those services will serve. This is a critical first step towards strengthening population-based planning arrangements for hospital services, working across Scotland. NHS boards will work together through three regional groups. In 2018, the appropriate national and regional groups will set out how services will evolve over the next 15 to 20 years, in line with the National Clinical Strategy.	2017	SG and NHS Boards	Transformational Change Elective Care Strategy	Better Value Better Care
22	Reduce cancellations and private care spend in scheduled care by rolling out the Patient Flow Programme from the current pilots across all NHS Boards. The Programme builds on the success of previous programmes – such as Day Surgery, Enhanced Recovery for Orthopaedics and Fracture Redesign – by increasing national and local capacity to use operations management techniques to improve care for patients. Four pilot boards are implementing improvement projects covering emergency and elective theatre operations, elective surgery planning and emergency medical patient flow. As this is expanded, it will introduce more responsive and efficient secondary care and reduce wastage and the unnecessary use of resources.	2017	NHS Boards	Elective Care Strategy	Better Value Better Care
23	Complete investment of £200 million in new elective treatment capacity and expanding the Golden Jubilee National Hospital. Overall, this investment will ensure that there is high-quality and adequate provision of elective care services to meet the needs of an ageing population.	2021	GINH	Elective Care Strategy	Better Health Better care
24	Complete investment of £100 million in cancer care to ensure: earlier detection with more rapid diagnosis and treatment; more and better care during and after		NHS Boards		Better Health

	<p>treatment, taking account of what matters most to people with cancer; increased entry to clinical trials/research; and an evidence driven cancer intelligence system for clinicians and patients with access to near-to-real time information through care pathways. Addressing cancer in such a comprehensive way will target one of the critical health issues facing the population.</p> <p>Improving outpatients</p>	2021			Cancer Care Strategy	Better Value Better Care
25	<p>Reduce unnecessary attendances and referrals to outpatient services through the recently-published Modern Outpatient Programme. The aim is to reduce the number of hospital-delivered outpatient appointments by 400,000, reversing the year-on-year increase of new appointments. It will draw on the existing Delivering Outpatient Integration Together (DOIT) Programme and other activities such as the Technology Enabled Care Programme to:</p> <ul style="list-style-type: none"> – give GPs greater access to specialist advice to reduce the time people wait to get appropriate treatment; – use clinical decision support tools to reduce the amount of time people wait to get the right treatment; – reduce the number of attendances for people with multiple issues through a holistic approach to their support and care; – enable GPs to have more access to hospital-based tests so that people can be referred to the right clinician first time; and – facilitate more return or follow-up appointments in non-hospital settings through virtual consultation from their own home. 	2020	NHS Boards		Modern Outpatient Programme	Better Value Better Care Better Health/Better Care Better care Better Value
	<p>Realistic medicine: Strengthening relationships between professionals and individuals</p>					
26	<p>Refresh our Health Literacy Plan, Making It Easy, to support everyone in Scotland to have the confidence, knowledge, understanding and skills we need to live well with any health condition we have.</p>	2017	SG		Realistic Medicine/ NCS	Better Health
27	<p>Review the consent process for patients in Scotland with the General Medical Council and Academy of Medical Royal Colleges and make recommendations for implementation from 2018 onwards. This is a key element in transforming the relationship between individuals and medical professionals.</p>	2017	SG		Realistic Medicine/ NCS	Better Health
28	<p>Commission a collaborative training programme for clinicians to help them to reduce unwarranted variation. This will support a workforce that can find more effective and valued ways of delivering medicine.</p>	2019	HIS and NES		Realistic Medicine/ NCS	Better Value Better Care
29	<p>Refresh the Professionalism and Excellence in Medicine Action Plan and align high-impact actions to realistic medicine.</p>	2019	Medical Directors		Realistic Medicine/ NCS	Better Value Better Care

	Reducing the unnecessary cost of medical action						
30	Incorporate the principles of realistic medicine as a core component of lifelong learning in medical education and mainstream the principles of realistic medicine into medical professionals' working lives at an early stage.	2018	Medical Directors and NES	Realistic Medicine	Better Value		
31	Develop a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost and reduce the overall cost of medicine.	2019	Chief Pharmacist	Effective Prescribing	Better Health Better Care Better Value		
	Public health improvement: Supporting national priorities						
32	Set national public health priorities with SOLACE and COSLA, that will direct public health improvement across the whole of Scotland. This will establish the national consensus around public health direction that will inform local, regional and national action.	2017	SG	Public Health Strategy	Better Health Better Value Better Care		
33	Support a new, single, national body to strengthen national leadership, visibility and critical mass to public health in Scotland. Such a body will have a powerful role in driving these national priorities and providing the evidence base to underpin immediate and future action.	2019	SG	Public Health Strategy	Better Health		
34	Have set up local joint public health partnerships between local authorities, NHS Scotland and others to drive national public health priorities and adopt them to local contexts across the whole of Scotland. This will mainstream a joined-up approach to public health at a local level.	2020	SG and NHS Boards	Public Health Strategy	Better Health Better Care		
	Supporting key public health issues						
35	Continue delivery of the ambitious targets set out in our 2013 Strategy, Creating a Tobacco Free Generation, including reducing smoking rates to less than 5 percent by 2034. We will implement legislation to protect more children from secondhand smoke and reduce smoking in hospital grounds.	2017	SG	Public Health Strategy	Better Health		
36	Refresh the Alcohol Framework, building on the progress made so far across the key areas of: reducing the harms of consumption; supporting families and communities; encouraging positive attitudes and choices; and supporting effective treatment. A key part of the Framework is the introduction of a minimum unit price for alcohol and we will work towards its implementation at the earliest opportunity, subject to the current legal proceedings. This will combine into a highly ambitious approach to reducing alcohol harm in Scotland.	2017	SG	Public Health Strategy	Better Health		
37	Consult on a new strategy on diet and obesity. There are huge preventable costs to NHS Scotland and society associated with poor diet, as one of the critical health issues we are facing, and it requires a different approach to diet and obesity.	2017	SG	Public Health Strategy	Better Health		

38	Introduce the Active and Independent Living Improvement Programme which will support people of all ages and abilities to live well, be physically active, manage their own health conditions, remain in or return to employment, and live independently at home or in a homely setting.	2017	SG and NHS Boards HSCPs	Public Health Strategy	Better Health
39	Deliver the Maternal and Infant Nutrition Framework with a focus on improving early diet choices and driving improvements in the health of children from the earliest years. This will include: by 2017, rolling out universal vitamins to all pregnant women; by 2019, consolidating best practice and evidence on nutritional guidance for pregnancy up to when children are aged 3, and developing a competency framework to promote and support breastfeeding; and by 2020, have integrated material into training packages for core education and continuing professional development.	2021	HSCPs	Public Health Strategy	Better Health Better Care
40	Supporting mental health Improve access to mental health support by rolling out computerised cognitive behavioural therapy services nationally.	2018	NHS24	Mental Health Strategy	Better Health Better Care
41	Have evaluated the most effective and sustainable models of supporting mental health in primary care, and roll these out nationally by 2020.	2019	SG and HSCPs	Mental Health Strategy	Better Health Better Care
42	Have rolled out nationally targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder.	2019	HSCPs	Mental Health Strategy	Better Care
43	Improve access to mental health services across Scotland, increased capacity and reduced waiting times by improving support for greater efficiency and effectiveness of services, including Child and Adolescent Mental Health Services and psychological therapies. This will be accompanied by a workforce development programme and direct investment to increase capacity of local services.	2020	NHS Boards and NES	Mental Health Strategy	Better Value Better Care
44	Deliver new programmes promoting better mental health among children and young people across the whole of Scotland.	2020	SG	Mental Health Strategy	Better Health Better Care
45	Invest £150 million to improve services supporting mental health through the actions set out in the 10-year strategy.	2021	Sg	Mental Health Strategy	Better Value Better Health
46	Supporting a More Active Scotland Publish a new delivery plan to support the Active Scotland Outcomes Framework and the Vision for a More Active Scotland, with greater action to address inequalities in physical activity across Scotland and a refocusing of resources.	2017	SG	?	Better Health
47	Embed the National Physical Activity Pathway in all appropriate clinical settings across the health care system, ensuring that: – hospitals routinely support patients and staff to be more physically active; – we build on our success in schools, creating a culture of being active		NHS Boards		Better Health

	<p>within children and young people. This will include rolling out the Daily Mile, extending the number of school sports awards, strengthening the Active Schools network creating more quality opportunities and supporting more active travel to and from school;</p> <ul style="list-style-type: none"> – all partners stay on track for delivering 200 Community Sports Hubs, providing local places for communities to be active designed by themselves around their own needs; and – we continue to build on the legacy of the 2014 Commonwealth Games using the European Championships in Glasgow in 2018 to encourage more Scots to be active. 	2019		?	<p>Better Health</p> <p>Better Health</p> <p>Better Health</p>
	NHS Board reform				
48	<p>Review the functions of existing national NHS Boards to explore the scope for more effective and consistent delivery of national services and the support provided to local health and social care system for service delivery at regional level. As part of this, clear guidance will be put in place to NHS Boards that their Local Delivery Plans for 2017/18 must show their contributions to driving the work of this delivery plan, not least their contributions in support of the regional planning of clinical services.</p>	2017	SG, National Boards and territorial Boards	Transformational Change	Better Value
49	<p>Ensure that NHS Boards expand the 'Once for Scotland' approach to support functions – potentially including human resources, financial administration, procurement, transport and others. A review will be completed in 2017, and:</p>	2017	National Boards and SG	Transformational Change	Better Value
49b	<p>New national arrangements put in place from 2019.</p>	2019	SG and National Boards	Transformational Change	Better Value
50	<p>Start a comprehensive programme to look at leadership and talent management development within NHS Scotland. This will ensure that current leaders are equipped to drive the changes required in health and social care, but it will also ensure sustainability of approach by identifying the next cohort of future leaders of NHS Scotland.</p>	2017	SG and NES	Leadership Programme	Better Value

Executive Director, Nursing, Midwifery and Allied Health Professionals

2017-18 DRAFT LOCAL DELIVERY PLAN

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

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

<ul style="list-style-type: none"> • The Board is asked to approve the draft 2017-18 LDP for submission to the Scottish Government. However, significant additional savings associated with the financial plan require to be identified. 	<p>2.1, 2.3</p>
<ul style="list-style-type: none"> • Scottish Government LDP guidance was issued on 16 January 2017 outlining priorities and actions for inclusion in NHS Boards LDPs. 	<p>3.1</p>
<ul style="list-style-type: none"> • Elements referenced within NHS Lothian’s draft 2017-18 LDP include: <ul style="list-style-type: none"> - An outline of 2017-18 Financial Plan and the need to identify a further £22.4m cost reduction - The impact of the financial position on the delivery of scheduled care - Clarity relating to the organisational effort to be supported by the Lothian Health and Social Care Partnerships and delivery of integration performance measures - Development of the Lothian’s Hospitals Plan - Work with partner boards to deliver a Regional Health and Social Care Delivery Plan - Actions associated with delivery of the 2020 Workforce Vision 	<p>3.2,3.3,3.4, 3.6</p>
<ul style="list-style-type: none"> • Key risks associated with the 2017-18 LDP relate to: <ul style="list-style-type: none"> - Business unit recovery plans - Financial exposure relating to elective and unscheduled capacity pressures - Availability of Scottish Government funding for programmes, initiatives and services - Revenue impact associated with the capital investment programme 	<p>4.1</p>
<ul style="list-style-type: none"> • The current financial gap associated NHS Lothian’s 2017-18 Financial Plan is £22.4m 	<p>8.1</p>

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NHS Lothian

Board Meeting
5 April 2017

Executive Director, Nursing, Midwifery and Allied Health Professionals

2017-18 DRAFT LOCAL DELIVERY PLAN

1 Purpose of the Report

- 1.1 The purpose of this report is to recommend that the Board approve the draft 2017-18 Local Delivery Plan (LDP) outlined in Appendix 1.

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

2 Recommendations

- 2.1 The Board is asked to approve the draft 2017-18 LDP for submission to the Scottish Government following discussion at the 5 April 2017 Board meeting.
- 2.2 Note the LDP will continue to be the contract between the Scottish Government and NHS Lothian
- 2.3 Agree to submission of the 2017-18 LDP with significant additional savings still to be identified.
- 2.4 Any further amendments to the 2017-18 LDP should be agreed through the Chairman and Chief Executive.

3 Discussion of Key Issues

- 3.1 The Scottish Government 2017-18 LDP guidance asked the NHS Boards outlined priorities and actions relating to:
- Increasing healthy life expectancy
 - Health and Social Care Delivery Plan (HSCDP) published in December 2016
 - LDP Standards
 - Patient Centeredness and Safety
 - Financial Plans for a minimum period 2017-18 to 2019-20
 - Workforce Planning to include an outline of local Everyone Matters :2020 Workforce Vision implementation plan
- 3.2 Key elements within the 2017-18 LDP include;
- An outline of the financial health of the organisation, outlined in 3.4 Financial Plan for 2017-18 noting that after deployment of all available resources and all savings plans and uplifts are accounted for, there remains a need to identify a further £22.4m cost reduction to achieve break-even;
 - A further deterioration in the recurring position within the Financial Plan;
 - Maintenance of provision in the financial plan for internal waiting list initiatives and the use of the Golden Jubilee National Hospital;
 - The Financial Plan, however does not include any provision for use of the Independent Sector to address the impact of capacity pressures and population growth on waiting lists. This is due to be discussed with Scottish Government colleagues after the Board meeting.

- Clarity about how each Health and Social Care Partnership will take forward its part of the organisational effort, reducing delayed discharges and preventing admission, as well as bolstering prevention efforts;
- A summary of the Lothian Hospitals Plan;
- A high-level description of how the organisation will work with partner Boards to deliver a Regional Health and Social Care Delivery Plan;
- Workforce planning

3.3 Of particular note for this year, the Scottish Government has an expectation that Integration Joint Boards will report directly on the delivery of 6 key targets arising from the HSCDP;

- unplanned admissions;
- occupied bed days for unscheduled care;
- A&E performance;
- Delayed discharges;
- End of life care;
- balance of spend across institutional and community services

3.4 As might be expected, summarising the intent for all parts of an organisation the size of NHS Lothian, however briefly, does lead to the production of a large and wide-reaching document. Further, the organisation is still fine-tuning its approach to both financial and activity modelling and some elements of the LDP will require updating following discussion at the Board meeting of 5 April 2017.

3.5 The Scottish Government 2017-18 LDP guidance also refers to the need for NHS Boards to work in collaboration to develop a Regional Health and Social Care Delivery Plan (RHSCDP) by September 2017.

NHS Lothian's management team have interpreted this latter ask as an opportunity to develop a regional "sustainability and transformation plan" (STP), along the lines of those developed in England. Here, 44 territorial groupings have been established across organisational lines and these have been tasked with identifying the major changes and challenges to be met in that territory. The STPs have been produced at pace and contain some interesting ideas, but also clearly need considerable additional work to make them truly transformative.

NHS Lothian's management team are therefore working closely with partner Boards from the East of Scotland (Fife, Borders, Tayside, and Forth Valley) on how the RHSCDP can be produced. The South-East and Tayside planning group has been refocused as an "HSCDP Board" and has agreed to a two-stage process for delivering a RHSCDP with a draft "statement of intent" by the end of March and a final version by September 2017.

The sections of the RHSCDP are;

- **Context** – outlining the demographic needs of the regional population and how these are likely to change, including disease patterns, the age structure of the population, inequality and inequity;
- **Prevention** – outlining how disease and care requirements could be mitigated by increased focus on prevention and health promotion;
- **Integrated Services** – outlining the priorities and actions for Integrated Joint Boards within the planning area and how these will deliver on the HSCDP aims, as well as how these will interdigitate with acute services in order to deliver a sustainable model of acute care, operating at 85% bed occupancy;

- **Workforce** – outlining how the workforce profile looks currently, and how this needs to change to support the aims and requirements of clinical services. This section will also outline the “HR services” elements of Board operations where alignment could be productive and efficient;
- **Finance** – covering the financial position across the involved Health Boards, savings and efficiency plans, capital plans, and the “finance services” elements of Board operations where, again, alignment could be productive and efficient;
- **Acute services** – outlining which 5-7 specialty areas within acute services where services could be planned regionally, focussing on a high-performing standard model across the region, with workforce, facilities, demand and capacity, and modernisation of models at the forefront of considerations. It is anticipated that over the next few years a rolling approach will be taken of dealing with 5-7 specialty areas in each planning cycle.

4 Key Risks

- 4.1 The 2017-18 LDP highlights a challenging year for NHS Lothian. A risk schedule highlighting the key assumptions and risks associated with the 2017-18 LDP which require to be considered by the Board relate to:
- Consolidation of individual Business Unit recovery plans
 - Continued management of financial exposure on elective and unscheduled capacity pressures including delayed discharge
 - Availability of Scottish Government Health and Social Care Department funding for funded programmes, initiative and services
 - Revenue impact of the capital investment programme

5 Risk Register

- 5.1 Responsible Directors are asked to ensure risks associated with targets and plans are clearly identified on the Risk Register and risks are escalated to the Corporate Risk Register as appropriate.

6 Impact on Inequality, Including Health Inequalities

- 6.1 Responsible directors and management teams supporting strategy development and service redesign outlined within the 2017-18 LDP should ensure an Equality and Diversity Impact Assessment is undertaken.

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

- 7.1 NHS Lothian Directors, IJB Chief Officers and their teams have supported the development of the 2017-18 LDP.

8 Resource Implications

- 8.1 The current assessment of the 2017-18 LDP financial plan shows that following the deployment of all available resources and uplifts to income, there remains a need to identify a further £22.4m of savings over and above those already delivered.
- 8.2 Board members are aware that there are several “ring-fences” of national priority areas such as mental health.
- 8.3 Should the Board decide to prioritise elective access targets, there could potentially be a requirement to find further savings of up to £14m.

Alyson Cumming
Strategic Programme Manager
27th March 2017

Colin Briggs
Associate Director

List of Appendices

Appendix 1: 2017-18 Local Delivery Plan



Local Delivery Plan 2017-18

Unique ID: NHS Lothian Local Delivery Plan 2017-18	Authors: A McMahon, A Cumming , C Simpson
Category/ Level /Type: NHS Lothian Local Delivery Plan 2017-18	Authorised By: A McMahon
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1. EXECUTIVE SUMMARY

NHS Lothian's 2017-18 Local Delivery Plan (LDP) reinforces NHS Lothian's mission to improve the health of the population, improve the quality of healthcare and achieve value and financial sustainability.

The Scottish Government published their [Health and Social Care Delivery Plan](#) in December 2016 which sets a range of actions to enhance delivery of health and social care services. This national plan prioritises the actions which have the greatest impact on delivery and focuses on three areas: better care, better health and better value. NHS Lothian's LDP is aligned to the national delivery plan and outlines our priority actions for 2017-18 relating to:

- Increasing healthy life expectancy
- Lothian Health and Social Care Partnership Strategic Plans
- Primary and Community Care
- Secondary and Acute Care
- Realistic Medicine
- Public Health Improvement
- Research and Development

Our plan also outlines details associated with delivery of the Scottish Government LDP Standards (previously HEAT standards), our actions to improve patient experience and safety, delivery of our financial plan over the next three years and actions associated with the Scottish Government 2020 Workforce vision.

NHS Lothian continues to face challenges with demographic pressures associated with an increase in our population and caring for an older population in Lothian. This impacts on our ability to deliver treatment time guarantees within the resource available to us. Our plan includes a range of actions to mitigate these challenges and our quality improvement programme and approach to realistic healthcare will assist to redesign the way we deliver care to the population we serve.

The four Lothian Health and Social Care Partnerships have all published their strategic plans which outline their approach to health improvement and delivery of health and social care within their localities. The partnership's Integration Joint Boards are currently discussing and agreeing their 2017-18 directions to be issued to NHS Lothian.

Our LDP also outlines details of our Lothian Hospitals Plan which will define the strategic direction for NHS Lothian's acute hospital services over the next 5 – 10 years. This plan will be further developed and consulted on over the next year.

We are currently facing a 2017-18 financial pressure of £22.4m and whilst we will continue to address financial recovery plans within our business units, this financial gap will impact on delivery of our services.

NHS Lothian is working with partner NHS Boards across the East of Scotland to develop a Regional Health and Social Care Delivery Plan. The aim of this plan includes the need to consider any efficiency and productivity gains which can be provided through a regional approach in the delivery of care. This regional plan will be submitted to the Scottish Government in September 2017.

2. INCREASING HEALTHY LIFE EXPECTANCY

Preventing poor health is essential if health inequalities are to be reduced. Many of the determinants of health lie outside health and care service provision so there needs to be a focus on actions that target inequalities both outside and within the NHS.

For almost every health indicator, there is a gradient showing poorer health with increasing deprivation. Barriers or disadvantages such as lower social status, poor educational attainment, poor housing, and lack of employment or low pay are key determinants of health inequalities. People from ethnic minorities, people with disabilities and particular sexual orientations are also likely to experience health inequalities. Actions to reduce health inequalities should not target only the most deprived areas; many disadvantaged families and individuals live in areas that are not identified as socially disadvantaged by commonly used indicators.

The roles of the Community Planning Partnerships (CPPs) and Health and Social Care Partnerships (HSCP) in tackling health inequalities cut across design and delivery of services. Maintaining universal services while also targeting resources where there is greatest need should be central to inequalities focused health and social care services.

Healthy life expectancy in Lothian has increased in recent years as outlined in Table 1.

Lothian Healthy Life Expectancy (years)

	1999-2003 Male	1999-2003 Female	2009-2013 Male	2009-2013 Female
Lothian	67.9	71.9	64.8	67.2
Scotland	66.3	70.2	63.1	65.3

Source : Scottish Public Health Observatory (ScotPHO)

NHS Lothian's actions to improve healthy life expectancy and to support people to live longer in good health, increasing capacity for productive activity and reducing the burden of ill health and long term conditions are detailed below.

2.1 Health Inequalities

NHS Lothian will continue to implement its Health Inequalities Strategy and monitor progress. The strategy outlines a series of actions relating to: Procurement; NHS Lothian as an employer; Planning and delivery of clinical services; work in Partnership; Monitoring and evaluation.

Key actions in 2017-18 will include:

Procurement – we have recruited a Community Benefits Officer within Procurement. In 2017-18 he will develop and implement actions to increase the number and quality of community benefits achieved through NHS Lothian contracts.

Employability – we will continue to implement the Socially Responsible Recruitment programme, which provides employability programmes for a range of groups including school leavers, graduates with a disability, people with autism and women returning to work education or training.

Welfare advice – we completed a needs assessment of welfare advice provision in NHS settings in 2016-17 and will use this in partnership with local authority and voluntary sector partners to increase the reach of these services.

Health inequalities indicators – we have been working with our Community Planning Partnerships to identify a set of health inequalities indicators. In 2017/18 we will use the indicators to raise awareness of the determinants of health inequalities and monitor progress to address these.

Communication and training – we will continue to disseminate our strategic approach and provide training in health inequalities for a range of staff and other audiences.

Health Inequalities faced by people with learning disability

Across Learning Disability Nurses, both community and in-patient, we are in the process of implementing the Health Equality Framework tool, as a means of assessing exposure to health inequalities in this population.

This tool will enable NHS Lothian and integrated services to establish a baseline, and evaluate impact of interventions on an individual patient level, evidencing outcomes and the impact/ success of the interventions in reducing the individual's exposure the health inequalities, including the social determinants of health and wellbeing.

NHS Lothian and HSCPs will also apply the aggregated data on a team and locality basis to inform strategic needs assessments, establish the health profile of people with learning disability and inform the strategic deployment of resources.

2.2 Children & Young People

Children & Young People Improvement Collaborative (CYPIC)

The Scottish Government launched CYPIC in November 2016 at a national eLearning set. There has been no formal approach to Community Planning Partnerships (CPPs) or Chief Executives of NHS Boards or Councils to ask them to buy into this approach and work to the new revised stretch aims.

NHS Lothian works within four CPPs areas and children and young people partnerships and therefore is a partner in four CYPICs locally.

We have created a Pan Lothian CYPIC group to share learning across Lothian, and to look at focused areas of improvement that may benefit all parts of Lothian. This group has membership from the four CPPs areas and qualified Improvement Advisors within NHS Lothian that studied under the Early Years Collaborative programme.

Healthy Start – Using Quality Improvement Methods to Address the Consequences of Poverty

Poverty has a detrimental impact on health and wellbeing. Quality improvement work makes small changes to achieve a larger goal, charting progress rapidly. The Early Years Collaborative was a Scotland-wide multiagency approach to improving outcomes in pregnancy and childhood. In Lothian we used quality improvement methods to boost family incomes during pregnancy. We started off with Healthy Start, a UK-wide food and vitamin

voucher programme for low income families promoting healthy choices, but ended up also addressing unclaimed entitlements more generally for these families.

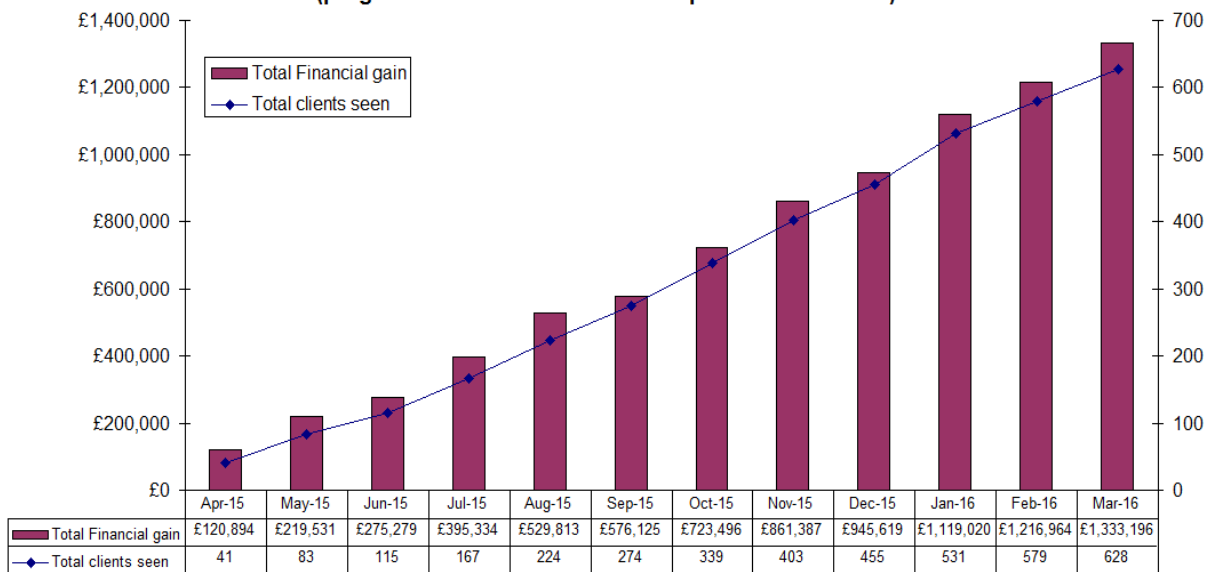
In NHS Lothian, we started with one midwife, focusing on sign-up for Healthy Start vouchers. We identified ways to simplify and improve the application process. Many women still struggled to complete the application form, so we linked women into welfare rights advice services.

Between January 2014 and August 2015 there was a 13.3% rise in voucher receipt in Lothian, compared with an 8.4% decline for the rest of Scotland. Figures varied by team, influenced by staff, family, and area factors. The number of women in receipt of vouchers fell subsequently, for Scotland and Lothian. Using quality improvement methodology we were able to identify that this was due to a change in the processing of applications at UK level by a private company on behalf of Department of Health; we worked with Scottish Government to press for a return to the original approach. We have also advocated for changes to eligibility for Healthy Start, particularly for women in work to receive vouchers during their first pregnancy, something that may be within the remit of the Scotland Act (2016) under the Welfare Food section. This work, starting with one midwife in Leith, has had an impact on policy, practice and potentially legislation at a national level.

We have continued testing, achieving recent increases in the number of women referred for welfare rights advice on benefits, tax credits, employment rights, childcare, and debt. Work in north Edinburgh and West Lothian (Granton Information Centre and West Lothian Citizens Advice Bureau respectively) has secured families £1.333m in previously unclaimed entitlements during 2015-16.

Following the testing described above, we have set up an automatic referral process for welfare rights advice in Leith and are working to extend this across Lothian. Our findings have relevance across the UK, and we have disseminated findings at conferences, including the International Forum on Quality and Safety in Healthcare (Gothenburg, April 2016) and in a peer-reviewed publication in BMJ Quality Improvement Reports.

Financial gain for families supported by Granton Information Centre and West Lothian CAB (pregnant women and families with preschool children)



27-30 Month Developmental and Wellbeing Assessment by Health Visiting

	East L		Edinburgh		Mid L		West L		Lothian Total	
All percentages are based on the total number of reviews	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15	13/14	14/15
All domains										
No. of eligible children	1,213	1,178	5,295	5,334	1,051	1,142	2,181	2,147	9,759	9,819
Number of reviews	963	974	4,913	4,517	829	911	1,928	1,665	8,648	8,081
% of eligible children reviewed	79.4	82.7	92.8	84.7	78.9	79.8	88.4	77.6	88.6	82.3
% meaningful complete assessment	96.7	96.5	93.6	95.4	96.3	97.4	96.7	96.6	94.9	96.0
N - No concerns across all domains	776	800	3,873	3,587	674	781	1,411	1,202	6,744	6,382
% No concerns across all domains	80.6	82.1	78.8	79.4	81.3	85.7	73.2	72.2	78.0	79.0
No with a concern in any domain	159	153	787	766	134	111	477	427	1,560	1,458
% with a concern in any domain	16.5	15.7	16.0	17.0	16.2	12.2	24.7	25.6	18.0	18.0

In 2014-15, 82.3% of children in Lothian who were eligible for a 27-30 month assessment were assessed (86.7% Scottish average). Of those assessed, 96% of the review forms were complete (most usually related to height and weight not being recorded). Our performance on complete reviews is better than the Scottish average of 87.8%. If the children screened in Lothian, 79% (71.6% in Scotland) have no concerns found across the developmental domains, with 18% (19.2% in Scotland) with one concern or more.

Therefore, overall NHS Lothian is performing well on providing the 27-30 month assessment. We have notes that we have some geographical variance in West Lothian which will focus on in 2017/18 using improvement methodology to alter processes and timing to ensure these figures improve in line with the rest of Lothian.

The 13-15 month new Scottish developmental assessment will commence across Scotland from May 2017, and NHS Lothian will begin this at the same time. This will be monitored in Lothian using the same detailed data analysis.

Early Ante Natal Booking

The Local Delivery Plan standard relating the need to ensure 80% of pregnant women are booked for antenatal care by antenatal booking by the 12th week of gestation has been exceeded and is supporting a reduction in antenatal inequalities and improving outcomes for the new born.

- We are above 80% for all Scottish Index of Multiple Deprivation (SIMD) quintiles in Lothian
- We are aiming to maintain and improve on our good results by continuing to implement our good practice and use improvement methodology
- Community Midwifery Services receive statistics monthly from centralised booking and this keeps us on target.
- A quarterly centralised booking meeting is a way of continuously improving our processes and to ensure that the information that we are distributing is current. This is done in conjunction with Health Promotion Services and contains relevant public health reminders and so this becomes a way to spread relevant public health messages (e.g. Flu vaccinations)
- As part of early intervention and prevention strategies, midwives undertake the following risk assessments at booking visit (7-10 weeks) These include:
 - Routine Enquiry for Gender based violence
 - CO monitoring/smoking
 - Alcohol brief intervention

Early booking compliments the pending new strategy for maternity and neonatal care; maternal and infant nutrition work; the new universal pathway pre-birth to preschool, Family Nurse Practitioner (FNP) support for teenage mothers, Getting It Right For Every Child (GIRFEC) and the Children and Young People (Scotland) Act aims.

Further details relating to booking of antenatal care are outlined in Section 4 LDP Standards within this plan.

Low Weight Birth Numbers/Rates of Birth with Weights

One aim of early booking, preconception planning, and good maternity care is to reduce the numbers of low birth weight babies. In Lothian, 6.36% of babies born were less than 2.5kgs birth weight in 2016, a reduction from 6.53% in 2009.

Delivery Year	Lothian Total	Lothian births less than 2.5kgs
2009	7827	511
2010	9575	565
2011	9569	622
2012	9563	520
2013	9304	534
2014	9205	523
2015	8777	514
2016	8927	568

Percentage of Women who are obese at Booking

Another factor that impacts on the health and wellbeing of the mother and the unborn child and future child is unhealthy weight. Changes with continuity of carer in midwifery and

increased health visiting support should support a reduction in this trend and promote a healthier weight and lifestyle.

5.8% of pregnant women in Lothian have BMI's of 35 or over in 2016, compared to 1.9% in 2009. Therefore, this will be an area of priority maternity services.

Delivery Year	Lothian Total	Lothian Pregnant Women with BMI ≥ 35
2009	7827	150
2010	9575	569
2011	9569	638
2012	9563	632
2013	9304	661
2014	9205	638
2015	8777	605
2016	8927	526

Midlothian Health and Social Care Partnership approach to increasing healthy life expectancy is by supporting improvements in health inequalities through 'Reducing the Gap'. Examples include NHS Lothian and Midlothian Council (Communities team) working together to provide a range of Food Programmes; and working with specialist acute hospital staff to develop more locally based, preventative-focussed services in the field of diabetes

3. NHS SCOTLAND HEALTH AND SOCIAL CARE DELIVERY PLAN

The NHS Scotland Health and Social Care Delivery Plan¹ published in December 2016 details actions to ensure whole-system, integrated plans are developed to deliver timely co-ordination of care which are appropriate to people's needs, ensuring people receive the right care, at the right time, in the right place and are supported to live well as independently as possible.

The delivery plan outlines a number of actions associated with:

- Health and Social Care Integration
- Primary and Community Care
- Secondary and Acute Care
- Realistic Healthcare
- Public Health Improvement

The plan also outlines the need to drive NHS Board reform therefore NHS Lothian is working in collaboration with South East Scotland NHS Boards to outline a regional transformation plan by September 2017.

3.1 HEALTH AND SOCIAL CARE INTEGRATION ACTIONS

Health and Social Care Partnerships governance structures are now well established with regular meetings of the Integration Joint Boards (IJBs); Strategic Planning Groups; and Audit and Risk Committees. A Risk Management Policy and IJB Risk Registers are now in place.

Within Midlothian, the Quality Improvement Team Structure has been reshaped to address quality in social care as well as health. At Head of Service level, responsibilities are across health and social care and a management review is underway to develop a more integrated approach at third tier level. More integrated arrangements are being pursued in operational services such as learning disability and substance misuse.

3.3.1 Delayed Discharge

East Lothian

East Lothian's performance had been steadily improving from a peak of 43 in 2014, reducing to 15 to 25 at each monthly census until spring 2016. From then until August 2016 the number rose, in part due to new reporting rules, but mainly due to suspension of admissions to a large local care home and capacity problems with care at home providers. This figure peaked at 61 in August 2016. Since then numbers have reduced and figures at the November 2016 census show 26 patients, with a delayed discharge. The care home in East Lothian, which had been closed to new admittances since early 2016, is being gradually returned to full capacity.

Actions to support improvement within the delayed discharge position include:

- East Lothian funding additional capacity in Hospital to Home using delayed discharge fund.

¹ <http://www.gov.scot/Resource/0051/00511950.pdf>

- East Lothian planning for implementation of living wage in home care
- East Lothian planning to invest c £1m of social care fund in purchasing additional capacity in care at home following introduction of living wage. Innovative procurement methods will be used to secure blocks of activity for people delayed in hospital.
- Investment in ELSIE through Integrated Care Fund to provide 24/7 cover to prevent hospital admission.
- Retendering of current care at home framework
- Introduction of second additional team in hospital to home service
- Introduction of third additional team in hospital to home service
- Support care home to reopen
- Consider bringing unused NHS or Council capacity into use.

It is anticipated that there will always be a level of delay in transfer associated with standard delays i.e. waiting for care home / specialist housing, care packages or home adaptations. The East Lothian Partnership has set out a trajectory for reduction in the level of delay during 2017-18 as outlined below.

**East Lothian Trajectory – Reduction in Delayed Discharge
(at monthly census, excluding code 9s and code 100s as reported to ISD)**

Month	April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Delayed Discharge	15	14	13	12	11	10	9	8	12	12	12	6

Edinburgh

The position on delayed discharge in Edinburgh remains a challenge. Low levels of unemployment in the city are a significant issue as providers of community based care and support services across all sectors struggle to recruit in order to meet the level of demand for services to support people on discharge from hospital.

In 2016 the Health and Social Care Partnership established a Flow Programme to adopt a whole system approach to addressing delays across the health and social care system. The programme consists of a number of work streams focused on admission avoidance, discharge, reablement, care at home and addressing the long delays in hospital experience by people waiting for Guardianship. Work streams are jointly led by senior members of staff from the Health and Social Care Partnership and NHS Lothian Acute Services.

Daily meetings are currently taking place in each of the four localities in the city focused on reducing the number of people delayed in hospital and the length of those delays. Tracking reports are produced daily to support this work and the Flow Programme has also commissioned the development of a whole system reporting tool that uses statistical process control to monitor performance at a number of key stages from A and E admissions to discharge from hospital in order to raise alerts where specific parts of the system are under pressure.

The implementation of the new locality based integrated structure during 2017-18 will provide a greater focus on admission avoidance and timely discharge from hospital through the Multi-agency Triage function within the locality Hubs.

The work of the Flow Programme is due to be reviewed by the Programme Board at the end of March 2017 to identify the benefits realised and barriers encountered and agree work streams to be taken forward.

Midlothian

The performance within Midlothian remains off-target, but there has been an improvement in performance in early 2017 and ongoing weekly monitoring demonstrates that this improvement is being maintained.

The increased number for December 2016 reflects the challenges around supporting discharge during the festive period, both in terms of availability to commence packages of care and opportunities to admit patients to care homes.

The decision to support early discharge from acute settings to the Midlothian Community Hospital has continued to result in a significant reduction in the number of patients delayed in the Royal Infirmary of Edinburgh, Western General and Liberton Hospitals.

Actions for improvement include:

- Action Plan developed and being implemented to address under-performance by Care at Home provider
- Increased capacity within Hospital Inreach Team to support improved discharge across acute and community sites
- Appointment of 10 additional Care Support Workers within the Complex Care Team to increase capacity
- Development of dementia and complex care beds within Partnership run Care Home to support increased choice for LA funded service users
- Increased medical input to MERRIT (Hospital at Home) with further 0.6 WTE doctor
- Agreement being reached with alternative provider to consider options for delivering care at home service
- Expansion of MERRIT (Hospital at Home) Service to enable growth in beds on virtual ward by 50% (10 to 15 beds)
- Agreement to recruit additional nursing staff within MERRIT to support the expansion noted above.
- Appointment of staff to review care packages to identify additional capacity within the system
- Implementation of a 4 week pilot to divert all possible nursing home admissions to the Flow Centre and then to MERRIT to prevent admission to hospital
- Increased use of Midlothian Community Hospital to support patient moves to downstream beds and relieving some of the pressures on acute sites
- Review of in-house service provision to increase capacity within Reablement through more effective use of the Complex Care service
- Additional management support being provided to external Care at Home provider to address concerns over service delivery
- Ensure the capacity of both Community Hospital and Highbank is fully utilised to minimise delays in Acute Hospitals and achieve the 72 hour target by 2018

West Lothian

To target a reduction in delayed discharge levels in West Lothian is based on scheduled investments and anticipated benefits. A comprehensive programme of actions to address delayed discharge is incorporated within the West Lothian Frailty Programme which is focussed on improvements across the whole system of health and social care. The Frailty Programme Board continues to monitor the programme and identify priorities for further work.

Some improvement is noted in Care at Home Contract provision which is being augmented with hospital to home and community nursing teams to facilitate discharge and provide interim care.

The partnership is continuing to review all delayed discharge cases to track the key issues and are addressing these within our unscheduled care plans. Additional Mental Health Officer (MHO) resource to Discharge Hub has been put in place to focus on Code 9 delays. A multi-disciplinary team approach is supporting a focus on consistent application of NHS Lothian's Moving On Policy and weekly meetings are held to progress work plans and monitor performance.

Additional actions for improvement include:

- Frailty programme work streams reviewed and priorities identified
- Delayed discharge clearly identified within the work stream
- Additional work stream on Intermediate Care commenced
- Proportion of reablement capacity blocked with clients with unmet needs reduced as independent providers are providing more packages of care leading to increased capacity in Reablement and Crisis Care teams
- REACT providing acute care at home, good evidence of success in reducing admission and high level of patient and carer satisfaction.
- Development plan in progress within overall Frailty Programme and within unscheduled Care plan to extend provision over 7 days
- Needs Assessment will inform priorities for IJB and Commissioning Plan
- Priorities identified within Strategic Plan
- Awareness sessions commenced with multi-disciplinary teams
- Discussion progressed with West Lothian Council and Scottish Care to establish capacity
- Intermediate care work stream established in Frailty programme
- Ensure patients correctly coded and actions progressed to facilitate discharge process

3.1.2 Reduce Unscheduled Hospital Care

To support the delivery plan action outlines the need for health and social care partnerships to support a reduction in unscheduled care beds days by 10%. The implications to support this reduction in the four Lothian partnerships are outlined in the table below.

IJB Area	Bed Days					Reduction in USIJB as beds	2015-16 DD as Beds
	Current Total	Current UC (all)	Current UC (IJB)	UC (IJB) @85%	UC (IJB)@85% w 10% reduction		
Mid	65,103	48,911	32,765	30,031	27,329	18	12
East	70,854	53,901	33,100	30,338	27,609	18	13
Edinburgh	374,930	292,431	180,773	180,773	164,512	105	149
West	145,712	110,267	65,335	65,335	59,458	38	14
Total						179	187

A reduction in bed days will be achieved by through:

- Reducing delayed discharge
- Preventing Admission
- Reducing Length of Stay

The West Lothian partnership will seek to support a reduction in unscheduled care through:

- Inpatient redesign through the frailty programme
- Roll out the discharge to assess model
- Support case management approaches

The Midlothian Partnership will seek to reduce Accident and Emergency (A&E) Attendances and Reduce Admissions through:

- Working with the Royal Infirmary of Edinburgh Alcohol Liaison Service to reduce A&E attendances of people with problematic substance misuse
- Developing a media campaign to reduce inappropriate use of A&E
- Strengthening links between A&E and local GPs to redirect inappropriate attendances
- Increasing the capacity of the Hospital at Home Service to support admission avoidance, both within the home environment and A&E
- Strengthening support through an Advanced Physiotherapist for COPD and the implementation of a Falls Prevention Strategy
- Reducing admissions of residents from Care Homes through the provision of specialist nursing advice; implementation of a falls strategy; improved skills of care staff through video conferencing training programme
- Reviewing the 1580 'Potentially Preventable Admissions' (2014-15)
- Providing proactive support to young people admitted through the Assertive Outreach Programme which is developing a stronger pathway to local services such as homelessness and substance misuse
- Preventing crises by the identification of frail older people through the eFrailty project, a methodology applied by GPs, which in turn would enable proactive support and anticipatory care planning
- Planning Ahead - Anticipatory Care Planning and Emergency Planning. Examples include further promotion of Power of Attorney uptake and an engagement exercises with the public about how to plan ahead whether as a carer or as someone with long term health conditions

- Recovery-Reablement, rehabilitation and self-management. Examples include the establishment of a Recovery Hub in Substance Misuse and Mental Health; and an Advanced Physiotherapist working with COPD patients

3.1.3 Adult Social Care

Edinburgh Health and Social Care Partnership

Negotiations on the rate of increase in care home fees to be applied to the National Care Home Contract (NCHC) are currently taking place between COSLA and representatives of care home providers. The basis for these negotiations has been the development of a 'cost of care' calculator which breaks down the components of care and seeks to identify benchmarks for assessing the costs of these. While progress has been made in respect of the 'care' cost elements no agreement has been reached on the benchmarks around capital, return on capital and provider profit. The calculator is therefore incomplete at this stage and there is a significant difference in expectations between the two parties.

Failure to reach agreement on the NCHC and a resulting requirement to carry out local negotiations would be particularly problematic for Edinburgh given its high property and staff cost base relative to other parts of Scotland. The Health and Social Care Partnership recognises that this is a significant risk to the sustainability of residential care provision in the city and has the potential to create additional budget pressures. We are therefore watching progress in the national negotiations closely and developing contingency plans should the need arise to move to local negotiations.

During 2016-17 the Health and Social Care Partnership in Edinburgh has been developing an integrated structure to deliver joint working at a locality level, bringing together social workers, nurses and allied health professionals. We believe that this structure will support the delivery of more efficient and effective services and better outcomes for citizens.

During 2017-18 we will implement the new structure and develop an integrated workforce strategy setting out the future staffing model required to deliver sustainable and affordable health and social care services that keep people safe.

A key element of our strategy will be to work with third and independent sector, NHS Lothian and City of Edinburgh Council partners to drive a mutually beneficial career in care campaign.

Midlothian

The Midlothian Partnership will support a shift in the balance of care by strengthening Hospital at Home services and developing more Extra Care Housing.

3.2 PRIMARY AND COMMUNITY CARE ACTIONS

3.2.1 Antenatal, Early Years, Children and Young People

Implementation of Children and Young Peoples (Scotland) Act 2014

In addition to the integrated planning in the four children's partnerships in the four Lothian Community Planning Partnership (CPP) areas, NHS Lothian has an Act Implementation Steering Group. The steering group reports to the Maternity, Children and Young People Programme Board to the Strategic Planning Committee of the board. The aim of the

steering group is to take the relevant guidance from Scottish Government on the different parts of the Act legislation and to ensure that the corporate and operational parts of NHS Lothian are briefed, advised and have processes and systems in place to ensure delivery of the Act requirements.

This has been complex across 2016-17 due to the Supreme Court ruling that the threshold for information sharing on wellbeing was not legal as written in the Act. The previous draft guidance on parts 4 and 5 of the Act were retracted from Scottish Government and we await further statements and guidance on the Scottish Government's plans to move forward relating to Named Person function and Child Plans.

NHS Lothian has an implementation plan for Act implementation and has been focusing on Act readiness and processes required for us to be legally compliant. The key areas of on-going work are:

Statutory Guidance on Part 3 – Children's Services Planning: All CPP areas must have a new children's services plan to Scottish Government by end of April 2017, which is a 3 year plan. This is the equal legal responsibility of NHS and Local Authority. Part 3 seeks to improve outcomes for all children and young people in Scotland by ensuring that local planning and delivery of services is integrated, focused on securing quality and value through preventative approaches, and dedicated to safeguarding, supporting and promoting child wellbeing.

These plans will have an annual reporting mechanism to Scottish Government. At present, Mid Lothian and East Lothian have plans ready. Edinburgh City has an agreed extension from Scottish Government until June 2017. West Lothian has a draft plan that will be submitted by end of April (as request to extend to June was declined despite current care inspection for integrated children's services). West Lothian's plan will therefore be submitted but may be significantly revised post inspection feedback.

Guidance on Part 1 – Duties of Public Authorities in Relation to the United Nations Convention on the Rights of the Child (UNCRC):

Part 1 places a duty on local authorities and NHS boards to report, "as soon as practicable" after the end of each 3 year period, on the steps they have taken to secure better or further effect of the requirements of the United Nations Convention on the Rights of the Child (UNCRC). The Act steering group have met with Co-Directors from the Scottish Children's Parliament in December 2016 to seek advice about embed a rights based approach across NHS Lothian work, and have embedded their recommendation into our Act Implementation Plan. This is complimented by our involvement of Children and Young People in the creation of our current *'Improving the Health and Wellbeing of Lothian's Children and Young People'* strategy for 2014-2020.

Guidance on Part 4 - Named Person

As described above, the draft guidance on this part of the Act was retracted post Supreme Court ruling for further consideration about how a named person function can work in the boundaries of family privacy law and information sharing requirements. In the Act the Named Person function was to be delivered for children from birth to school entry by the NHS and named professions of Health Visiting and Family Nursing. NHS Lothian already uses the GIRFEC practice development model of exploring wellbeing needs and ensuring families and children are supported and cared for. NHS Lothian already offers families a

named Health Visitor or Named Family Nurses, but not in the legal function of the Act, as this has not in place at present across Scotland. The Act steering group in planning for the previous implementation date of August 2016, had already delivered a training programme and awareness raising campaign across NHS Lothian teams. We await further announcements from Scottish Government to allow us to progress to planning a new implementation date if this is the chosen route. Health Visitors and Family Nurses in Lothian have attended further training on meeting the named person function.

Guidance on Part 5 Child's Plan

As described above, the draft guidance on this part of the Act was retracted post Supreme Court ruling for further consideration about how statutory child's plan processes can work in the boundaries of family privacy law and information sharing requirements. The intended purpose and definitions of a plan were:

- (1) For the purposes of this Part, a child requires a child's plan if the responsible authority in relation to a child considers that—
 - (a) the child has a wellbeing need, and
 - (b) sub- section (3) applies in relation to that need.
- (2) A child has a wellbeing need if the child's wellbeing is being, or is at risk of being, adversely affected by any matter.
- (3) This subsection applies in relation to a wellbeing need if—
 - (a) the need is not capable of being met, or met fully, by the taking of action other than a targeted intervention in relation to the child, and
 - (b) the need, or the remainder of the need, is capable of being met, or met to some extent, by one or more targeted interventions in relation to the child.
- (4) A "targeted intervention" is a service which—
 - (a) is provided by a relevant authority in pursuance of any of its functions, and
 - (b) is directed at meeting the needs of children whose needs are not capable of being met, or met fully, by the services which are provided generally to children by the authority.

Parts 9 -14 of the Act focus on a range of duties and powers that affect those in care and care-leavers. NHS Lothian has duties and responsibilities as a corporate parent. The Act:

- provides for a clear definition of Corporate Parenting, and define the bodies to which it will apply;
- provides for additional support to be given to kinship carers in relation to their parenting role through the kinship care order and provide families in distress with access to appropriate family support;
- introduces continuing care - an entitlement to stay in a care placement up to age 21, from 2015 onwards;
- extends entitlement to aftercare support from 21 to a young person's 26th birthday;
- sets the eligibility for continuing care and aftercare to 'being in care at age 16 or above; and
- puts Scotland's Adoption Register on a statutory footing.

Corporate parenting represents the principles and duties on which improvements can be made for these young people. The term refers to an organisation's performance of actions necessary to uphold the rights and secure the wellbeing of a looked after child or care leaver, and through which physical, emotional, spiritual, social and educational development is promoted, from infancy through to adulthood.

Corporate parenting is not a task which can be delegated to an individual or team. Inclusion in schedule 4 means that the whole organisation (or the staff who support the individual listed) is responsible for fulfilling the corporate parenting duties set out in Part 9.

- (1) It is the duty of every corporate parent, in so far as consistent with the proper exercise of its other functions to —
 - (a) Be alert to matters which, or which might, adversely affect the wellbeing of children and young people to whom this Part applies,
 - (b) Assess the needs of those children and young people for services and support it provides,
 - (c) Promote the interests of those children and young people,
 - (d) Seek to provide those children and young people with opportunities to participate in activities designed to promote their wellbeing,
 - (e) Take such action as it considers appropriate to help those children and young people—
 - (i) Access opportunities it provides in pursuance of paragraph (d),
 - (ii) Make use of services, and access support, which it provides, and
 - (f) Take such other action as it considers appropriate for the purposes of improving the way in which it exercises its functions in relation to those children and young people

Implementing the Universal Pre-Birth to Preschool Pathway in Lothian – including health visiting and family nurse partnership work streams

Scottish Government issued CEL 13 (2013): Public Health Nursing, Future Focus, which stated that the role of the HV should focus on prevention and early intervention to improve outcomes for the 0-5 year's population. A national Children and Young People's Nursing Advisory Board was established and a new universal pathway for pre- birth to age 5 years created. This has an increased assessment and home visiting approach. This was to commence across Scotland from October 2015, but NHS Lothian will commence incrementally from October 2016.

The Scottish Advisory Board also developed and recommended use of a national HV Caseload Weighting Tool that calculated the numbers of whole time equivalent (WTE) health visitors required to meet the pre-birth to preschool populations needs taking into consideration national SIMD data and the demands of the new pathway and named person.

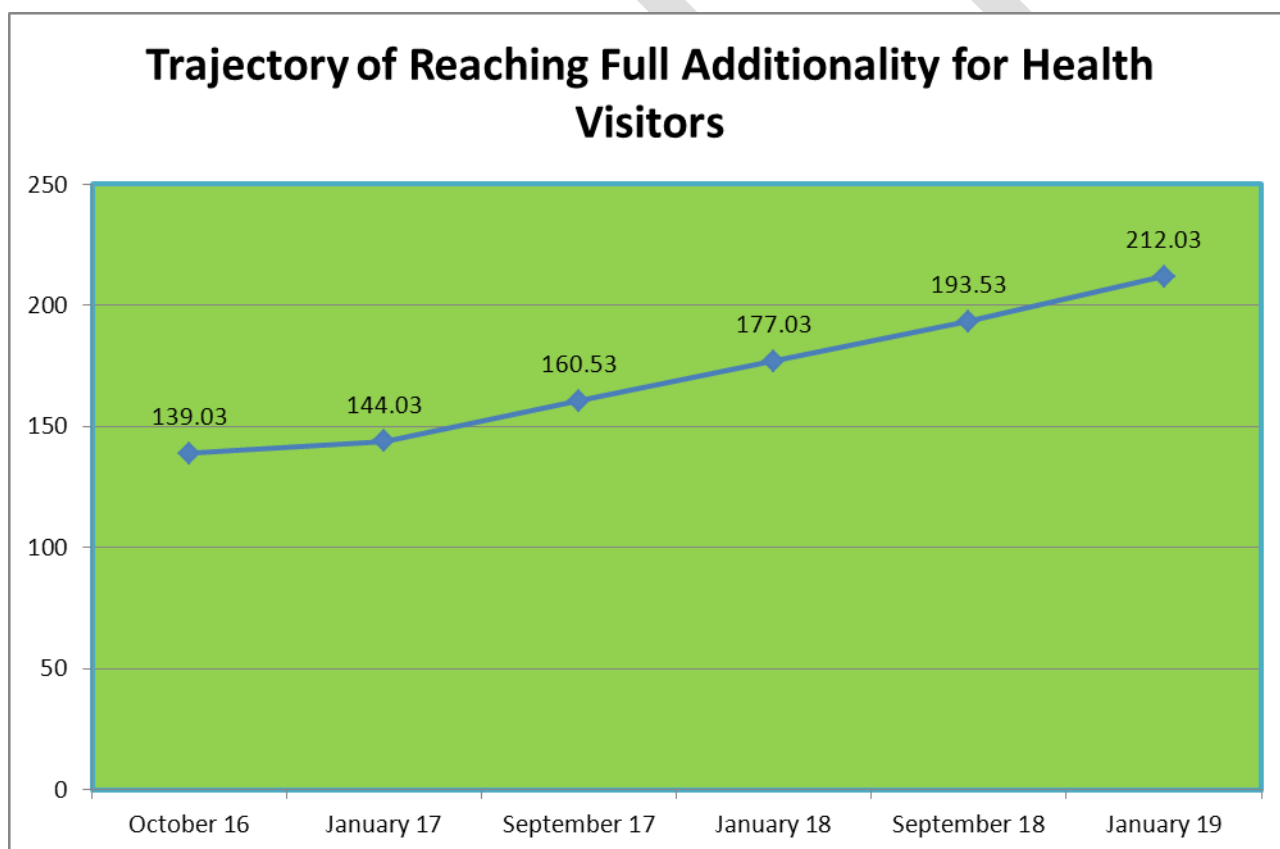
In response to the pending Named Person role, Scottish Government have committed to an additional 500 HV posts across Scotland and allocated £20 million recurring funding over an incremental four year time line (2014 – 18) to NHS Boards. The allocation of funding for 61wte for Lothian was agreed (however this does not include the usual 22.55% uplift to allow for full year service or any savings applied centrally to the bundle allocation.

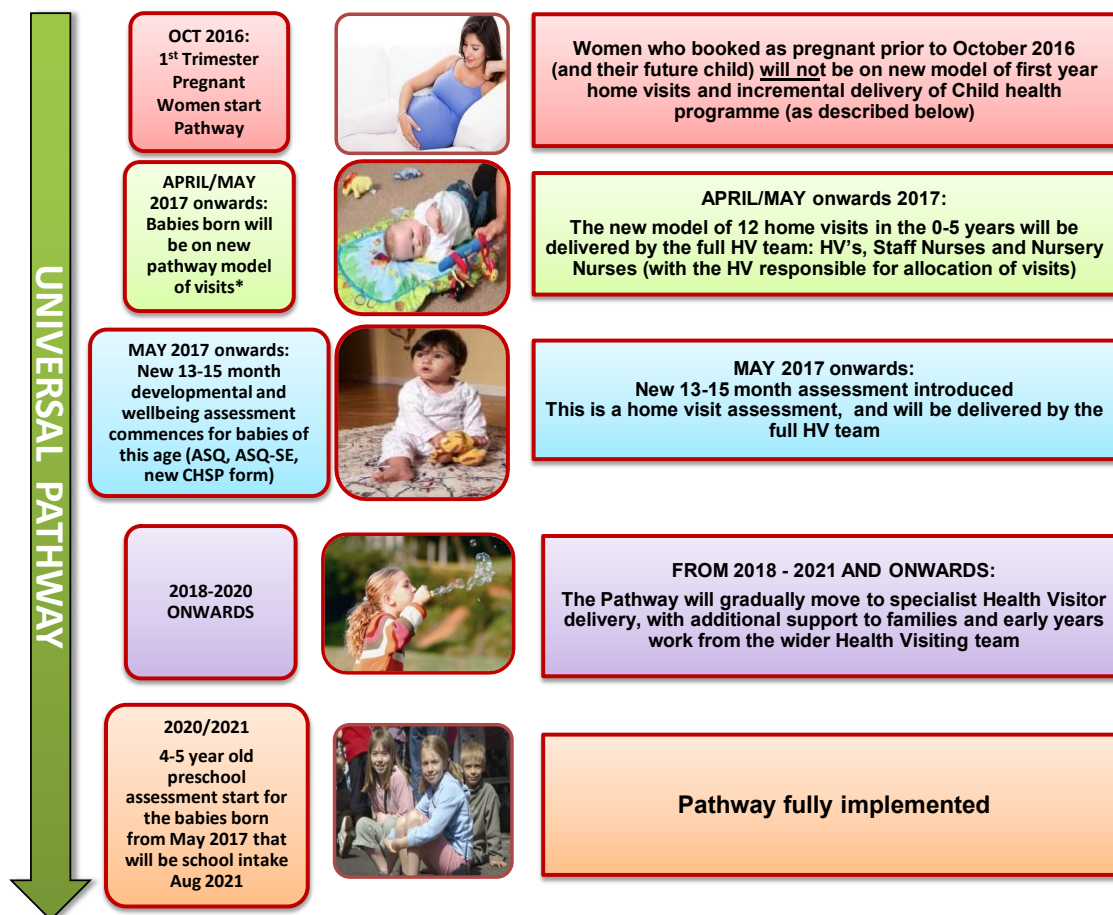
A pathway implements group has been working for a year and has an agreed timescale for implementation of the pathway. The group has a detailed plan on systems, processes, training, workforce and communication that it is working to. Women in Lothian having their 16-18 week scan from October 2016 commenced the new cohort of pathway model. Therefore babies born from April/May 2017 will be the children to commence the new suite

of visits and development and wellbeing assessments. This will significantly increase the prevention opportunities for early years and for family health and wellbeing.

Health visiting teams have undergone training in the new developmental assessments and role and are ready to proceed with this pathway. Nationally the model is for this to be a band 6 Health Visitor delivered pathway (or by a family Nurse if a teenage mother on the FNP programme up until the child is 2). However, NHS Lothian have advised Scottish Government that until 2020-21 that we will require to use our full skill mix within Health Visiting teams to deliver this model, i.e. nursery nurses, staff nurses and health visitors. This will gradually transition out over 2017-20 as numbers of additional health visitors are embedded into operational teams, and staff nurses are phased out within this role.

Health Visiting workforce continues to be a key focus for the strategic women and children's team for 2017-18, with 37 student health visitors in training at present over 2 cohorts, and a further 40 places to commence in 2017-18. This will mean that the vacancies experienced in NHS Lothian, (over 20% pan Lothian in December 2015 and now down to 7-8% in February 2017) will move into a new additionality add phase, where the historic establishment will start to increase from September 2017. This will then rise each year till we reach full additionality at a predicted point in 2020-21.





Family Nurse Partnership (FNP) has been fully rolled out across Lothian (having commenced fully in the last CPP area of East Lothian in April 2016). Across NHS Lothian there are approximately 280-300 clients per year offered the FNP service.

The concurrent model of working enables the service to reach all eligible teenage first time mothers. The Scottish Government are delighted that the concurrent model of working in Lothian is now fully sustained and continue to support the programme delivery. Boards have now been asked to consider offering the programme to additional first time mums up to the age of 24 years if there is capacity to do so within current established teams. During 2017, NHS Lothian will look to test a model of expansion which will involve increasing the age range of eligibility for the programme to age 20 years and under (this has now commenced from February 2017).

Improving the Health and Wellbeing of Lothian's Children and Young People Strategy for 2014-2020

This NHS Lothian Strategy was launched in November 2014. The strategy:

- is underpinned by the Getting it Right for Every Child (GIRFEC) approach
- is aligned with the United Nations Convention on the Rights of the Child
- was widely consulted on and took account of the views of 351 children and young people aged between 3-25
- is outcome focussed and supported by an implementation plan that includes actions to take forward the requirements of the Children and Young People (Scotland) Act 2014 (The Act).

The strategy is based on a tiered approach to improving health and wellbeing for children and young people, from primary prevention (such as supporting pregnant mothers to book as early as possible for maternity care); to early intervention (such as 27-30 months development and wellbeing assessments); to care and treatment when health issues have been identified and providing this in the right place at the right time by the right person.

Aspects of our outcomes focus and improvement methodology work are leading to improvements in main areas (as listed and described below). Our priorities for 2017-18 are to:

- continue to measure the areas we have already started improvement in
- To ensure that this strategy and outcomes measures and complimented by the new 4 CPP statutory children's services plans and outcomes within
- To use our data system to explore gaps and areas of weakness where improvements should be focused on in 2017/18 e.g. uptake and outcomes of 27-30 months in West Lothian

The Best Start – Maternity and Neonatal Care – Scottish Government Five Year Forward Plan for Scotland 2017-2022 and Development of NHS Lothian's new Five Year Strategy

Following a national Review of Maternity and Neonatal Services in Scotland, the Scottish Government published its new five year plan for maternity and neonatal care across Scotland in January 2017.

NHS Lothian had an existing Maternity and Neonatal Strategy was produced in 2009-10 and set out a 5 year plan for services (based on the last Refreshed Maternity framework for Scotland). This plan delivered on many service improvements in both clinical care and in capital planning investments, with modernisation in labour ward at St John's Hospital (SJH), Neonatal Units at SJH and at Simpsons Centre for Reproductive Health (SCRH) and the building and opening of the Birth Centre at SCRH.

The creation of the new NHS Lothian Maternity and Neonatal Care Strategy 2017 -2022 has commenced and will be a key focused area of work for 2017/18. The national strategy proposed a radical change in maternity care, to a model of community focus and a primary midwife with small caseloads. There is also a plan to move to 5 neonatal intensive care units for Scotland, then further reducing to 3, and this will have a large impact on the bed modelling for obstetrics in Edinburgh and cot numbers of neonatal intensive care in Edinburgh.

The strategy steering group have been charged with drafting the Lothian strategy and action plan and this will be processed through to sign off over 2017 to allow an incremental start in changing from a the existing model to the new model.

Some of the challenges in moving to the new model of care are:

Maternity trends: The national birth rate has been relatively static, with around 54,000 births in 2015 (9,463 in Lothian); however the changing health and social needs of the overall population mean that our services are no longer fit for the future. e.g. high levels of long term conditions, mental health problems, older and younger mothers, deprivation, obesity etc.

Care Setting Trends: Nationally, there is a range of midwife-led and obstetric-led care in both hospital and community settings, with 97% of births taking place in hospitals (in 2015 the Lothian home birth rate was 0.93%, 88 births).

Interventions in Labour: There has been a steady rise in interventions in labour and birth, largely from a rise in caesarean sections to 31.1% of all births in 2015 (30.47% in Lothian in 2015), and significant variation in rates across health board areas.

Increased demand for neonatal care: In Lothian we have: RIE 39 cots: 9 intensive care, 8 high dependency care and 22 special care; and at SJH 10 cots, 2 HDU and 8 special care

Workforce Trends: a review of midwifery and nursing (neonatal) staff in NHS Lothian has shown the age of our workforce is going to be a challenge for us within the life span of the coming strategy:

Within midwifery services there are 530.73 whole time equivalent (wte) (652 head count) registered midwives/nurses and of these staff 32% are 50 year of age and over (of which 12% are 55 years and over). In addition, there are 119 wte (152 head count) non registered staff (midwifery care assistants, healthcare support workers etc.) and of these staff 46% are 50 years and over (of which 28% are 55 years and over). The majority of these midwives and nurses are on pension scheme options for retirement at 55 years and therefore the loss in workforce is anticipated to be high within the life span of this strategy. Impacting on this has been reduction in student midwives in recent years. This is now being addressed nationally and there is to be an increase in those training. At present there is 518 student midwives in training across Scotland and there is to be an increase to 191 students, up 4.9% from last year.

In neonatal nursing, there is a national shortage of specialised nurses. In Lothian, 24% of the nursing staff in neonatal are 50 years and over (11% of these being 55 and over).

Children & Young People Improvement Collaborative (CYPIC)

The Scottish Government launched CYPIC in November 2016 at a national eLearning set. There has been no formal approach to Community Planning Partnerships (CCPs) or chief Executives of NHS Boards or Councils to ask them to buy into this approach and work to the new revised stretch aims.

NHS Lothian works within 4 CPP areas and children and young people partnerships and therefore is a partner in 4 CYPICs locally.

We have created a Pan Lothian CYPIC group to share learning across Lothian, and to look at focused areas of improvement that may benefit all parts of Lothian. This group has membership from the 4 CPP areas and qualified Improvement Advisors within NHS Lothian that studied under the EYC programme.

Children and Young People Allied Health Professional Programme for 2017-18

Allied health professionals working with children and young people, are similarly trying to alter their model of approach in working more upstream in prevention work.

Ready to Act, the first Children & Young People (CYP) AHP services plan in Scotland and was launched in January 2016. Ready to Act is a transformational plan for CYP, their parents, carers and families requiring support from allied health professionals (AHPs). It is the first plan to focus on AHPs working with CYP in Scotland and connects to the current policy and legislative context for CYP in Scotland, supporting AHPs in their duties in relation to the Children and Young People (Scotland) Act 2014. The plan was based on a consultation with the public, the workforce, partners and stakeholders across health, social care, education and 3rd sector.

The plan delivers on key actions from the AHP National Delivery Plan and will contribute to the developing active and independent living improvement programme (AILIP), highlighting the critical place that addressing CYPs health and wellbeing has on later life chances and experience on their future use of health and social care resources.

The plan sets out five key ambitions for AHP services for CYP based on the outcomes they, their parents, carers, families and stakeholders told us mattered in their lives.

These are:

Issue	Ambition
Participation and engagement	Children and young people's views will be asked for, listened to and acted upon to improve individual and environmental well-being outcomes and AHP services.
Early intervention and prevention	Every child will have the best possible start in life, with AHP services using an asset-based approach to aid prevention through universal services and supportive nurturing environments at home, nursery and school.
Partnership and integration	Children and young people, their parents, carers and families will have their well-being outcomes met at the most appropriate level through the creation of mutually beneficial, collaborative and supportive partnerships among and within organisations and communities.
Access	All children and young people in Scotland will access AHP services as and when they need them at the appropriate level to meet their well-being needs, with services supporting self-resilience through consistent decision-making.
Leadership for quality improvement	Children and young people, their parents, carers and families will experience services that are led by AHPs who are committed to a leadership and quality improvement approach that drives innovation and the delivery of high-quality, responsive, child-centred care.

The plan creates a map for all AHP services for children and young people and provides an opportunity to reach families we are not currently reaching. The achievement of the ambitions will deliver transformational service change building on best practice in partnership with parents and others and with effective strategic support.

A clear national reporting and evaluation framework including metrics, targets and timescales is being developed to support local implementation in conjunction with the AILIP framework.

Lothian has a local Children & Young Peoples AHP improvement forum/hub to support transformational service delivery and is involved in national and local work streams & tests of change. Request for assistance pathways are in revision across a number of AHP services and there is ongoing development of universal and targeted approaches to support early intervention and prevention.

Reprovision of the Royal Hospital for Sick Children (RHSC) and Department of Clinical Neurosciences (DCN)

The new RHSC and DCN will provide a modern 'state of the art' hospital, specifically designed around the needs of patients in a modern and efficient environment. The building will be co-located at the RIE and will enable Children's services to provide enhanced age appropriate services. The reprovision also provides the opportunity for enhanced redesign of current service and review of clinical capacity for regional and national services such as paediatric intensive care. Detailed work has been undertaken to identify the changes required in workforce numbers and these are in the process of being reviewed with the other boards across the region. There will be increases within both the clinical workforce as a result of additional capacity within both the RHSC and DCN and also within the support services workforce that will service the building.

- RHSC will move clinically into the new site to go live in February 2018.
- Significant service redesign work continues in advance of move, to work within the Sophie house of care model to have some services in community child health hubs in localities rather than at the new RHSC site. In 2017-18, work is commencing on this hub model in South West of Edinburgh at Wester Hailes.

3.2.2 Primary Care

NHS Lothian is committed to rapidly modernising its primary care services in order to increase their resilience and sustainability, and this section of our LDP summarises the actions we are taking to do so. The vast majority of the work is being taken forward by individual HSCPs but we intend to coordinate this through our Primary Care Programme Board, jointly chaired by the NHSL Executive Medical Director and Chief Officer of East Lothian IJB.

Pan-Lothian actions

GP Recruitment and Retention

NHS Lothian is seeking ways to enhance the profile and visibility of Lothian as a place to live and work to support recruitment and retention of GPs. A first step has been to commission and review a 'testing the market' package which has been supported with £35,000 funding. A survey has been commissioned to seek views on the following areas:

- Promote relevant aspects of Wisedoc scheme, i.e. workload for sessional locums, payment and Continuous Professional Development (CPD) support;
- Consider offering locum sessions to retired GPs that consist only of face-to-face consultations;
- Discuss the burden of appraisal of retired GPs with the Lothian GP Appraisal Adviser and Deputy Adviser;
- Consideration should be given to a local support scheme for retired GPs to who may provide sessional locums This could include CPD events, study groups and

organisational support e.g. Weekly email, mailing lists, distribution of Prescribing Bulletins, BNFs, etc;

- Review the requirement for GPs to do an average of one session per week in clinical practice order to remain on the Performers List and what safe alternatives or modifications there may be;
- Consider promoting OOH work to peri-retiral GPs

A Lothian GP recruitment and retention group has been convened who will review the survey outcomes and the national salaried GP contract to maximise the benefits of the contract arrangements to support recruitment.

The Scottish Government have started a project on a national GP Recruitment website to promote GP vacancies, as an alternative to Scotland's Health on the Web (SHOW) which will include photographs and videos to showcase living and working in Scotland's cities and rural areas.

Primary Care Premises

Improving General Practice Sustainability and Practice Premises

A number of GP premises replacement and improvement projects to modernise and improve general practice sustainability have commenced during 2016-17 supported through capital investment totalling £34.7m.

The following table confirms the completion dates of the projects underway:

	HSCP	Capital Cost	Completion Date
Allermuir Health Centre	Edinburgh	£7.3m	August 2017
Blackburn Partnership Centre	West Lothian	£8.2m	September 2017
Leith Walk Surgery	Edinburgh	£1.1m	May 2017
Loanhead Surgery	Midlothian	£2.7m	August 2017
NW Edinburgh Partnership Centre	Edinburgh	£12.1m	October 2017
Prestonpans Health Centre	East Lothian	£1.9m	April 2017
Ratho Surgery	Edinburgh	£1.4m	November 2017

In addition to the above the Lothian Capital Investment Group has approved investment of circa £5m on a number of small primary care schemes during 2016-17. Additional investment has also been required to resolve lease and ownership issues with a number of GP practices.

In addition to the 2016-17 premises projects outlined above, further work is in the pipeline to deliver:

- New Leith Walk Surgery (£1.2m)
- New Newtongrange GP Practice (£0.3m)
- New Ratho Surgery (£1.3m)
- South Queensferry additional accommodation (£0.3m)
- Minor Premises Improvements (£0.3m)

Planning is underway for work to relating to the following practices:

- Cockenzie Health Centre
- Newton Port Medical Centre in Haddington
- Edinburgh Access Practice

- Gamechanger (in partnership with Hibernian Football Club)
- The Leith Community Partnership Hub
- Whitburn Health Centre.

GP Cluster Quality Work

The aim is for the clusters to promote peer led quality improvement and more responsive working based on professional values. The expectation is that in time clusters will have external as well as internal influence. Cluster quality leads are being appointed across Lothian – six of seven posts have been appointed to in Edinburgh, all three in East Lothian, one in Midlothian and two in West Lothian.

Cluster quality working is being supported by NHS Lothian Quality Directorate. Lothian wide meetings are taking place to support communication, share experiences and project clinical input is arranged to take place in April 2017.

District Nursing

There is a nationally-recognised challenge inherent in the District Nursing (DN) workforce, particularly in recruiting to band 6 caseholder level. Within NHS Lothian there is a funded establishment of 89.18 WTE B6 district nurses across Lothian with a vacancy rate of 17.7% as at January 2017. This vacancy rate is significantly higher in Midlothian and Edinburgh with additional pressures from maternity leave and sickness absence. The situation is exacerbated by experienced Band 5 staff leaving District Nursing teams for promoted posts within other services where a post-registration qualification is not required, such as general practice, within acute hospitals, or elsewhere.

We are also aware that there are significant challenges associated with the demography of the current workforce, with approximately 47% of Band 6 and 7 district nurses being eligible to retire by 2021. Most district nurses have retained NHS 'special status' and therefore could potentially retire at age 55 years. Staff retirement plans are personal to them and therefore there are limitations to the exact predictability that can be applied to estimate the loss of workforce per year moving forward. Regardless, there is clearly a significant challenge to the sustainability of the workforce, which in turn increases the pressure on general practice. Our human resource and workforce teams, in partnership with staff-side organisations, exploring what could be done to help staff members who wish to retire from full time roles as district nurses or practice teachers to return in part time or more flexible roles.

Weekly telephone huddles with the Executive Nurse Director NHS Lothian, IJB Chief Nurses and Clinical Nurse Managers have been set up to monitor progress against specific actions and ensure risks are regularly monitored. Summaries of the huddles are shared with the Health and Social Care Partnership Joint Directors. A paper will be taken to the NHS Lothian Healthcare Governance Committee in March 2017 to provide an update and give assurance re patient and staff safety.

NHS Lothian launched a UK wide recruitment campaign combining professional journal adverts, web based targeting, plus SHOW advertising. This has, unfortunately, resulted in no B6 vacancies being filled. In addition, a higher proportion of new recruits to community staff nurse posts are newly qualified staff with limited nursing experience, who require higher levels of direct and indirect supervision for longer periods as they develop their skills and competencies to work independently in a community setting.

In 2016-17, eleven trainee district nurses were funded and recruited to undertake their PG Dip in Person Centred Practice at Queen Margaret University (QMU), Edinburgh. Six of these of the trainees were funded with recurring funding within HSCPs. The additional five were funded with non recurring funding from NHS Lothian corporate nursing as a measure to address these pressures. However, this number is inadequate to fill the current and pending gap across Lothian. We would need to train at least 15 students per year for the next 3 years. This is based on the current and predicted vacancy factor within the services based on the past 12 months data.

In addition, all of the district nursing students require supervision from a Band 7 Practice Teacher (PT). There are currently 8 PTs across Lothian (of which 6 will be eligible to retire in the next 5 years). Five additional PTs are currently being supported to undertake the course at QMU. It will be essential therefore that we can double run the current District Nursing programme to achieve this number and sustain this for the future against normal attrition levels. The Executive Nurse Director and HSCP Chief Nurses are working to progress this. An incremental modular programme is currently being developed as an alternative to the 9 month QMU programme which will enable B5 nurses to gain the knowledge and skills required which will provide an alternative route for staff to gain the qualification.

In recognition of the changing demands on District Nursing and Practice Nursing the Chief Nursing Officer for Scotland commissioned a review of Community Nursing for Health Visiting, District Nursing and Practice Nursing (2016). The final recommendations from this review are still awaited.

Meetings have been held with all district nursing staff across each part of Lothian to enlist their support to manage the current situation corporately and to learn from them their thoughts and ideas on how to support the workforce and other potential solutions to support the service.

Advanced Nurse Practitioners

The nature of clinical practice in the community has changed significantly over the last decade. In order to complement the contribution made by district nurses we also need to increase the number of Advanced Nurse Practitioners (ANPs) working within the community setting.

There are currently 14 ANPs in training for Primary Care within Lothian to support primary care sustainability. However there is no defined plan for additional ANPs across the District Nursing services or how such roles will interface to provide a seamless service delivery for patients and so this is a priority for resolution during 2017/18.

Primary care actions being undertaken by individual Health and Social Care Partnerships

Edinburgh HSCP

In terms of District Nursing, EHSCP is progressing the integration of the Day and Evening nursing services. This model will help to ensure more efficient use of resources and

maximise the potential of the workforce and deliver improved outcomes for patients. EHSCP is also looking to maximise the existing workforce profile and work closely with pan-Lothian initiatives to ensure that technology, education, and workforce planning are all aligned to support the development of new, sustainable, models of care. Edinburgh is also closely considering how ANPs could further support admission avoidance and rapid discharge.

Consideration will also be given to the use of Liberton Day Hospital and Leith Community Treatment Centre to identify services and diagnostics can be used to manage more people in community settings.

Ensuring a sustainable model of primary care is a key area of focus within the Health and Social Care Strategic Plan for Edinburgh in recognition of the significant challenges in maintaining GP capacity. A number of actions have been taken during 2016-17 including:

- The deployment of 94 sessions of direct pharmacy support to Edinburgh Practices agreed through the 8 GP clusters
- The use of Scottish Government Transformation funding to support practices in difficulty to innovate with new roles which directly support workload capacity at practice level

The experience of supporting practices with new ways of working has been developed into a proposal which combines Transformation funds, NHS Lothian funding and practice contributions to develop a sustainable and proportionate flexible workforce pool to replace circa 10% of medical capacity to compensate for current 'overheating' or steady population growth and demand of 1% per annum.

In respect of practice premises:

- 4 new premises (5 practices) will be occupied in 2017/early 2018.
- 1 practice had an 'intermediate' scheme (Liberton).
- 20 practices have had minor schemes over last three years.
- Circa 20 practices have had grants to facilitate list expansion of 500 or more over last 3 years.
- 1 practice relocated to new premises.
- 1 practice will be dispersed in 2017, partly using new premises capacity and further small schemes.
- Practices have been facilitated to adjust historic boundaries to reflect concentration of their practice premises.
- A full review of the Primary Care Infrastructure plan took place in consultation with GPs after the city LDP was published in September. This produced a proposal for £70M investment over 10 years.

EHSCP is in the process of implementing an integrated structure with multi-disciplinary teams based around two GP clusters in each locality. The cluster teams will provide develop close working relationships with the GP practices in their cluster in order to provide joined up support to those with on-going health and social care needs.

East Lothian HSCP

Currently practices in East Lothian remain relatively stable. While some limitations in GP recruitment have been experienced, support has been given to practices to manage short-term GP absences. Work continues with practices to help medium to long-term business

planning. By supporting growth and stability of practices we hope to ensure practices with stronger business models, which see list increase as a positive, and are more attractive for future recruitment. This engagement has also helped identified the potential for joint working and sharing of resources between practices, and we continue to work on projects to facilitate these principles.

The role of other members of the primary care team continues to be evaluated. Projects to quantify both the volume of demand and the type of presentation in primary care are being carried out. Data gathered from this should help ELHSCP and GP practices in workforce planning.

GP clustering has allowed an opportunity for innovation from individual practices to be shared, thereby improving both quality of care and sustainability of GP Practices. Improvement and change has often been generated from acute challenges in primary care, but sharing of this has not previously been facilitated. Engagement with GP clusters has already seen work carried out on demand, access, administrative burden, and prescribing processes. Sustainability is likely to be improved further by engagement with other clinical team members and East Lothian Health and Social Care Partnership is supporting activity to ensure this happens.

Currently a project is underway to change how the primary care service is delivered in Musselburgh. This is intended to involve joint working across three GP Practices and focuses on managing "same day demand". Work is being carried out in partnership with NHS 24 which looking to support in-hours triage. The project is intended not just to support GP surgeries to focus care on more chronic and complex illnesses, but to ensure structured needs assessment of presentations, and reduce health inequalities, while increasing satisfaction with access to primary care services. Presentations involving mental health symptoms are part of this project and consideration is being given to significantly changing patient pathways for these patients.

Referral pathways into outpatients are also being reviewed. Patients being referred for assessment of possible dementia are currently seen in a hospital outpatient setting. In keeping with an ethos of people being managed in the community as far as reasonably possible, alternative pathways are now being evaluated. Outpatient management of patients with Diabetes is also being reviewed with consideration being given to greater emphasis on locally managed services.

West Lothian HSCP

To support the building of primary care capacity in West Lothian, the partnership will undertake the following actions during 2017-18:

- Develop a workforce plan to delivery primary and community care
- Develop an agreement with the Scottish Ambulance Service to support primary care
- Work with pharmacy to appoint advance skilled pharmacists
- Support GP cluster development

Midlothian HSCP

The Midlothian Partnership's delivery of primary care services is focusing on the following actions:

Reduce the workload on existing practice teams

- A new GP Practice will be opened in existing refurbished premises in Newtongrange
- The Health Centre premises in Newbyres will be upgraded
- Complete the development of a new Health Centre in Loanhead within the Community School campus
- Review practice-catchments to manage the increased demand on practices from the new house-building in Midlothian
- Redirecting patients to other services with the 'Making the Right Choices' communication initiative

Redefining the relationships required for collaborative working between practice teams and other health, care and voluntary services

- Develop closer relationships between GPs and key specialist staff in the acute sector, particularly in relation to Diabetes
- Work with GPs, social care staff and local voluntary organisations in Penicuik to pilot new ways of working with people who are housebound
- Review our local Out of Hours arrangements on a multi-disciplinary basis. We will also contribute to the development of a new model of emergency health care such as out of hours care hubs across Lothians
- Support the established GP-Acute interface programme

Culture Change and People Development

- Provide support to Practices to strengthen the team and improve how services are organised, including input from external agencies
- Continue to fund GP management sessions to create clinical leadership capacity of General Practitioners in Midlothian within the areas of Older People, Prescribing and Mental Health

Create multidisciplinary capacity within practice teams

- Continue to work on a Pan-Lothian basis to train and deploy nurses and trained to an advanced level to strengthen the skill mix in Health Centres
- Develop the role of Advanced Physiotherapy within practice teams
- Evaluate the new services introduced to Health Centres including the MH Access Point in Penicuik and Midlothian Community Hospital; the Wellbeing Service in 8 Health Centres; and a Carers' Advice Service in Dalkeith Health Centre

Better care for individuals, better health for populations, lower per capita cost

- Establish use of the e-frailty index across all practices in Midlothian to support coordination and anticipatory care for people with frailty.
- Work with practices and the public to understand the experience of people accessing general practice services and work with both to improve the experience.
- Implement the local Prescribing Action Plan to manage the expenditure on medicines (approximately £17m per annum) within the allocated budget.
- Work with the newly established GP Quality Cluster to contribute to improving the quality of all health and care services
- Develop a local plan in collaboration with NHS Lothian Oral Health to improve the uptake of dental services by those groups less likely to do so such as people involved in offending.
- Develop a more comprehensive approach to Anticipatory Care Planning

- Continue to develop and implement a public communication strategy

3.2.3 Out of Hours Primary Medical Services

Out of Hours (OOH) primary medical services in Lothian are delivered by Lothian Unscheduled Care Service (LUCS) who cover over 75% of total hours per week- evenings, overnight, weekends and public holidays. Demand on the service has increased by 18% since its establishment in 2005-06.

The service is delivered by a multidisciplinary team including salaried GPs and ad hoc (independent contractor) GPs. The current ratio of ad hoc to salaried GPs is around 50:50. There are significant difficulties in recruitment and retention of both ad hoc and salaried GPs by LUCS. Although previous shortages were limited to specific periods such as Christmas and summer holidays, there are increasingly regular occasions when bases have to run on less than a full complement of staff, offer a reduced service or even close for short periods.

Anecdotally there appears to be an overspill of work from day time GP practice presenting to the OOH service. This may be a reflection of the difficulty that patients may have in accessing daytime general practice.

NHS Lothian and the four Integration Joint Boards (IJBs) in Lothian have developed draft proposals to transform local urgent care services during the out of hours (OOH) period.

Lothian Unscheduled Care Service (LUCS), on behalf of and with the four IJBs, has reviewed a self-assessment plan of urgent care in the OOH period and areas for improvement have been identified in line with the recommendations in the Ritchie Review². This review has informed the strategic work streams and the Lothian IJBs and NHS Lothian will focus on how to transform local urgent care services and these are described in the Transforming urgent Care submission.

Within Lothian the four health and social care systems, though interconnected, will develop differently under the leadership of their IJBs. This submission responds to the Ritchie report by developing OOH provision that fits well within each partnership's health and care services.

One of the main difficulties in developing an action plan for OOH is that we don't know what we don't know, we are not necessarily aware of how other areas in Scotland practice and what areas of best practice we could "borrow" and implement in Lothian.

The Review funding offers space and time to seek out best practice and to test whether alternative approaches would work within the LUCS service and what the cost and service delivery benefits would be.

A number of the proposals outlined below aim to provide the time to source best practice and knowledge from other sectors. It is also essential to involve and listen to others working in or requiring care in the OOH period so that we ensure that what we develop is embraced by all and works well for our service, patients and other stakeholders.

² <http://www.gov.scot/Topics/Health/Services/Primary-Care/nrpcooh>

This document outlines the range of initiatives that will be tested by LUCS and partners. The proposed initiatives are listed below.

Outline of Proposed Work streams

Initiative	Title
1.	Urgent Care Resource Hub (UCRH)
2.	URCH – Mental Health service model
3.	URCH – Pharmacy service model
4.	URCH – AHP Therapy service model
5.	OOH Nurse Practice – enhanced service model
6.	OOH General Practice – Induction training
7.	URCH – Non-Clinical Staff – Training package
8.	OOH Infrastructure & Logistics

A dedicated programme manager will be required to progress initiatives 1 and 2; a job description has been developed and is currently with recruitment.

LUCS management have had 2 meetings with Pharmacy colleagues and 3 areas have been highlighted for testing, these include upskilling local community pharmacies working OOHs, improving understanding and communication between community pharmacies and OOHs services and placing a prescribing pharmacist within the LUCS hub to manage both medication request and a number of minor illnesses.

There has been considerable work within LUCS nursing teams and we now have a senior team of 5 Advanced Nurse Practitioners (ANPs), a programme of team meetings and enhanced practice plans are in place for testing nurse telephone triage.

NHS Lothian and partner organisations are hosting a national primary care out-of-hours services peer review visit on 29 March 2017. The visit programme includes an overview of the out-of-hours primary care services in Lothian and future plans, discussion with patient and service user/carer representatives and LUCS operational staff and will include a visit to a Primary Care Emergency Centre (PCEC).

3.2.4 Pharmacy Services in Primary Care

“Pharmaceutical care for people involves the responsible provision of drug therapy to achieve agreed outcomes that improve a person’s quality of life. From pharmacy this requires a person centred approach that supports shared decision making with people, often with their carers, and the wider clinical and care team.” - Rose Marie Parr, Chief Pharmaceutical Officer for Scotland

Prescription for Excellence (PfE) supports the Scottish Government’s 2020 Vision Route Map, the Quality Strategy ambitions and Realising Realistic Medicine.

Lothian Integration Joint Boards have referenced Prescription for Excellence and the role of pharmacists within their strategic plans. Pharmaceutical Care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists, and their technical support staff, to work in partnership with the people we care for and other health and social care professionals to obtain optimal outcomes with medicines and eliminate adverse events whenever possible. People regardless of their

setting should receive high quality pharmaceutical care. This is particularly important for people with complex health issues including multi-morbidities and those living in care homes.

The emerging New Models of Pharmaceutical Care aim to support delivery of changes in primary care across Pharmacy and general practice medicines services as follows:

- Access to safe, flexible and responsive pharmaceutical care services where and when required
- Pharmaceutical care designed around the needs of patients, offering the right decisions at the right time
- Informed and engaged patients
- Pharmaceutical care designed around the needs of patients, offering the right decisions at the right time
- Informed and engaged patients
- A consistent approach to delivery across NHS Lothian which is sustainable, flexible and resilient

Our Primary care pharmacy teams working in and with general practice continue to drive forward strong formulary compliance, continue to make more challenging Prescribing Indicators attainment and make the available prescribing data easier to visualise and interpret (through dashboard). The integrated care clinical pharmacy team are supporting new and on-going initiatives around supporting early discharge and preventing admission of the Frail Elderly population.

Moving forward the plan is to ensure pharmacists are working with clinical colleagues to enable patients to maximise benefit from their medicines.

- Increased access and availability of pharmaceutical care in and out of hours
- Increased clinical capacity of the pharmacy workforce
- Pharmacist integral to the multi-professional team
- Enhanced person centred pharmaceutical care
- Enhanced confidence in the pharmacy profession
- Using our expertise to inform safer use of medicines
- Improved access to patient information for pharmacy teams
- Optimised use of technologies for improved service delivery
- Services designed to meet population needs

Primary Care Transformation – Building Clinical Capacity

In 2016-17, we have continued to develop, implement and enhance the existing Integrated Care Clinical Pharmacy teams across the Health and Social Care. The aim is for the clusters to promote peer led quality improvement and more responsive working based on professional values. The expectation is that in time clusters will have external as well as internal influence i.e. influence health and social care partnerships, NHS Lothian and the voluntary sector.

Prescription for Excellence monies have been utilised to put in place the infrastructure to maximise the benefits from the primary care fund team. The money being used for pharmacists, pharmacy technicians and additional infrastructure that supports the development of these roles across NHS Lothian.

The primary care transformation funds have been utilised to recruit additional pharmacists in line with national developments having advanced clinical skills training or those undertaking the training.

The intent is for them to work directly with GP practices to support the care of patients with long term conditions and so free up GP time to spend with other patients.

Recruitment to 22.5 WTE new pharmacist posts plus a further 3.4 WTE pharmacy technician posts has been completed and all are now in post. In light of these appointments and in conjunction with the 5 WTE from the February 2014 funding obligation on NHS Boards, we anticipate having 161 clinical sessions per week to offer GP practices. The division of this was agreed at our Health and Social Care Partnership Joint Management meeting in June 2016. On estimation of 4 clinical sessions per practice per week this would amount to work across up to 40 GP Practices.

Pharmacists are linking with the practice clusters. Systems are now in place which allows GP's and their multi-disciplinary team to refer patients in Lothian who require access to a GP Clinical Pharmacist.

The team continues to support the delivery of polypharmacy reviews of patients in care homes and living in the community.

The Polypharmacy Teach and Treat Clinic established at the Craigmillar Medical Group Practice in Edinburgh is well established and the model is now being rolled out to each of the Health and Social Care Partnerships / localities to continue to deliver and further implement Teach and Treat Clinics, across the partnerships in 2017-18.

The purpose of the 'teach and treat' post(s) is to provide a clinical governance platform for the roll-out of the Lothian wide polypharmacy service. The current post has established a self-assessment training tool and set up links with medicine of the elderly hospital pharmacists/consultants and outpatient clinics who have agreed to provide an opportunity for training if required.

Clear processes are being developed and implemented to document and agree initiatives with practice staff. This may be fairly narrow initially and broaden out as good working relationships develop and confidence builds up.

In addition, 19 Independent Prescribing Clinics are delivered from community pharmacies in Lothian. Currently different specialist clinics are delivered e.g. one model is pharmaceutical care delivered to include International Normalized Ratio (INR) monitoring and warfarin prescribing. Each of these will be reviewed for consideration of rolling out wider. Each Independent Prescribing Pharmacist involved in these clinics has responded positively to calls for their clinics to evolve and use additional capacity to undertake polypharmacy medication review. We will continue to review these clinics through 2017-18

The Pharmacy Technician Carer support worker project which is funded through Edinburgh and Lothian's Health Foundation provide guidance and advice on both pharmaceutical issues and carer support needs following hospital discharge is now well established. The post based on the Medicine of Elderly wards at Western General

Hospital provides the carer and the person they care for, with medication related help in a process of transition from the hospital to the community.

- Prepare medication charts on discharge
- Follow up phone calls to the carer within 48 hours after patient discharge
- Home visits
- Help to organise and review medication stored at home against the discharge letter
- Organise repeat prescriptions, deliveries in the community

The integrated clinical pharmacy team are attending the relevant training courses on offer from NHS Education for Scotland (NES) to support their development towards advanced pharmacist practice. These include Core clinical skills programme, advanced practice workshops and where required the IP course. We have 9 IP/advanced clinical pharmacists in the team with the remaining team members at the relevant stages of their development programme.

2017-18

The Pharmacy Service in Lothian is an integrated service and building capacity in GP practices will require support from all sectors, across primary care, acute care and community pharmacy.

Across 2017-18 the primary care pharmacy team and newer general practice pharmacy posts will work closely together to deliver clinical support initiatives, efficiency initiatives and building capacity initiatives.

We will continue to build on our experience of supporting General Practices struggling with GP workforce issues. We will work with practices in a phased approach, in order to establish relationships, develop trust and understand the patient population served. It is our intention to tailor our response to individual practice needs, agreeing objectives aligned to the relevant Health and Social Care Partnership strategic plan and performance managing this within a pan Lothian framework. The Lothian framework will continue to develop in line with nationally agreed frameworks. In developing this work, we recognise the need to build a career structure which facilitates clinical support, professional development and line management.

We will continue discussions with Clinical Directors and Management Teams across the 4 health and social care partnerships to identify those practices which are a priority for pharmacist support and to define the number of clinical sessions each practice requires. This work requires to be aligned with the partnerships Strategic Plans.

The team based approach that is now in place will be consolidated whereby a clinical team of lead pharmacist and clinical general practice pharmacists deliver pharmaceutical care to a cluster of GP practices. The Lead Advanced Clinical Pharmacist will have a clinical session commitment including involvement with Teach and Treat clinic. This may amount to 6-7 clinical sessions per pharmacist. These colleagues also have leading/co-ordinating and service development responsibilities. Each of the clinical team members is now involved in becoming part of practice teams, building relationships and supporting continued individual patient care. This approach will facilitate the growing of teams to deliver a greater number of clinical sessions within growing sizes of clusters without losing existing relationships with practices or any significant moving of staff.

All of these pharmacists should be independent prescribers with advanced clinical skills or working towards by year 3.

We have continued to engage with an additional 11 pharmacists, delivering clinical sessions, who are qualified Independent Prescribers to continue to deliver this integrated care service. This has afforded us the opportunity to utilise Independent Prescribers who are not currently using this skill.

In delivering work plans it will be important to have a signed agreement with the practice that defines the work to be undertaken, and which identifies a named lead GP and other key staff for the various elements of the agreed work.

These clinical and building capacity initiatives will encompass;

- Pharmacists and their technical teams supporting optimised practice based Repeat Prescribing systems.
- Promotion of Community Pharmacy as a First port of call.
- Supporting safe and effective transfer of care incl. Medicines Reconciliation.
- Pharmacists role in Chronic Disease Management.
- Pharmacists as key part of Multi –Agency- Teams (MATs).
- Pharmacists undertaking Polypharmacy medication review.
- Pharmacists case holding appropriate patients as Independent Prescribers.
- Optimising use of Community Pharmacy Contracted Services i.e. Patient Group Directions for uncomplicated UTI, sexual health services and smoking cessation services
- Supporting mental health and wellbeing. Providing care to people with substance misuse and making use of social prescribing.

We will work to local health and social care partnership and Lothian priorities, contributing to and cognisant of the national approach to enable meaningful and clear outcomes.

It is our intention that as we move into year 2 and beyond that there is an increased emphasis on the delivery of professional clinical practice.

The pharmacy team will continue to progress through the NES training programme on offer – this planned into their personal development plans. The clinical practice guidance document and the Framework for Foundation Training programme for primary care will key.

Prescribing Action Plan 2016-18

The NHS Lothian Prescribing Action Plan formalised actions for 2016-18, to determine clear strategies to support high quality, cost-effective, evidence-based prescribing. The HSCP Prescribing Action Plans have been developed using a joint framework and the individual HSCPs continued to produce local delivery plans that reflected and addressed local variations and pressures. Within this, a discussion about investing in an acute hospital electronic prescribing system was pursued, aligned to the national E-health Strategy.

In developing the plan, the HSCP Prescribing Forum focused on prescribing actions to support NHS Lothian's strategic intent. The plan was developed by the Primary Care Pharmacy Team, NHS Lothian and progressed through the HSCPs Prescribing Forum as the management group with collective responsibility for primary care prescribing.

Key areas in Implementation of Lothian Prescribing Plan 2016-18 are;

- With clinical engagement understanding expenditure and volume of dispensing variation through Data Visualisation – Tableau® dashboard development.
- Improving Lothian Joint Formulary (LJF) Adherence.
- Maximising performance against Lothian and National Prescribing Indicators.
- Support of the Scottish Patient Safety Programme (SPSP) in Primary Care.
- Delivery of the efficiency initiatives

3.2.5 Oral Health

National Dental Action Plan

NHS Lothian responded to the Scottish Government consultation on Scotland's Oral Health Plan. The National Dental Action Plan is due to be published later in 2017, following which NHS Lothian will develop a local action plan to implement recommendations.

Oral Health Care Survey in the Care Homes and Long-stay Hospitals in Lothian

Oral health is integral to general health; oral hygiene should be part of routine daily care and therefore care staff need to have appropriate knowledge and skills to be able to carry out routine oral hygiene and know how and when to refer to the dental team. *Caring for Smiles*, Scotland's national oral health programme, promotes a multi-faceted approach, encouraging enhanced training for staff, promotion of oral disease prevention and equity of access to dental services through increasing dental registration. Poor oral health can lead to pain, discomfort and disease and impact on dehydration and the inability to eat, speak, smile, chew, swallow and convey a range of emotions.

The Scottish Government published their Oral Health Outcome Framework 'to improve the oral health of adults with priority care needs' through a) access to oral health improvement programmes, b) dental assessment and c) referral for prevention and dental treatment for all dependent older people and people with special care needs.

The oral health survey undertaken in 2016 resulted in a number of recommendations which will be taken forward during 2017-18 in collaboration with four Lothian health and social care partnerships.

- Participation in Caring for Smiles programme
- Marking dentures
- Oral health part of admission process to care homes or NHS long stay
- Improved access to routine dental care
- Training on recording dental care
- Documented evidence of dental care
- Information available for staff
- Information available for residents and family about dental services available and accessible to staff in care

Childsmile Outcome Framework

NHS Lothian provided feedback to the Scottish Government in relation to the Outcomes Framework and Performance Measures for Childsmile and going forward development of the National Dental Improvement Plan for the follow up of children with severe dental infection (abscess) or gross caries.

3.2.6 Mental Health Quality Improvement Programme

The aim is to have a comprehensive and effective quality improvement programme in mental health in NHS Lothian by April 2018 in order to ensure safe, effective and person centred care for all. The collective goal is to deliver the right care, at the right time and in the right place for all patients with mental health difficulties, to drive and support the integration of services and improve the standardisation of clinical tools and outcomes across departments. To support this programme, a clinical lead and project manager were appointed in October 2016 and a Mental Health Quality Improvement Steering Group has been established. A stakeholder event was held in September 2016 and in November 2016 a learning event took place in collaboration with colleagues from the East London Foundation Trust in order to share their experiences of quality improvement which involved around 60 staff.

The key priority areas for the programme are:

- Improve the quality of the inpatient care pathway in the context of the reprovisioning of the hospital based Mental Health Services
- Timely access to evidence based assessment therapies and treatment
- To improve the safety and quality of mental and physical healthcare for patients

Improve access to mental health support through roll out of computerised cognitive behavioural therapy services nationally

NHS Lothian is a partner in the national Mastermind programme which aims to increase the availability of computerised cognitive behavioural therapy (CCBT) to people experiencing anxiety and depression. Our programme commences on 1 April.

Effective and sustainable models of supporting mental health in primary care to support national roll out by 2020

A range of initiatives across the four partnerships have been introduced and will continue to be developed over the coming year. These include:

- A weekly open access, self referral “Mental Health Information Station” in the centre of Edinburgh with a range of partners.
- Midlothian – “Access Points” which offer a single point of access and standardised assessment and triage process.
- East Lothian Improved support for people in crisis across a number of different settings across the county and support through dedicated telephone helpline and
- West Lothian - Development of exercise referral scheme and open access groups for people experiencing depression with third sector partners.
- A small scale pilot of a clinical psychologist within GP Practices providing an effective first line response to people presenting with mental health problems, and an alternative from patients accessing the GP had demonstrated positive results for GPs and patients. Work is underway to secure funding to fully test this approach.
- Training in evidence based brief interventions for common mental health problems (Interpersonal Psychotherapy) and for people in crisis, a wide range of staff across statutory and third sector with ongoing supervision from mental health specialist.
- Introduction of Psychological Therapists throughout the workforce who deliver psychotherapy groups in the five identified core therapies with groups delivered in community locations across Lothian.

NHS Lothian has five strategic Public Social Partnerships (PSP) which are transforming how we deliver a range of health improvement, promotion, care and treatment interventions.

- The Wayfinder Partnership is an academic practice partnership between NHS Lothian and Queen Margaret University. The aim of the partnership is to redesign rehabilitation services for people with complex mental health needs with a focus on shifting the balance of care into the community. Stakeholders identified three priorities for the Wayfinder Partnership which has been used to guide the development of the PSP.
- To develop a well-defined Rehabilitation Pathway which responds to individuals' needs, has clear criteria and expectations and supports referrers and service users to make informed choices, is underpinned by evidence and is regularly evaluated.
- To establish effective mechanisms for the joint commissioning of services which includes local authority, third sector, service users and carers in joint decision making. Ensure the provision of community placements meets the needs of rehabilitation service users, providing support which best meets their needs and allows them to progress when appropriate.
- To ensure early identification of rehabilitation needs. Develop standards for access to rehabilitation pathways which are informed by best practice and monitored through key performance indicators with the goal of reducing waiting times for rehabilitation and reducing delays in discharges for patients.

Green space: art space PSP focuses on enhancing the therapeutic milieu of the Royal Edinburgh campus for patients, carers, staff and the general public. This is a creative opportunity to challenge stigma around those with mental health issues and to create robust links to communities, building and sustaining social capital.

The Rivers PSP is an opportunity to bring together a wide range of partners who deliver trauma-informed services. An open access all age's service delivered from a community setting (shared building with long established public library opened in January 2017). The Partnership aims to:

- see all types of trauma working with a number of different providers creating a simple pathway
- provide self referral and drop in capacity
- has no discharge
- provide a holistic model to both multi and individual need.
- provide community connections including GP practices.
- provide an Impartial service
- enable engagement to main stream services

GameChanger is an exciting and innovative Public Social Partnership led by NHS Lothian, Hibernian Football Club and the Hibernian Community Foundation. The aim is to unlock the power and passion associated with football and to make greater use of all Hibernian's physical, cultural and professional assets, to deliver a better, healthier future for the most vulnerable, disenfranchised or disadvantaged in our communities.

Edinburgh Wellbeing - The catalyst for this PSP was service review and redesign to meet the strategic priorities of the Integrated Health and Social Strategic Plan for Edinburgh. There are three themed areas for development and delivery:

<p>Social Prescribing Improving access and supporting people to get help and support as early as possible</p> <p>Information and Advice</p> <p>Peer workers</p> <p>Link workers</p> <p>Community facilitators</p>	<p>Meaningful activities Supporting people to access activities, interests, education, which are meaningful to them</p> <p>Volunteering</p> <p>Employment</p> <p>Arts</p> <p>Ecotherapy</p>	<p>Support Specific supports and treatment for people experiencing mental ill health</p> <p>Psychological support including counselling</p> <p>Support in Crisis</p> <p>Supporting early discharge and providing an alternative admission to</p>
<p>Delivered in places where people feel safe and secure</p>		

This new PSP has the ability to transform not only the service provision resulting in a greater number of partners collaborating to improve outcomes for Edinburgh’s citizens but also to radically transform the way Health and Social Care Partnerships can commission services in the future

Clinical Psychology Posts - Older People’s Services/Other priority areas

With the development of health and social care, we need to organise the clinical services to reflect locality management. This means that services need to be sensitive to local demands and to respond quickly to the needs of older adults who have mental health and physical health conditions who either are looking to avoid hospital admission or are to be discharged from hospital. This flexible service provision fits with ‘Scotts pathway’, the strategic perspective taken within NHS Lothian to support the frail, elderly population with complex needs and psychological morbidity. We recognise that we need to develop ageless service provision across Lothian to better meet the needs of the population, so that care can be more sensitively supported. This approach emphasises the importance of service integration and linking in across health and social care as well as the voluntary sector to better meet patients needs, from mild to more complex presentations.

The new Clinical Psychology posts will:

- Provide specialist/High Intensity supervision to band 8as in Edinburgh in our core therapies Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), Acceptance and Commitment Therapy (ACT).

- With professional lead, in 2017/18 support the implementation of NHS Lothian OA Psychological Training plan for CBT, IPT and ACT and Low Intensity (LI) Behavioural Activation (part of NHS Lothian trainer pod).
- Support and coach Locality Sector Leads and qualified therapists in their delivery of CBT supervision, IPT provision and LI supervision of groups/BA in teams.
- Responsibility for evaluation of training outcomes
- To provide highly specialist psychological treatment to those with complex presentations
- Supervision of CBT therapists and Clinical Associates in Applied Psychology (CAAP)
- Support the delivery of psychological treatments using a Demand Capacity Activity Queue (DCAQ) model with agreed expectations of numbers of treatment sessions to be delivered across the sector to meet demand
- Evaluate the impact of psychological treatment across the service.
- Specialist training and supervision of core therapies ACT, CBT and IPT.

These posts will develop the capacity within a matched care model to provide psychological interventions for older adults supporting a range of services with ageless provision. This will be achieved through supporting training of evidence based psychological treatments and supervision with a focus on those older adults with mild to moderate presentations across health, social care and the voluntary sector.

MSc Applied Psychology in Primary Care (Clinical Associates in Applied Psychology/other relevant roles)

Across Lothian, there is a requirement to provide more primary care based services to deliver psychological treatments for those with mild to moderate presentations across the age range. These additional posts will provide this needed capacity across each sector in Lothian, working closely with providers in the voluntary sector, so that people can be matched to the care they need. This flexibility will also strengthen the local delivery plans, supporting high quality provision of psychological interventions through appropriate systems of governance. The overall objectives of this tier of service delivery will be as follows:-

- Advice/rapid weekly assessment clinics for OAs in mild to moderate category
- Signposting to local services/3rd sector at above
- Run 6 steps for senior stress group, LLLTF group, guided self help project (see HiM project), MIND men's group, CBT for insomnia (classes, short term structured interventions) – in OA settings (local libraries, residential homes, local GP surgeries)
- Work with GP surgery and locality huddles (within health and social care) in collaboration with Sector Lead.
- One to one CBT treatment

Early Psychological Intervention Practice Support Children's Services

There is dedicated clinical psychology time to work with the children's well-being social work team in East Lothian. These sessions will be co-located with the social work team with an emphasis on consultation, supervision and supporting formulations and report writing to inform decision making. (promoting secure attachment and nurturing relationships).

Edinburgh and West Lothian are continuing to deliver Incredible Years (IY) as part of PoPP. Child and Adolescent Mental Health Service (CAMHS) are very fortunate to have an IY accredited Peer Coach. This funding will allow that practitioner protected time to deliver

peer coaching to support and sustain the ongoing roll out of the model promoting secure attachments and nurture of relationships). Alongside this, the rollout of the Connecting with Parents Motivations training to Early Years staff will be supported,

Dedicated time has been provided to support the roll out of the anxiety and depression pathway and to support in partnership with Educational Psychology. Training in Midlothian and East Lothian has taken place with school nurses to enable them to deliver low intensity CBT interventions using the Guided Self Help resources. East Lothian (North Berwick) has appointed a Youth Work post who will also deliver low intensity CBT intervention using the Guided Self-help resources. To support and sustain flexibility to the CBT model protected time will be required to allow ongoing CBT supervision and further training. This will also support a test of change regarding the mental health pathway in the new School Nursing Pathway that has been developed nationally.

Edinburgh Connect – dedicated Clinical Psychology sessions to work with residential staff and foster carers etc (understanding trauma and adverse events plus promoting nurturing relationships)

Meadows – support education for school and health staff around trauma informed work and support the roll out of psycho-education resources such as the newly developed Survive and Thrive resource for teenagers.

We will employ Band 8B and 8A - the phasing of this and WTE is being worked upon.

Roll out of national targeted parenting programme for parents of 3- 4 year olds with conduct disorder

- Roll out of PoPP will continue across the four partnerships.
- There will be Clinical Psychology time to support the work delivered by other staff to parents of children who have a learning disability and restricted eating .(Promoting secure attachment)
- Dedicated time to work jointly with education staff to deliver parenting interventions for parents of children with severe Learning Disability (Confident Parenting)

Plans to deliver new programmes to promoting better mental health among children and young people.

- An extensive review has been undertaken in Edinburgh including participation of over 150 young people who have set out how they would like things to change in order that their mental health and wellbeing is better supported. This will form the implementation of locality working for CAMHS , the development of multi-agency pathways for a range of common mental health conditions and disorders and the development of young adult services. (16 – 25)
- There will be a focus in June 2017 on improving out service response and corporate patterning responsibilities for looked after and accommodated children.
- A detailed action plan to improve the mental health and wellbeing of students across the regions' eight universities and college settings is in place.

Investment (£150m) to improve services supporting mental health set out in the national 10 year strategy

- The strategy is not yet published.
- NHS Lothian has identified a number of groups including veterans, women with multiple and complex needs, young people experiencing first episode psychosis

whose needs require to be priorities and sustainable funding is in place to support current and developing models.

New Royal Edinburgh Hospital

Phase 1 of the new Royal Edinburgh Hospital opened in February 2017. The other wards that will provide support to adults with acute mental illness, old age mental health and intensive psychiatric care needs will be operational during May and June of 2017. The second phase of the re-provision is now underway with an Outline Business Case progressing during the summer of this year.

Midlothian Health and Social Care Partnership's approach to prevention focuses on good physical and mental wellbeing. Examples include the expansion of health and wellbeing services; promotion of safe exercise for cancer and stroke patients; and the weight management programme. Establishment of Mental Wellbeing Access Point to enable open access to mental health support to reduce demand for psychological therapy.

3.2.7 Palliative and End of Life Care

The national vision for palliative care indicated by 2021, everyone in Scotland who needs palliative care will have access to it.

The Scottish Government has identified 10 National Commitments and is committed to working with local stakeholders to:

1. Support Healthcare Improvement Scotland in providing Health and Social Care Partnerships with expertise on testing and implementing improvements in the identification and care co-ordination of those who can benefit from palliative and end of life care.
2. Provide strategic commissioning guidance on palliative and end of life care to Health and Social Care Partnerships.
3. Support the development of a new palliative and end of life care educational framework.
4. Support and promote the further development of holistic palliative care for the 0-25 year age group.
5. Support the establishment of the Scottish Research Forum for Palliative and End of Life Care.
6. Support greater public and personal discussion of bereavement, death, dying and care at the end of life, partly through commissioning work to facilitate this.
7. Seek to ensure that future requirements of e-Health systems support the effective sharing of individual end of life/Anticipatory Care Planning conversations.
8. Support clinical and health economic evaluations of palliative and end of life care models.
9. Support improvements in the collection, analysis, interpretation and dissemination of data and evidence relating to needs, provision, activity, indicators and outcomes in respect of palliative and end of life care.
10. Establish a new National Implementation Support Group to support the implementation of improvement actions.

Pan-Lothian Palliative Care Strategy

The *Strategic Framework for Action on Palliative and End of Life Care: 2016-2021*, was launched by the Scottish Government in December 2015. It heralds a new approach in terms of a vision, aims and objectives, underpinned by a set of national commitments.

It will be important to explore the governance arrangements required to support the development of any pan-Lothian strategy and to also consider how local populations/ needs may best be served through the development of aligned local strategies for palliative care. The Strategic Framework now requires support and action from a wide range of statutory, independent and third sector organisations nationally and locally. We are committed to ensuring that the membership of these groups, as well as the public at large, will be able to contribute to future implementation actions.

Palliative Care Managed Clinical Network (MCN)

The Palliative Care MCN supports the delivery of a person centred approach to all aspects of palliative and end of life care and strives to support delivery of an equitable and sustainable service across the whole of Lothian. The MCN supports the notion of care being provided on the basis of need and not diagnosis and supports individuals to maximise their time spent in their chosen place of care.

The MCN Membership has been refreshed to ensure the engagement of key agencies and stakeholders in the strategic outlook for palliative and end of life care across Lothian and has the benefit of a strong and capable MCN that can best influence and support a step change in palliative and end of life care service delivery in Lothian. The MCN now ensures inclusion and engagement of all Lothian Health and Social Care Partnerships, Acute Hospital services, Hospice representatives as well as a host of other key stakeholders including research and education colleagues, Hospital Based Complex Clinical Care (HBCCC), Healthcare Improvement Scotland, Realistic Medicine colleagues. It also ensures a connection with national developments/ agenda, such as Scottish Government and National Improvement Advisory Group (NIAG).

The MCN will be instrumental in supporting a pan-Lothian/ whole-systems response to the national Strategic Framework for Action on Palliative and End of Life care.

Palliative Care Redesign Programme

The funding for the Lothian palliative care redesign programme is due to come to an end in March 2017. The majority of projects have now either completed or are moving towards the completion phase. A series of Projects have been identified and supported, these are:

- Training and Education for Care Home and Home Care Workers
- Early Identification of Patients Using IT Systems
- Evaluation of the Anticipatory Care Questionnaire
- Workplace Policies for Carers
- Health Promoting Palliative Care
- Hospice service / MCNS redesign
- Lothian Approach to palliative and end of life care
- Capturing Feedback on palliative and end of life care

The evaluation of the programme is split into two distinct aspects: that of qualitative and quantitative evaluation, with two organisations commissioned to undertake the work.

- National Services Scotland, through their electronic Data Research and Innovation Service (eDRIS) team have been commissioned to undertake an analysis of the impact on the wider healthcare system of patients who had been seen by Marie Curie and St Columba's before and after the development of services. Whilst it is

evidenced that there has been an increase in patients and service provision within the hospices, this research will establish the overall health impact of service changes.

- *BrightPurpose* have undertaken a number of service evaluations for Marie Curie. They have been commissioned to undertake a qualitative evaluation, focusing on stakeholder interviews, and the production of a report of the redesign programme.
- The qualitative and quantitative research is scheduled to be completed throughout February and March. Following review of all gathered information, a final report is due to be submitted in May 2017.

2017-18 and Next Steps

Whilst the redesign programme in its official capacity is coming to an end in March 2017, the work does not stop then. The evaluation report is due to be completed by May 2017 with a requirement for sign off of the report from the Programme Board.

- It is proposed to have the final Programme Board in its current state in May 2017 in order to review the evaluation report and to bring the Programme to a close.
- In addition, two projects (Lothian approach to palliative and end of life care and capturing feedback on palliative and end of life care) are continuing into 2017-18. Whilst the programme will have finished, it is both appropriate and essential that a form of governance surrounds this work going forward.
- The Programme is co-sponsored by both NHS Lothian and Marie Curie. Governance arrangements are required to oversee this work and agreement is required relating to who should be providing overall authority for this work and who should provide representation throughout this time period until March 2018.

Palliative Care Service Level Agreements (SLAs)

A number of SLAs are in existence for palliative care in Lothian. The following provides a brief outline of each:

Marie Curie

- Funding is made available for specialist palliative care; specialist palliative medical services; specialist palliative community services including specialist day hospice and outpatient care. Funding is provided for Core Services (plus drugs) – this is paid in two 6 month payments
- West Lothian Specialist Palliative Care – the majority of monies is payable from the West Lothian Community Health and Care Partnership for nursing and admin services. Further monies are payable from the Cancer & Palliative Care Clinical Management Team of Lothian Acute Services (6 Consultant sessions PW in Palliative Medicine and for 50% of out-of-hours cover associated with the West Lothian consultant.)
- NHS Lothian also provides funding to the Marie Curie Nursing Service (including Fast-track), to cover the NHS contribution for the Fast-track element of the service. Further monies are also transferred from the core Edinburgh Hospice SLA as part of the redesign, to enable greater support for non-cancer patients.

St Columba's Hospice –

- Funding is made available for the four types of services provided (specialist palliative care; specialist medical services 24/7; specialist day care; specialist community palliative care nursing service.) in addition to education services.

Other Funding

- Further funding for Medical Education is invoiced directly from ACT funding. This is negotiated separately with NHS Lothian Finance Department and the University of Edinburgh.
- Edinburgh City Health and Social Care Partnership already host the SLA budget for community patients

Going Forward

- Funding and payment methods vary across each SLA. The duration of each of the SLAs is due to end in March 2018
- Negotiations on new SLAs from April 2018 will be led via Edinburgh Health and Social Care Partnership in its capacity as 'host' for palliative care services in Lothian.

Transition Planning and 'Hosting Arrangements'

It will be necessary to ensure that the transition of a number of operational requirements is understood. It will be important to share what any 'hosting arrangements' will mean for each stakeholder and to acknowledge the new group dynamics that will emerge. Included within this tranche of work will include:

- Current and future commissioning arrangements
- Performance review via SLA s
- Consideration of new SLAs from April 2018
- On-going development of the Palliative Care MCN (Role, remit, membership)
- Palliative Care Redesign Programme (mainstreaming/ exit strategies etc.)
- Current and future funding arrangements
- The impact that any new palliative care framework for Lothian on all of the above

These and any other key issues will be taken forward on an integrated basis noting that City of Edinburgh Health and Social Care Partnership takes receipt of the new 'hosting arrangements' from 1st April 2017.

During the run up to this hand over, it will be essential to engage with all key stakeholders over the nature of these new arrangements and the implications for future palliative care service delivery in the respective organisations.

3.3 SECONDARY AND ACUTE CARE ACTIONS

The actions described in this section are specifically referring to the actions that NHS Lothian intends to take during 2017-18. We expect these to be mirrored, where appropriate, in the refreshed Strategic Plans for our 4 IJBs, and indeed we expect that the Regional Health and Social Care Delivery Plan will demonstrate how the Health Boards constituting the East region intend to align their work plans and approaches for the short, medium, and long-term.

3.3.1 Unscheduled Care

Complete Roll Out of Unscheduled Care Six Essential Actions

The 6 essential actions were evident in all aspects of winter planning 2016-17 and for 2017-18 feature strongly in both the NHS Lothian LDP and in IJB Strategic Plans. We also

anticipate that these will be key planks of the Regional delivery plan scheduled for release in autumn 2017.

This year's winter plan was the first fully integrated plan and a high percentage of the funding went into Hospital at Home, Hospital to Home, Community Respiratory Teams, Discharge to Assess, and Virtual Ward and Admission Avoidance Models of Care. This will be continued through 2017-18 as we further integrate our systems, and in particular we see tremendous potential in Essential Action 6 - the right to be cared for at home.

The integrated Unscheduled Care Committee has been established to replace the Winter Programme Board. The meetings are chaired by the Chief Officer for the West Lothian IJB. This committee and collaborative working will establish the 6 Essential Action Improvement Programme across the whole system, while also underlining the crucial interdependency between our Unscheduled and Scheduled Care systems.

A local Service Improvement Team on each acute site inclusive of Analytical support is in place funded by Scottish Government as well as a Pan Lothian Programme Manager for UCC. These local teams are facilitating the roll out of the Daily Dynamic Discharge Methodology to enhance optimum discharge planning seven days a week and early discharges before 12 mid day.

The next stage is to introduce the methodology to the downstream hospital wards in our HSCPs, focussing on;

- Rehabilitation for patients under 65 years, at the Astley Ainslie Hospital for Brain Injury, Orthopaedic, and Amputee care
- Older people's rehabilitation in Roodlands Hospital in East Lothian and Mid Lothian Community Hospital. This enhanced discharge planning approach enacts a Check, Chase, Challenge approach and is evidenced to be particularly useful with complex discharges encouraging a step by step goal setting and proactive approach to end of hospital stay requirements,. (e.g. housing adaptations, transport, care at home needs)

This programme roll out to community hospitals will commence in April 2017.

The impact of these work streams is demonstrated by the improvement in performance against the 4-hour Emergency Access Standard, with a 4.4% improvement between January 2016 (88.4%) and January 2017 (92.8%).

The roll out of the Scottish Government In Out Balance Methodology has commenced where each Medical Ward on each acute hospital site, based on the front door footprint for their site, will drill down the number of emergency beds required. Adequate capacity and demand planning based on local site data. This is work in progress facilitated by the local improvement teams and complimented by the daily dynamic discharge work and the collaborative working in relation to admission avoidance.

1st stage data has been included in our quarterly reporting to the Scottish Government and will be presented to site leadership teams in mid April 2017.

SEFAL (Safe Effective Flow across Lothian) known as the flow centre has been operational since July 2016. This innovative new service is supporting the proactive reduction of batch

delivery of patients who require an assessment at our hospital sites, as well as signposting GPs and Locality Hubs to outpatient slots. As well as sign posting all Care Home requests for hospital assessment to local Hospital At Home teams to enable patients to be looked after at home.

***Enhanced recovery orthopaedics and fracture redesign
(increase national and local capacity to improve care)***

Work streams associated with orthopaedic enhanced recovery and fracture care redesign are now well established within NHS Lothian.

There is an Enhanced Recovery After Surgery (ERAS) Group which meets quarterly and reviews performance in line with the benchmarking from other units.

The Scottish Government have commended NHS Lothian for their good performance at the Getting it Right First Time Review for Fracture Redesign. The fracture pathway is well established in the Emergency Department and virtual trauma triage clinics are undertaken every weekday by Consultants and Trauma Practitioners. This has reduced demand for fracture clinics significantly.

Separation of elective and emergency care

As noted elsewhere in this LDP, the Unscheduled Care infrastructure for NHS Lothian is focussed on improving performance in that stream, thereby improving protection for the scheduled care workstream. This is linked very clearly to the Delivery Plan for Health and Social Care's focus on a 10% reduction in unscheduled care bed-days through reduction in delayed discharges, reduced length of stay, and prevention of admission by working more closely with primary care services.

3.3.2 Scheduled Care

The financial position for the Board remains challenging, with an estimated financial pressure for 2017-18 of £22.4m. This position includes an estimate of £12m associated with maintaining, but not improving current performance.

The NHS Lothian Board is currently in the process of agreeing its financial plan for 2017-18 and is due to discuss the impact of the financial position on delivery of scheduled care with the Scottish Government in April 2017.

NHS Lothian has a long-standing challenge in multiple clinical specialties across its acute sector, whereby demand exceeds capacity. In some specialties this mismatch is significant. In previous years this gap has been filled by investing in additional capacity, either "in-house" through waiting list initiatives and locum provision, use of Golden Jubilee National Hospital or by purchasing capacity from the independent sector. In March 2016, the NHS Lothian Board took the decision to cease the latter in order to mitigate financial pressure, understanding that this would lead to deterioration in performance against the 12-week standard for outpatient appointments, and against the 12-week treatment time guarantee. The table below shows the March 2016 estimate of this deterioration.

Estimated position for NHS Lothian performance, number of patients exceeding 12-week outpatient standard and treatment time guarantee

Category	Position as at 31 st March 2016	Estimated position as at March 2017
Outpatient 12-week standard	7,036	20,009
12-week treatment time guarantee	289	1,057

Following discussions with the Scottish Government in September 2016, NHS Lothian invested £4m in purchasing of independent sector capacity, with the Scottish Government providing a further £2m. As at 31st December 2016, 32% of NHS Lothian's outpatient list was beyond 12-weeks, with 14% of the inpatient and daycase list beyond the 12-week point. A comparison of the position as at 31st March 2016 and the most recent estimate of performance for 31st March 2017 is outlined below.

Comparison NHS Lothian performance, number of patients exceeding 12-week outpatient standard and treatment time guarantee, 31st March 2016 and early March 2017 estimate of 31st March 2017 position

Category	Position as at 31 st March 2016	Estimated position as at March 2017
Outpatient 12-week standard	7,036	Approx 17,000
12-week treatment time guarantee	2,89	Approx 1,400

It is clear we have a number of specialties with long wait pressures.

Outpatient services with most significant long wait pressures:

	> 24 weeks	> 52 weeks
Orthopaedics	1128	0
Gastroenterology	1885	601
Dermatology	207	0
Ear Nose and Throat	678	26

In Patients and Day Cases with most significant long wait pressures:

	> 24 weeks
Urology	247
Orthopaedics	94
General Surgery	44
Vascular Surgery	80

Mitigating Actions for 2017-18

NHS Lothian is undertaking significant redesign and improvement activities to improve the access position over and above additional capacity sourced through internal waiting list initiatives and use of Golden Jubilee National Hospital.

Patient and GP Communication

We are developing our communication with patients where individuals are informed that they have been added to the waiting list, receive contact details for the appropriate booking office so the patient can access more information if required and advised of specialty level waiting times. GPs receive monthly updates on specialty level waiting times.

Clinical Risk Management

Detailed work is underway to identify a clinician based risk assessment framework. We have agreed to work with NHS Grampian to develop a risk management framework; the outcomes from this work will be deployed in the coming months.

Reduce Elective Cancellations

As noted above, all parts of the Lothian Health and Social Care system are now fully aware of the interdependency of unscheduled and scheduled care systems. All of the plans and work in the Unscheduled Care assist in bed occupancy, length of stay, management of capacity and demand, and reducing the risk of cancellation of scheduled procedures for patients due to unscheduled care patients boarding into scheduled beds. Our plan is to continue this work and to reduce the impact on individual patients.

As a prime example of work to date and which we intend to roll out in an accelerated fashion, NHS Lothian would point to work in Orthopaedics. In order to maintain Orthopaedic Surgical flows elective beds have been protected by a new protocol which ensures all patients who are boarded have an MRSA / CPE screen completed and an Estimated Date of Discharge of less than 3 days. The protocol was introduced in January 2017 and there has been a 47% reduction in Orthopaedic cancellations compared with the same time period last year (69 cancellations from 1st January - 28th of February 2016 compared to 36 cancellations from the 1st January - 28th February 2017).

In addition to the boarding protocol, a new service has been developed to expedite discharges by supporting medically fit patients at home after recovery from surgery. Since being introduced at the end of January 2017 the service has saved an average of 4 bed days per day. NHS Lothian has also recognised the requirement to increase Orthopaedic Trauma capacity and from May 2017 there will be 5 additional sessions of Trauma Surgery available. This will help to prevent elective cancellations due to trauma activity.

NHS Lothian will also continue to build upon successful regional planning to support improvement in diagnostic waits through the regional endoscopy unit and radiology services.

Theatres Improvement Programme

NHS Lothian is also acutely aware of the need to ensure that theatre performance is at a "best in class" level. To this end it has a pan-Lothian Theatres Improvement Programme (TIP), which is methodically working through the following workstreams to maximise the use of these assets;

- Workforce – recruitment, training, retention;
- Scotland Patient Flow Analysis (SCOTPFA) – more accurate allocation of emergency theatre capacity, to ensure best flow;
- Hospital Sterilisation and Disinfection Unit (HSDU) – ensuring effective provision of sterilisation services;
- Booking and scheduling – including provision of effective pre-assessment work;
- Culture and performance;
- 7-day working

This programme is well underway and will be maintained through 2017.

In associated work, the long-term objective within the Lothian Hospitals Plan to move short-stay surgery to St John's Hospital needs to be seen as part of a continuum of redesign, with current day-case procedures being converted to outpatients, and inpatients to daycases. The maximisation of outpatient treatment capacity is a key priority for all of NHS Lothian's surgical management teams, in particular

Anticipated benefits of the TIP includes;

- HSDU - reducing cancellations, late starts and finishes due to lack of equipment
- Booking and Scheduling – increase in session utilisation, reduce cancellations, reduce early finishes
- Pre Assessment – reduce cancellations due to patients not being medically fit
- Participations in the National ScotPFA programme sponsored by Scottish Government at the Western General hospital
- Establishment of Quality Improvement projects at the Western General hospital looking at pre assessment and scheduling by the most recent cohort of the Quality Academy
- Review of the process for reviewing and allocating theatre lists

In addition NHS Lothian have:

- Established the Delivering for Patient Group (DCAQ) to monitor performance and work with individual specialties to delivery efficiency improvements against key performance indicators such as sessional uptake, in session utilisation, cancellation rates etc.
- Established a Benchmarking group to review individual specialty performance against preselected peers an national and UK level and suggest corrective action as required.
- Established monthly 'Deep Dive' reviews of theatres performance by Director and the Chief Officer for Acute, scrutinising consultant level data on utilisation and cancellation rates focussing on underperforming specialties.

3.3.3 Outpatient Services

NHS Lothian has established an Outpatients Programme Board, which for 2017-18 will be chaired by the Executive Medical Director. This Programme Board has previously delivered improved knowledge transfer for GPs through the RefHelp portal, implemented planned return waiting lists, and improving access to specialist advice without requiring referral.

This programme board has been given renewed momentum by the publication of the national strategy *The Modern Outpatient*. As a result NHS Lothian has refreshed the Ref Help portal and continues to work with primary care services in Lothian to mitigate the current clinical position and maximise knowledge transfer. In addition NHS Lothian is in the process of transforming its use of everyday technology with a focus on minimising capacity lost through “did not attend”, with texting, “call-back”, Patient Focussed Booking (PFB) and focus on “doing simple things well”.

In addition, the Outpatients Programme Board is taking forward a number of work streams relating to:

- Rolling out Advice Only as an alternative to clinic appointment. In a three month period there were 247 referrals for request only and 590 referrals converted to advice only.
- Implementing Planned Return Waiting Lists. This has started in ophthalmology with a plan to roll out to other services.
- Implementation of Ref Help. 12 key specialities have been identified with Ref Help guidelines updated with GP and Consultant engagement during this process.
- Implementing an outpatient accommodation matrix, similar to the theatre matrix with the aim of optimising clinic room utilisation
- Template Harmonisation roll out. This process includes review of triage categories to ensure reflects demand, and clinic templates and the removal of site specific queues.

NHS Lothian is absolutely committed to transforming the use of all outpatient capacity, with radical redesign of return capacity, in order to support additional new capacity. This will increasingly move to patients having the ability to re-enter the system as required/designed, rather than “follow-up in six months” being the default approach.

Further actions include;

Patient Initiated Follow Up

Patient-initiated follow up (PIFU) is an initiative that allows patients to initiate hospital follow-up appointments on an ‘as required’ basis compared with the traditional ‘physician-initiated’ model. The main principle is to reduce inappropriate regular follow-up appointments. This will progressed throughout 2017, and there has been initial interest shown recently to explore this idea for the Epilepsy Service.

Patient Experience

In partnership with the Outpatient Managers and Service Teams, the Modernisation Team carry out patient experience questionnaires within many of the waiting rooms across NHS Lothian Outpatient Departments. This allows opportunity to engage and consult with patients on emerging work streams, finding out what matters most to them and how their experiences of outpatient services could be improved.

Key Performance Indicators and Monitoring

The Outpatient KPI dashboard has been developed this year and provides information for Clinical and Outpatient Managers that is accessed via Tableau. It provides information on attendances, new : review ratios, % of urgent referrals, DNA rates, outcome rates and

cancellations. On-going performance monitoring is discussed and taken forward via the Operational Group.

The redesign team have also pulled referral data from SCI-Gateway for the full year 2015-16 which has been circulated to colleagues on the Programme Board and Operational Group for review and feedback in relation to how this information might be used to provide some direction on referral management. The use of this data will be the subject of discussion led through the new Benchmarking Group which has been established by the Interim Chief Officer.

Out of Area Referrals

NHS Boards in Scotland have a responsibility to plan and provide health services for the population living within their geographic area. The Scottish Government has recently reinforced that whenever possible, treatment should be provided within patients own health board area.

During 2015-16 almost 10,000 referrals were made to NHS Lothian from other Health Boards and Authorities. Many of those referrals were for services that could be provided closer to the patient's home.

The Outpatient Modernisation Team is progressing a work stream to develop a standardised report to identify all out of area referrals along with guidance on how those patients should be managed.

3.3.4 Cancer Services

NHS Lothian has commissioned a review of the current governance arrangements for Cancer, considering how the vast landscape can be managed in a more streamlined way. The recommendations from this review will be considered and implemented during 2017-18.

The Lothian Hospitals Plan proposes the establishment of a new planning mechanism to support more effective planning of cancer services, chaired by the Medical Director and with broad representation from across the system.

As part of this renewed commitment, and as a result of the work of the Lothian Hospitals Plan, NHSL has worked with Scottish Government colleagues to identify support for NHS Lothian to move forward with the business case for a new **Edinburgh Cancer Centre (ECC)**.

The current ECC is no longer fit for purpose, physically. NHS Lothian has delivered a Strategic Assessment for the replacement of ECC. The move of DCN to the RIE provides the opportunity to clear space on the WGH campus and use this for the new ECC.

However, given the scale of the project to replace ECC, it will be some time before this is operational. There will therefore need to be significant changes made to the fabric of ECC in the meantime;

- Additional LinAc bunkers;
- Redesign and expansion of inpatient ward space;

- Changes to the Ward 1 outpatient service

Part of this will be delivered through patient flow redesign, but there is also a clear requirement for capital investment.

These “transitional arrangements” – and the delivery of the business case for a new ECC – will be the work of a new dedicated project team, working closely with the Site Management, Capital Planning, and Strategic Planning teams.

As part of this commitment, clearly signalled in the Lothian Hospitals Plan, to see the WGH as South-East Scotland’s “Cancer Hospital”, this will also see a range of other services included in the further development of these services, including;

- Clinical genetics;
- Cancer research;
- Maggie’s Centre;
- Symptomatic and screening services for breast cancer;
- Bowel screening;
- Specialist palliative care services (to be agreed with IJBs);
- Specialist cancer diagnostics

Work is underway to finalise what capacity should be made available on the site to accommodate joint working between gynaecologists, urologists, and colorectal surgeons in a pelvic surgery service

3.3.5 The Lothians Hospitals Plan

The Lothian Hospitals Plan (LHP) is the strategic plan for NHS Lothian’s acute hospital sites – The Royal Edinburgh Hospital, St John’s Hospital, the Western General Hospital, and the Royal Infirmary of Edinburgh. The LHP is intended to act as the focal point for the NHS Lothian Board, its staff, the public, the Scottish Government, and planning partners including Integration Joint Boards and other Health Boards, in defining the strategic direction of the Board over a 5-10 year planning timescale.

The LHP is constructed around strategic headlines for each of the four sites, as shown in the table below. These headlines are the focus for the sites going forward. They have primacy over other interpretations but are not exclusive of other needs for the sites (such as medical services);

Strategic Headlines for NHS Lothian Acute Sites

Site	Strategic Headline
Royal Edinburgh Hospital	Edinburgh’s inpatient centre for highly specialist mental health, physical rehabilitation, and learning disability services, incorporating regional and national services
St John’s Hospital	An elective care centre for Lothian and for the South-East Scotland region, incorporating highly specialist head and neck, plastics, and ENT services.

Western General Hospital	The Cancer Hospital for South-East Scotland, incorporating breast, urology, and colorectal surgery
Royal Infirmary of Edinburgh	South-East Scotland's emergency care centre, incorporating a major trauma centre, orthopaedic services, neurosurgery, and children's tertiary care

In addition, the LHP has 3 cross-cutting work streams applying to St John's, the Western General, and the Royal Infirmary – medical, elective, and cancer.

Medical covers services which are now delegated to IJBs to plan and commission. NHSL is developing options for the sustainable configuration of medical services, starting with the acute receiving function. It is anticipated that those IJBs which utilise services in the City of Edinburgh will all ask for a case to be developed for a single receiving unit in the City, incorporating more use of ambulatory care approaches, better liaison with primary care, and more efficient use of staffing. Options are being worked up with staff. This work also focuses on the National Delivery Plan target to reduce unscheduled care bed-days by 10% by 2018, which for Lothian equates to between 175-200 beds.

Elective aligns closely with the national Diagnostic and Treatment Centres Programme, and again focuses on efficient use of staffing resource and clarity for the public and other Boards. NHSL aspires to build on the SG commitment to develop a DTC at Livingston to create an elective centre at St John's Hospital, which would become the default site for all surgery with a length of stay of less than 2 days, with the precise cut-off to be concluded. This site could also incorporate activity from Fife, Borders, Lanarkshire, Tayside, and Forth Valley, and all of these Boards are represented on the NHSL Diagnostic and Treatment Centre Programme Board and the Clinical Reference Group which supports it and brings clinicians together from across the region. In addition, NHSL has a business case in train to replace the Princess Alexandra Eye Pavilion and is examining how to expand Orthopaedic Inpatient Capacity, and both are planned to involve expansion onto the Edinburgh Bioquarter.

Cancer is built around the replacement of the Edinburgh Cancer, the Transitional Arrangements to bridge the timescale between the present day and the new Cancer Centre, as well as considering whether arrangements for cancer treatment on the other acute sites are configured appropriately.

The LHP has been built around the opinions of clinical staff, including their detailed understanding of how staff availability is likely to change over the 5-10 year timescale. More than 500 staff have attended LHP sessions during 2016 and this momentum is being maintained through dedicated quarterly engagement sessions for physicians and surgeons, and working groups mapping the future of each specialty.

IJBs have been involved throughout this engagement process and their evolving Directions reflect this engagement and recognition of their role in planning and commissioning.

Partner Health Boards are closely involved in the detail of the plan and detailed discussions indicate that other Boards can see how their own plans can dock with the LHP, leaving open the possibility of a clear "South-East Hospitals Plan", built around the principles and

structure of the LHP – with IJBs taking the lead on medical services, and elective and cancer plans aligning ever more closely.

The LHP is under discussion with stakeholders currently, and the intention is that a final version will be brought to the NHSL Board in June 2017, incorporating detailed financial modelling of the proposals. This would be structured along the lines of an English Sustainability and Transformation Plan.

3.3.6 Regional Health and Social Care Delivery Plan

Scottish Government Health Department guidance regarding the 2017-18 LDP includes explicit reference to the development of a Regional Delivery Plan for the National Health and Social Care Delivery Plan, and work is on-going at some pace to develop such a regional approach.

The South-East and Tayside (SEAT) regional planning group has begun to reframe itself as the East of Scotland Health and Social Care Delivery Plan. Arrangements are on-going to identify Chief Executive leadership for this Board and to ensure delivery of an east of Scotland plan for end September 2017. Clearly, the Lothian Hospitals Plan provides a solid basis for this work, and the following work streams have been identified;

- Needs assessment and context;
- Primary, Community, and Social Care;
- Prevention;
- Acute services;
- Finance;
- Communications;
- Workforce

Key to this is ensuring, on the one hand, that the model for primary, community and social care is focussed on the sustainable, reliable, consistent delivery of an acute system that operates at 85% bed occupancy, and on the other that the acute system maximises the use of regional assets, both workforce and estates, in both strategic and tactical approach.

The acute stream will be based around identifying 5-7 work streams which are agreed, on the basis of robust risk analysis, Demand Capacity Activity Queue (DCAQ), and a strategic vision, to be fruitful for regional collaboration and development, as shown in the schematic below;

Strategic Headlines	DCAQ	Speciality Assessment
<ul style="list-style-type: none"> • “What [name] is for” • VHK • WGH • SJH • RIE • BGH • Strategic coherence – the whole picture for the region 	<ul style="list-style-type: none"> • “Just the facts” • Fife • Lothian • Borders • Others? • Aligned across region • Regional picture 	<ul style="list-style-type: none"> • “What worries us is...” • Workforce • Fit with Strategic Headline • Duplication and variability • At specialty level within and across Boards • Regional picture

These 5-7 work streams have to be finalised but are expected to include regional pressure points such as ophthalmology, orthopaedics, gastroenterology, opportunities such as laboratories, and strategic priorities such as major trauma, diagnostic and treatment centres.

3.3.7 Diagnostic and Treatment Centres

The Scottish Government, in the Delivery Plan for Health and Social Care, has made a commitment to invest £200m in 6 new Diagnostic and Treatment Centres, opening by 2021. Two of these centres have been committed to NHS Lothian, with one at St John’s Hospital, Livingston, and one on the Edinburgh BioQuarter campus. These are intended to be regional assets to manage growth in demand associated with demographic change across the East of Scotland.

As it stands, NHS Lothian has completed a Business Case for the replacement of the Princess Alexandra Eye Pavilion, and is working with partners in the Scottish Government to move this forward. NHSL is also working collaboratively with regional partners (Fife, Borders, Forth Valley, Lanarkshire, and Tayside) to explore how these centres can, both in the longer-term and in the short-term future, lead to an alignment of management approach and of capacity across larger population level.

3.4 REALISTIC HEALTHCARE

Realistic healthcare supports the concept of person-centredness as defined by NHS Scotland’s Healthcare Quality Strategy:

‘Mutually beneficial partnerships between patients, their family and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making’.

In realistic healthcare, the focus is on how to develop the concept of shared decision making within clinical consultations.

The house of care model has been developed to help us think about what needs to be in place to deliver truly person-centred care and support. As in the definition above, the model is about promoting real partnerships between patients and professionals, supporting

both patients and professionals to enable them to have a “good conversation” about “what matters”, rather than “what is the matter”. Patients need as much support as professionals, if not more.



The house of care model is endorsed by Realistic Healthcare. It is an important metaphor because it reinforces the fact that all elements of the house need to be in place for the good conversations to take place. Shared decision making is an important element of these good conversations. All components of the house need to be there to allow this to happen. These elements are:

- Left hand wall: Support for the patient to have that good conversation with relevant professionals and to manage their health and life generally. This is about more than giving people information. It often requires supporting people to develop confidence and coping skills, and enabling them to recognize and use their own assets.
- Right hand wall: Health and care workforce are committed to working with in a partnership approach with people, and have the skills and experience to engage in “good conversations”.
- Roof: Organisational and supporting processes are established that facilitate rather than hinder good conversations – this often involves establishing longer consultation times, and sharing information with people ahead of consultations.
- Foundation: Resources are allocated in a way which is responsive to people’s needs identified in the care and support planning process, and resources across statutory and third sectors are used as appropriate – this refers to the “More than Medicine” approach.
- Centre of house: Using shared decision making as part of the process, the good conversations are translated into an ongoing care and support planning process, taking account of patient’s mental health as well as physical health needs

maximising their assets and the resources available in health, social care and third sectors.

In recognition of the coherence between Realistic Healthcare and the House of Care approach, a national summit was convened in August 2016 to explore the role of Collaborative Care and Support Planning (the centre of the house) in achieving the aims of Realistic healthcare. Two representatives from Lothian's House of Care Collaboration attended and contributed to the summit.

3.4.1 Lothian House of Care

NHS Lothian continues to lead the House of Care Collaboration in partnership with the Thistle Foundation to support implementation of the approach to deliver more person centred integrated care. The Chief Medical Officer endorsed the approach in her annual report, Realistic Medicine. Strategically, links were established with the Edinburgh and Midlothian Health and Social Care Partnerships Strategic Plans.

In Edinburgh, this led to:

- Additional funding being secured from the Integrated Care Fund to support primary care practices through provision of a Wellbeing practitioner embedded in the practice. Primary care staff refer people with long term conditions to the service who would benefit from the time and skills of the wellbeing practitioner, often in terms of building confidence and coping skills and supporting them to self-manage. In addition, a Locality Development Coordinator has been appointed to explore and develop the supported self- management capacity in the third sector.
- The model being used as the framework to redesign the performance management “rubrics” approach for people living with long term conditions.

The need to change the relationship between statutory, voluntary and independent sector organisations, their workforce and people who use health and social care services through ‘good conversations’ is at the heart of the Health and Social Care Strategic Plan for Edinburgh. Work is underway in a number of areas to support people to take more control over their health and wellbeing. Examples include:

- the development of models of social prescribing with link workers attached to GP practices
- an initiative aimed at making information available to people with learning disabilities in accessible formats focusing on eating healthily, being active, health checks and screening, good mental health and accessing health care
- the establishment of Local Opportunities for Older People in each locality to provide information and advice to older people about what is going on in their locality and support them to make their voices heard

The move to an integrated model of working within four localities with multi-professional and multi-agency teams based around GP clusters during 2017-18 should provide a sound basis from which to support people to take control over their own health and wellbeing.

In Midlothian, this led to:

- High level strategic buy-in to the model with the formation of a Midlothian House of Care Steering Group which coordinates the provision of generic cross-sectoral support to people, with “good conversations” as the common approach.
- Additional funding being secured from the Primary Care Development Fund to roll

out the Wellbeing Service, and create cross sectoral teams of wellbeing practitioners. This approach is being formally evaluated with support from Healthcare Improvement Scotland.

Lothian's House of Care collaboration currently includes:

- 7 GP practices within the British Heart Foundation work stream. The initial £65,000 funding has been doubled and the project now extends until March 2018. The extension is designed to improve sustainability and evaluation opportunities. The seven practices offer the house of care approach to cohorts of patients with multi-morbidity.
- 18 GP practices that are supported by wellbeing practitioners.
- Lothian's Cardiac Rehabilitation service.
- West Lothian's secondary care diabetes service which are using the model as a framework for redesign.
- A proposal to roll out a diabetes house of care project in 6-7 practices in Edinburgh within the next few months.

A cross-sectoral multi-disciplinary Learning Advisory and Resource Group supports early adopter partners through regular reflective learning cycles which identify learning needs and other forms of support and coordinates a menu of training options. This includes the training delivered by the Year of Care Partnership as part of the British Heart Foundation support. Using Primary Care Prescribing Development Funding, a cohort of primary care pharmacists are to receive training on the House of Care approach. The training is also to be offered to others within the primary care team and to a number of practices who will be taking part in the Diabetes project.

A measurement and evaluation team meets regularly and is combining quantitative and qualitative approaches.

A third sector led group, Collective Voice has been formed to support and enable people living with long term conditions to act as Supported Self-Management Champions at operational and strategic levels.

3.4.2 Realistic Healthcare

There is a widely-held concern that 'more treatment' has become synonymous with 'better quality treatment'. Whilst sometimes true, often 'best clinical outcomes' defined in guidelines might not reflect the actual wishes of individual patients. Moreover, these wishes are not always sought or heard properly when discussing treatment options. Factors contributing to this situation are complex.

Individual patients present with varying co-morbidities, psychological and physical frailties, social challenges, coping strategies and support networks. Guidelines, standards and large clinical trials have to reflect the general case of 'best care', rather than what's best for individuals.

The fear of being found in 'breach' of guidelines or standards can be a powerful disincentive against individualised person-centred care. Much of this fear comes from potential criticism by peers, regulators or public figures, and doubts about an employer's strength of support if 'things get tough'. Interestingly, it has been established that clinicians frequently wish for less treatment themselves than they would usually prescribe to their patients.

Developing a more permissive, pragmatic culture that balances the best biomedical outcomes with the wishes of informed individual patients is an increasingly hot topic.

Various terms for these concepts have been used including *Minimally Disruptive Medicine*, *Prudent Medicine* or – when focussed particularly on decision making - ‘*Choosing Wisely*’. Recognising the challenge these issues posed, Dr Catherine Calderwood - Scotland’s Chief Medical Officer- offered the concept of *Realistic Medicine* in her latest Annual Report. In *Realistic Medicine*, Dr Calderwood described an approach to care that combined clinical effectiveness and individualised care and giving far greater weight to the patient’s voice in treatment decision making. The impact of this CMO’s report has been unprecedented; commentary from professional bodies, patient groups, high-profile commentators and the wider public through the media have been overwhelmingly positive.

Realistic Healthcare encourages clinicians to take account of multi-morbidity and the overall burden of care faced by the individual patient and consider treatment strategies in partnership that might minimise that burden. By providing ‘more thoughtful care’ in a holistic fashion, it is argued that effectiveness, experience and other elements of quality can be improved.

A key component of Realistic Healthcare is candid and empathic discussions of treatment options including the option of no, or less, intervention. Patient preference around treatment options needs to be explicitly sought and relies on good communication and mutual trust between practitioner and patient, mutual understanding about acceptable risks and outcomes, accessible information and acceptable health literacy levels.

The degree to which realistic medicine is currently practiced varies across services and professional groupings. For example, the experience of many doctors is that the stimulus to initiate difficult discussions around the direction of clinical care with a patient comes from a nurse or AHP colleague. The vital – perhaps pivotal – roles for nurses, AHPs and other clinicians as champions of realistic medicine should not be underestimated.

There will be significant variation amongst doctors in the degree to which realistic medicine is practiced. Whilst evidence to support generalisations is patchy, there is a strong sense that it is more established component of General Practice than most other specialities. Realistic medicine in Primary Care medical encounters often focuses upon:-

1. Managing risk factors to prevent development or worsening of long term conditions
2. Deciding how far to investigate and treat, including specialist referral
3. Having meaningful conversations about wishes for the future care in the event of deterioration (also known as anticipatory care planning: ACP)

Successful nurturing of Realistic Healthcare will in part depending upon understanding and responding to current variation in practice and resisting a ‘one size fits all’ approach.

Ultimately, for Realistic Healthcare to become a standard component of high quality care, a range of developments will be required. Some will occur as part of a movement amongst staff and patients, some through planned changes to the way we work. Fundamentally the Board can influence all of these events by leading the creation of a more person-centred culture of care within which Realistic Medicine can flourish.

The way forward for NHS Lothian

It is proposed that the core values and approach of Realistic Healthcare are nurtured and ultimately embedded into practice in NHS Lothian being:-

- Creating meaningful opportunities for patients to understand their condition, all treatment options and how each will impact upon them
- Honesty and compassionate candour in what 'realistically' will be achieved from each treatment option in terms that mean something to patients
- 'Permission' for clinicians and patients to agree to a treatment plan that meets the individual patient's needs rather than exclusive application of the 'ideal' clinical care described in guidelines or standards
- Patients to be empowered and enabled to articulate 'what matters to me'; clinicians to be empowered and enabled to listen and understand with compassion

We propose a framework that we believe if developed into a wider programme for transformational change will create the conditions enabling this nurturing process.

There will be a need to engage the wider community of our public, patients, staff and partners to ensure that the primary motivation behind Realistic Healthcare is the provision of high quality, individualised care for patients. This engagement should include ongoing proactive monitoring of the experience of all key stakeholders.

We believe that Realistic Medicine aligns with Scotland's National Clinical Strategy and will complement the *NHS Lothian Clinical Quality Strategy and NHS Lothian Our Health Our Care, Our Future Strategic Plan 2014-2024*, all of which will contribute to sustainable best population health, quality and patient experience.

Key Actions for NHS Lothian

A framework outlining an approach to nurturing Realistic Healthcare in NHS Lothian includes the key actions outlined below:

Clinicians will be supported and encouraged to:

- understand the overall burden (combined impact of illness, prior comorbidities and treatment effects) challenging many patients.
- ascertain patient preference i.e. "What matters to me"?
- question the applicability of evidence-based guidelines and standards for the individual patient and have the clinical confidence through peer and organisational support to deviate from guidelines when they judge that to be appropriate.
- question the added value of proposed investigations, interventions or treatments in the individual patient in the light of knowledge of the 'whole patient'.
- understand the impact of multi-morbidities, make some assessment of prognostic impact of these and judge whether that knowledge shifts the risk/benefit ratio for "usual" treatment strategies.
- understand the burden of treatment and expected impact on the patient.
- undertake shared decision making through explicit and open discussion of treatment options, expected benefits and risks of harm.

Clinicians will need support to deliver the above. This may be provided by:

- Education and training in communication strategies.
- Provision of decision-aids e.g. accessible information from data to help clinicians and patients understand impact of multi-morbidities on overall prognosis and understand the potential impact of treatment strategies.

- Support and mentorship of clinicians who may be concerned about ‘not doing something’ in some cases. Development of local Ethics Committees and ‘champions’ could support existing Multi Disciplinary Teams to foster a culture where a realistic healthcare approach is embedded.
- Allowing sufficient time in clinical settings to ‘stop and think’, enable meaningful discussion, ensure medicines optimisation and ultimately enable delivery of the ‘right care to the right patient the first time’.
- Support from the Board and Executive management when there is a challenge to a considered recommendation not to offer a treatment/intervention: where there is insufficient clinical indication; or where there is no evidence of benefit for a treatment option; or where there is significant risk of increased harm such that the risk benefit ratio is adverse.

Patients should be encouraged and supported to:

- Understand the complexity of clinical decision making, the absence of evidence for much practice and the uncertainty of outcome in some clinical situations.
- Ask whether specific treatments or investigations will help them.
- Ask whether specific investigations are actually necessary, particularly if they have been recently performed.
- Express their preferences regarding proposed investigations or treatments.

NHS Lothian Board members will be required to:

- Provide strategic leadership for the development and implementation of action plans to implement the framework.
- Engage with and influence wider activities within Scotland in support of Realistic Healthcare
- Hear, reflect and learn from regular patient stories illustrating the reality of Realistic Healthcare in clinical practice and the challenges faced by patients and clinicians in decision making.
- Understand the impact that Realistic Healthcare has on the quality of care, including active review of cases leading to compliments, comments or complaints.

Collaborative training programme to reduce unwarranted variation.

The ‘*NHS in Scotland 2016*’, Auditor General’s Report highlighted the untapped potential of frontline teams as agents for continuous quality improvement and recommended a number of actions regarding investing in (in-house) leadership development and training to lead quality improvement programmes.

This distributive approach to quality management aligns to NHS Lothian’s “Our Health, Our Care, Our Future”, recognising that delivering the outcomes required to meet healthcare challenges will not be achieved without radical change, accelerating innovation and redesigning how we work. Furthermore, the commitment to prioritising quality, safety and transparency is at the heart of how we plan and deliver services for patients

We have established a transformational change programme to build and embed the NHS Lothian Quality Management System (QMS) as our vehicle to deliver best patient experience, outcomes and sustainable cost. Creating the QMS focuses on two key drivers

- Increasing the capacity of frontline teams to manage continuous quality improvement
- Creating an organisational culture within which distributed leadership for quality will flourish

A summary of the progress to establish the QMS in 2016 and plans for further development in the coming year and beyond are summarised below.

Building capability within our workforce:-

Quality Academy Training Courses began in February 2016. A pilot 'Leadership' and 'Skills' course was run, aimed at those who would undertake Quality Planning and Quality Improvement respectively, 26 participants attended the Leadership Course, and 33 the Skills programme. Cohort 2 of the programme was revised and began in September 2016, with an expanded class size of 36.

Other training activities developed by/with the Quality Directorate in 2016 included:-

- NHS Board Development Session on measurement for quality and engaging patients and carers (with HIS).
- Training for QI coaches to support those undertaking continuous quality improvement within frontline services and the Quality Academy.
- Supporting candidates for lead-level national programmes in Quality Management, including the Scottish Quality and Safety Fellowship and Scottish Improvement Leaders Programme.

In 2017 NHS Lothian plans to:

- Develop the Quality Academy programme for 2017 to provide increased capacity in both courses.
- Develop a coaching framework and additional QI coaching capacity to support the QI Academy programme. 20 coaches received training in 2016 and we intend to train at least 60 in 2017.
- Develop the Academy Faculty utilising some external partners and mostly skilled staff in-house.
- Increase access to organisational development expertise.
- Develop the capability of the Executive Team and Board members on QI management.
- Increasingly integrate Quality Management training into existing CPD process across the workforce.

Building capacity to manage continuous quality improvement:-

The 'vehicle' for continuous quality improvement within individual clinical services is what we have termed a 'Clinical Quality Programme' (CQP). This is an organised and coordinated local system to: a) develop a shared vision of best experience outcomes and affordability of care from the perspective of patients, the public and workforce; b) agree a rolling programme of CQI work; c) plan, initiate, monitor, develop and complete individual projects with that programme; d) repeat continuously. We committed to establish 3 core CQPs and commence a second wave of CQPs in 2016. As there's no generic template for how to establish them we created one, tested and adapted it through deployment in our pilot Clinical Quality Programme areas.

Developing and deployed the QI Coaching Role and Capacity:-

Eventually services will develop experienced leaders and practitioners in quality management. We have co-developed a coaching model with existing in-service experts and established a short development programme to develop a bank of 40 coaches and we aim to have more than 60 in place by November 2017.

Programme Management;-

Programme Managers have been appointed to support our pilot Clinical Quality Programmes in Stroke, Cancer and Mental Health services.

Health Analytics;-

Quality Improvement methodology is entirely dependent on data. Access to data and analytical expertise to guide continuous quality improvement in services has been provided. In October 2016 a review of the support provided and lessons learned was completed. NHS Lothian has begun work to develop an Information Strategy and it is anticipated that a major focus for this work is to support the development of the Lothian Quality Management System.

Understanding the Cost Benefit of Quality

Providing high-quality healthcare at the lowest possible cost is an explicit aim of the QMS. The Finance Directorate has been developing an approach to Patient Level Information Costing (PLICS) for a number of years.

PLICs can be used to

1. Identifying high-spend areas, based on costly procedures and high-volume procedures
2. Identifying variation in treatment costs, analysed in a number of different ways, based on diagnosis, consultant, specialty
3. Monitor the reduction in variation in treatment costs following the implementation of a quality improvement project

An implementation programme linked to the spread of PLICS is underway to support the Finance Directorate team to engage with and contribute to all three phases of the Clinical Quality Programme approach.

In 2017 NHS Lothian will:-

- Continue to support and learn from the wave 1 Clinical Quality Programmes.
- Proceed with the establishment of wave 2 Clinical Quality Programmes.
- Develop bespoke support for Primary Care Quality Management and the General Practice Redesign Programme in line with the recommendations of our review "Mapping Quality Improvement in Primary Care"
- Identify and develop up to a further three Clinical Quality Programmes in 2017-18, taking account of the quality improvement priorities identified through the NHS Lothian Hospitals' Plan under development.
- Evaluate and refine the scope and scale of support needed to establish CQP.
- Continue to develop a larger cadre of coaches and our coaching model, to include evaluation of coaches and our approach to coach recruitment and development.
- Continue to develop healthcare analysts' confidence, knowledge and impact upon supporting continuous quality improvement.
- Support the design, creation and implementation of a high-quality Information Strategy and collaborate on its implementation.
- Work with NES and NHS Lothian to co-create Knowledge Management roles to support CQI.
- Continue to support the development, testing and promotion of the Performance patient-level accounting system by Finance Directorate.

Building a supportive Organisational Culture;-

Creating a culture that will sustainably support continuous quality improvement driven by frontline teams is of vital importance. The single most important cultural change is to develop an engaged, trusting and supportive relationship between frontline teams and 'Management' to overcome quality challenges together. Of particular importance is to understand how risks (clinical, financial and other) are experienced by different professional groups. We have established 'Clinical Change Forum' meetings on all major acute sites across Lothian.

In 2017 NHS Lothian will:-

- further extend the geographical spread and frequency of Clinical Change Forum meetings, hosting some in our H&SC Partnerships with a focus on Primary Care.
- formally track progress of work presented, with report back on development at the subsequent meeting.
- We will create a facilitated communication network to enable GPs and other Primary Care professionals to share their experiences, ideas and lessons driving CQI.

Support innovation as a driver of quality improvements in Lothian;-

NHS Lothian has been developing its innovation programme creating an innovation network of internal and external stakeholders to sit alongside the existing organisation's structure. Key to this approach is the identification of "Big Opportunities" for innovation. Outcomes have included:-

- Supporting a number of staff in the subsequent development and deployment of their innovative ideas
- Maintaining NHS Lothian's role as a leading test bed site for the development and adoption of new technology
- Developing a network of academic, third sector and industry partners, in line with the Scottish Government's 2020 Vision for Health and Wealth that aims to make Scotland a world-leading centre for innovation in healthcare

NHS Lothian has been chosen to be the lead NHS Board for the hosting of the Scottish Enterprise two-year funded Open Innovation Collaboration Programme. This Programme will deliver twenty national open innovation challenges across a range of service delivery areas, with NHS Lothian a test bed for transformational change in a number of these, including Type 1 Diabetes, Stroke, and Chemotherapy Outpatient services.

In 2017 NHS Lothian will develop a range of transformation changes through open collaboration for testing and evaluation at a local level potentially covering:

- The evaluation of a non-invasive 3D diagnostic technology for people suffering chest pain – which will be formally approved by NICE in January 2017.
- The development of new pathways for outpatients, piloting these initially in Adult Audiology services.
- Setting a national health and social care innovation challenge for housing, with support from the Design School of the Glasgow School of Art.
- Being a test bed site for the development of innovations in the identification, treatment and self-management of hypertension, resulting in a reduction in the number of people who will have a primary /secondary stroke, and other associated morbidities.
- Being a test bed area for three national open innovation challenges in Primary Care.

In addition to providing the opportunity to further develop and refine a methodology in Creative Problem Solving for open innovation collaboration, the next year will also be used to:

- Create an organisational “Culture for Innovation”, with a particular focus on bringing people out of their silos to collaboratively solve challenges, whilst removing the barriers that constrain innovations being tested and evaluated at a local level – without the need for broad high-level approval.
- Plan how the learning from the open innovation collaboration work being progressed both at a local NHS Lothian and a national level can be sustained and further enhanced beyond March 2018, when the Scottish Enterprise funding ends.
- Set up for wider deployment the recently programmed Innovation Web resource that will support both the local and national innovation programmes through functionality that includes:
- The promotion of innovation challenges to existing networks and potentially the world wide web, seeking out ideas to create the required solutions
 - Enabling stakeholders to vote on the ideas that have been proposed
 - Promoting successful innovations that have been co-created and then successfully implemented
 - Providing secure digital zones where staff and others can have robust and open discussions around innovation challenge

Engage in influencing and shaping broader organisational strategy

As an Executive Director the Chief Quality Officer attends Board meetings and has influenced and supported the development of many organisational strategies and plans ensuring that quality is at the heart of how we manage our business. The quality directorate has supported the Board in developing the principles and framework regarding Realistic Medicine and has worked closely with Lothian Analytical Services to improve their processes for continuous quality improvement.

In 2017 NHS Lothian will:-

Work closely with Health & Social Care Partnerships & Health Board to ensure that the Quality Management System supports the implementation of key strategies, including ‘Our Health, Our Future’, National Clinical Strategy, Realistic Medicine, Lothian Hospitals plan and Scotland’s 2020 Vision.

Effective patient, public and workforce engagement in Quality Management

Seeking, learning and applying the experience of those using our services are key to successful quality management. The ‘Voice of the Consumer’ and the ‘Voice of the Workforce’ is of increasing importance as work progresses.

In 2017 NHS Lothian will:

With the support of the Feedback and Assurance Quality Improvement Committee, the Quality Directorate is leading a 90 Day Innovation Process. This process aims to capture a) best and innovative practice from all ‘industries’ b) engage with stakeholders to see how that might work locally and c) assimilate all this learning into an action plan. This action plan will become the basis for our organisation-wide engagement work for the coming years.

With the support of Partnership and HR, we will help services undertaking Clinical Quality Programmes to incorporate staff experience and well-being information into 'data packs' for Quality Management.

We will launch a Quality Directorate website as part of a wider communication plan (co-developed with Communications Department) to keep patients, public and workforce aware of developments in Quality Management.

Promote and value internal and external partnerships

Over the last year, NHS Lothian has been developing work with a range of partners to facilitate the establishment of our Quality Management System

In 2017 we will:-

- Continue to nurture and develop existing relationships. Develop stronger links with community and social care colleagues to extend work of Clinical Quality Programmes beyond 'Acute' care.
- Work with universities to give opportunities for students and researchers to contribute to our Quality Management System.
- Work in partnership with Exec. Nursing and Medical Directors to bring Quality Management training and experience into the pre- and post-registration clinical training programmes.

Measuring change across a whole system

We have created 'data packs' to allow changes in process and outcome to be measured locally. These will form a rational basis for testing changes and their impacts as part of continuous quality improvement. We will need to deploy a measurement tool appropriate to that task.

In 2017

- we will 'benchmark' NHS Lothian using a global quality measurement tool
- This process will be repeated in the following 12-18 months to assess organisational change and help direct our future developments.

Resource Impact

Investment in the development of a Quality Management system has been supported by NHS Lothian (£560k), and the Edinburgh and Lothian's Health Foundation (£640k). Support from the Scottish Government has also been indicated but not yet confirmed (£200k).

This investment has supported the establishment of a core infrastructure including the Chief Quality Officer, and the Quality Academy and the Quality Programmes. The current profile of expenditure shows that funding agreed to date will support the development of Quality Management until March 2018. We will work with the Finance Department to develop an evaluation framework to measure the impact of the investments in Quality Management to support achievement of the Triple Aim. This will inform on-going investment decisions.

3.5 PUBLIC HEALTH IMPROVEMENT

To support an increase in healthy life expectancy, the Scottish Government Health and Social Care Delivery Plan outlines the requirement to deliver a number of public health improvement actions. NHS Lothian's approach to delivering these actions is outlined in the sections below.

3.5.1 Tobacco Free Generation

Smokefree Lothian

The National Tobacco Strategy sets out a 5 year plan for action across the key themes of health inequalities, prevention, protection and cessation. Key actions include: setting 2034 target date for reducing smoking prevalence to 5%, pilot of the schools-based A Stop Smoking in Schools (ASSIST) programme, a requirement for smokefree hospital grounds, national marketing campaign on the dangers of second hand smoke in cars and other enclosed spaces.

The NHS Lothian Tobacco Strategy Board with representatives from NHS, Local Authorities and third sector is co-ordinating efforts to meet the aims of the Strategy and Health Promoting Health Service. This includes the Cessation LDP target and other related tobacco work linked to the WHO Framework for Tobacco Control that will lead us towards a Smokefree generation.

Health Inequalities

To support the inequalities dimension to smoking prevalence rates, NHS Lothian provides specialist services in the 40% most deprived within the Board SIMD areas. Partnerships established with GP Practices, AHP's and key community organisations to help develop a more asset based approach. Services are located not only in Health Centres but Community venues are also targeted.

We have continued our partnership with West Lothian Drugs & Alcohol Service using a community based organisation to help achieve the strategic actions. During 2017/18 they will support the delivery of Cessation services, ASSIST Schools Programme and protection of Second Hand Smoke exposure.

Prevention

It has been agreed that NHSL will deliver a 4th year of the ASSIST Schools Programme, targeting Schools in the areas of highest deprivation. We are awaiting the full evaluation of the 3 year national pilot which will support our strategic planning from March 2018.

On-going work continues with the youth sector to support smoking prevention programmes, having a dedicated tobacco youth team in NHSL. Priority areas have included the 16-24 age group with good working relationships established in higher and further education establishments including vocational training. During 2017 we are planning to target vulnerable young people such as looked after children and young offenders.

NHS Lothian's Director of Public Health and Health Policy has recently submitted evidence, to influence the preventative agenda, to the Scottish Parliament Health and Sport Committee.

Protection

Work continues to maintain all NHSL Smokefree grounds including Smokefree Implementation Groups being set up in all acute sites to support the imminent legislation. Specialist staff continue to be based in all acute sites not only providing cessation services but offering staff training and development and policy advice.

As part of the NHS Lothian 'Stop for Life' service second hand smoke advice is provided in ante natal settings, working in partnership with Midwives, post natal information is also shared with local services. All NHS Lothian Midwives have completed the 'Raising the Issue of Smoking Training'. Opportunities for NHS Lothian to support further research are currently being investigated.

Cessation

NHS Lothian met the 2016-17 LDP target but there is clear evidence for improvement in the Pharmacy Service, quits rates of pregnant woman and Prisons. A working group between Smokefree Management and key personnel from Pharmacy services has been convened to support target performance and investigate future joint working with local services. NHS Lothian continues to work in partnership with Lothian's prisons to help become Smokefree.

Smokefree Lothian Service Manager was appointed and started in early December 2016. Smokefree Services continues to develop with plans to complete an administration review early 2017, assess the impact of the current service model in line with the strategic targets and actions and develop a proposal to pilot a 'shared care model' between local services and Smokefree Pharmacies. More joint working between Smokefree Lothian and Health Promotion has been implemented with both service managers agreeing to develop a joint tobacco action plan.

3.5.2 Reducing Harm Associated with Drug and Alcohol Consumption

NHS Lothian will work together with Lothian's Alcohol and Drug Partnerships (ADPs) to support the implementation of an alcohol and drugs strategy to reduce the burden of morbidity and mortality through reduced availability and reduced consumption.

2017-18 presents a major challenge in maintaining a balanced budget to deliver awareness and preventative services, provide a full range of local and specialist treatment services and to encourage patients to engage in and maintain recovery. Following on from work undertaken in the past year and a reduced national drug and alcohol allocation, NHS Lothian and the three Lothian ADPs have reviewed service provision associated with Prisons, Ritson Inpatient Clinic, Lothian and Edinburgh Abstinence Programme (LEAP), Harm Reduction Team, Primary Care Facilitation Team, Alcohol Brief Interventions, Regional Infectious Disease Unit, GUM Clinic and Hep C Treatment and Prevention Services, Toxicology and Psychological Support and have outlined a proposed spending plan for 2017-18. This spending plan and proposed service changes will be discussed by NHS Lothian Board and IJBs during March and April 2017. The proposed service redesign will see a greater focus of service provision based and managed locally, development of local treatment and recovery hubs, as well as a redesign of some pan Lothian services such as inpatient and day patient programmes for detox and abstinence.

Provision of health care within prisons remains a responsibility of NHS Lothian but an additional pressure in 2017-18 will be the redirection of dedicated prison funding, previously

used for alcohol counselling services. This funding is within the overall ADP allocation and the suggestion from ADPs is that this will be used for residents and prisoners who reside within Lothian.

We will continue to work towards ensuring that people access treatment promptly within 3 weeks of referral and are supported in their recovery by services provided locally and in an integrated way. Local teams will be based and managed in each locality. All staff groups with the exception of Psychology (who are still managed via single system) will be managed within the localities and appropriate professional links will be maintained with the Substance Misuse Directorate. This supports the retention and development of current clinical governance infrastructures, sub specialty provision and cross-cover arrangements. Further opportunities are being considered that will bring together substance misuse and mental health services which will look to build on but provide a new model of care that improves the relationships and pathways within patient services, as well as prison services.

During 2017-18, the City of Edinburgh Council and NHS Lothian will continue to provide the inpatient rehabilitation service at Penumbra Milestone for patients with alcohol related brain damage acquired as a result of alcohol misuse. The Alcohol Related Brain Damage Unit is providing intensive rehabilitative support to enable people to return to their own home resulting in reduced inpatient bed days, fewer delayed discharges and reduced re-admission to the acute sector. The service is to be further reviewed and potentially developed alongside other residential inpatient substance misuse services.

We will work with partners to try to reduce the availability and consumption of alcohol and maintain and expand the use of take home naloxone kits to reduce the numbers of Drug Related Deaths.

We will continue to provide support to the Substance Misuse Directorate reviews on drug related deaths at a local level with a view that this prevention/early intervention activity will contribute to work to reduce health inequalities and promote the health and well-being of communities by focusing on the needs of the local population in the harder to reach groups where deprivation is greatest.

During 2017-18 the Edinburgh Alcohol and Drug Partnership will:

- Review the overprovision of licensed premises in the city
- Roll out Alcohol Brief Interventions
- Review the approach taken to alcohol/drug prevention in schools
- Evaluate the alcohol problem solving court

3.5.3 Alcohol Brief Interventions (ABIs)

NHS Lothian and other partners within each of Lothian's Alcohol and Drug Partnerships will sustain the delivery of ABIs in the three priority settings (Primary Care, Antenatal and A&E) during 2017-18. This prevention/early intervention activity will contribute to work to reduce health inequalities and promote the health and well-being of communities by focusing on the needs of the local population in the harder to reach groups where deprivation is greatest.

We will continue to deliver a comprehensive education and training programme for groups of staff in both statutory and voluntary agencies, for example in prisons, police custody suites, criminal justice programmes, fire and rescue services youth and sexual health

programmes/services and welfare rights teams. This helps to ensure that disadvantaged groups receive a quality service.

We will further explore opportunities for joint topic brief intervention training e.g. smoking cessation/alcohol interventions for dental services.

Work with our local ADP's, Criminal justice services to further develop an ABI training module for staff working with persons entering police custody suites/criminal justice settings and evaluate and report outcomes.

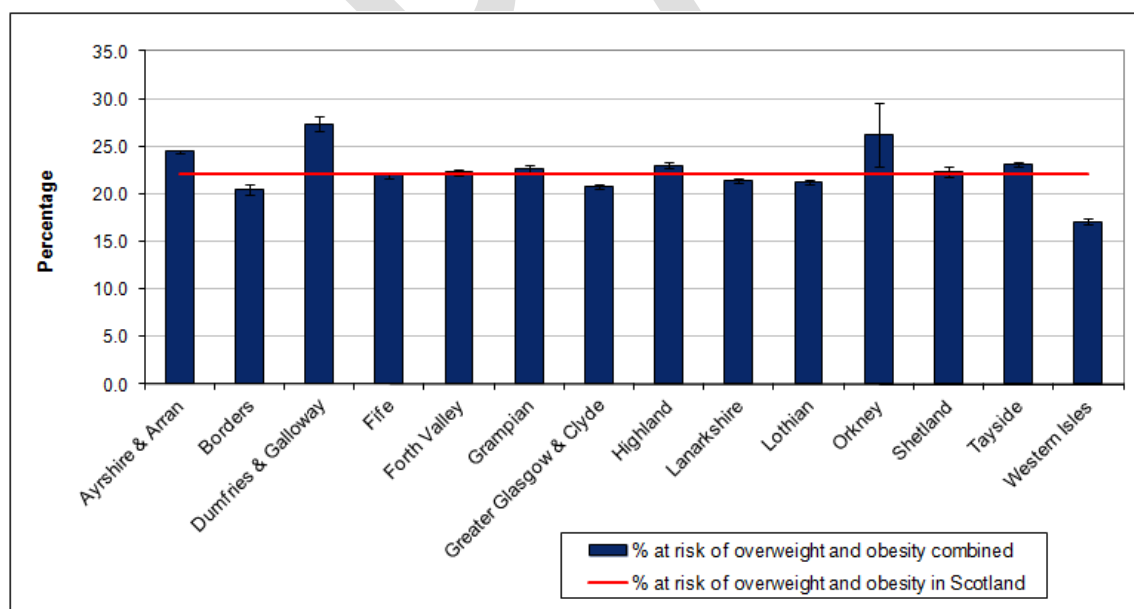
Working with local neighbourhood partnerships across the city we will facilitate ABI training and further develop our ABI toolkit for local authority staff. We will ensure that staff working in specialist projects which have been established to address the needs of people from disadvantaged communities, receive ABI training e.g. the Access Point (working with homeless people), specialist midwifery staff (working with gypsy travellers and temporary residents)

We will continue to monitor and evaluate the ABI e-learning module and further develop our local Training for Trainers module in order to sustain ABI training in the wider community. Working with Queen Margaret University and Napier University we will further develop and evaluate the training module for Allied Health Professional students and embed the module in the core curriculum for undergraduate.

3.5.4 Diet and Obesity

Childhood Weight – Overweight or Obese at Primary 1

Percentage of Primary 1 children in Scotland at risk of overweight and obesity combined, by NHS Board of Examination, School year 2015/16 (epidemiological categories)



School Year										
06/0	07/0	08/0	09/1	10/1	11/1	12/1	13/1	14/1	15/1	
7	8	9	0	1	2	3	4	5	6	

NHS Lothian

Number of children measured	25,217	28,285	34,470	45,996	41,220	52,544	54,498	55,069	54,995	53,637
Underweight (clinical)	0.5	0.6	0.6	0.5	0.6	0.4	0.3	0.4	0.4	0.4
Healthy weight (clinical)	84.3	84.9	85.2	84.7	84.7	84.6	85.1	84.1	84.7	84.7
Overweight (clinical)	9.1	8.7	8.6	8.8	8.8	8.8	8.8	9.2	8.7	8.6
Obese (clinical)	3.7	3.4	3.4	3.6	3.4	3.6	3.4	3.8	3.7	3.7
Severely obese (clinical)	2.4	2.3	2.2	2.3	2.6	2.5	2.3	2.6	2.5	2.6
Overweight, Obese and severely obese combined (clinical)	15.2	14.4	14.2	14.7	14.7	14.9	14.6	15.6	14.9	14.9
Obese and severely obese combined (clinical)	6.1	5.8	5.6	5.9	6.0	6.1	5.7	6.4	6.2	6.3

BMI Distribution in Primary 1 School Children by NHS Board – Clinical Categories

Percentage of children in primary 1 receiving a review whose BMI falls within the following clinical categories:

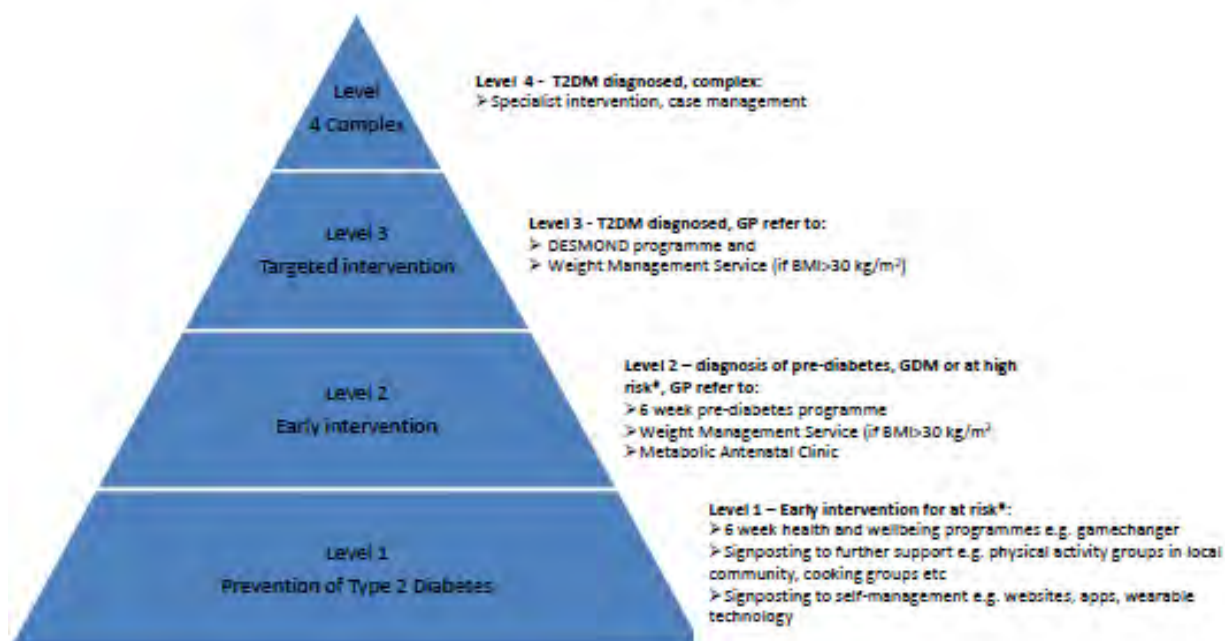
Whilst the percentages of those children within normal health weight remains stable at 84.7% across Lothian at P1 entry, this does not represent any changes in later primary school or high school age groups, being a snap shot in time. There has been an increase in referrals to the NHS Lothian Child Healthy Weight Programme and a number of concerning clinical cases which have led to significant reviews of children requiring hospital admission and child protection factors relating to clinical obesity and health risks. Therefore, prevention and early intervention in the early years will continue to be a key focus within the Children's Strategy. We await also the Scottish Government announcement on a new obesity strategy for Scotland, which we anticipate will focus on early years as one of its key result areas.

Weight Management Tiered Model of Care

All local authorities have signed a Service Level Agreement with NHS Lothian Weight Management Service and this includes data sharing to support adult and children's weight management in the tiered model of care. This includes physical activity and a weight management programme provided by local authority staff who have been trained in the evidence based model of Counterweight, and they are mentored by Dietitians.

The weight management tiered model of care is shown below, with specific reference to Diabetes Prevention for adults.

NHSL Weight Management proposal for formal strategy



*there is an absolute need to agree and ratify what is being considered in each risk category as this must be in keeping with nationally agreed guidelines.

For children's weight management we have:-

- Tier 1 - Health Promotion
- Tier 2 - is the GET GOING programme for children and
- Tier 3 - is the Dietetic Service for children.

NHS Lothian's tiered model of paediatric weight management is illustrated below:

Figure 1



The paediatric weight management team work very closely with Health Visiting, School Nursing, GP's, Community Paediatricians and Local Authority Education partners. The Tier 2, Get Going programme is a 9 week community based programme for children (5-17 year olds) and families aimed at supporting lifestyle changes to enable families to make healthier choices regarding food and activity. The Tier 3, Dietetic service is accessible for children and families with complex needs requiring more intensive support on a one to one basis. This service is also the only service accessible for children under 5 years of age. As part of both the Tier 2 & 3 services there is additional support accessible from a Specialist Child Psychologist as required.

There is a clear correlation between paediatric obesity and areas of deprivation with there being an 8% difference at Primary 1, between levels of children at risk of overweight and obesity, between the most deprived (SIMD 1) and least deprived (SMID 5) areas. Due to this correlation the paediatric weight management services are focussed in areas of deprivation and the majority of children and families seen within the service tend to have a high level of need with a variety of complex issues ongoing.

The Paediatric Weight Management service has seen a marked increase in referrals for the under 5's over the past 12 months and we are working closely with the Health Visiting teams to address this.

The service has also seen a marked increase in complex cases where they are raising child welfare concerns as a consequence of complex obesity and as a result the service is now working more closely with Child Protection Services so that greater guidance and support is available to the service.

3.5.5 Maternal and Infant Nutrition Framework

In November 2016, NHS Lothian was awarded UNICEF Baby Friendly Accreditation for West Lothian midwifery and in St John's Hospital and has achieved stage 2 across all the Health Visiting and Family Nurse teams in Lothian. Work has begun with the Neonatology Service to consider how these standards might benefit their service. In the coming year we will build on this work further and intend to achieve full accreditation for the Health Visiting and Family Nurse teams, reaccredit the Simpsons Maternity Unit and obtain a certificate of

commitment for NNU and SCUBU. The roll out of our breastfeeding assessment tool this year should also help these teams to join up their care to provide a seamless service to breastfeeding women.

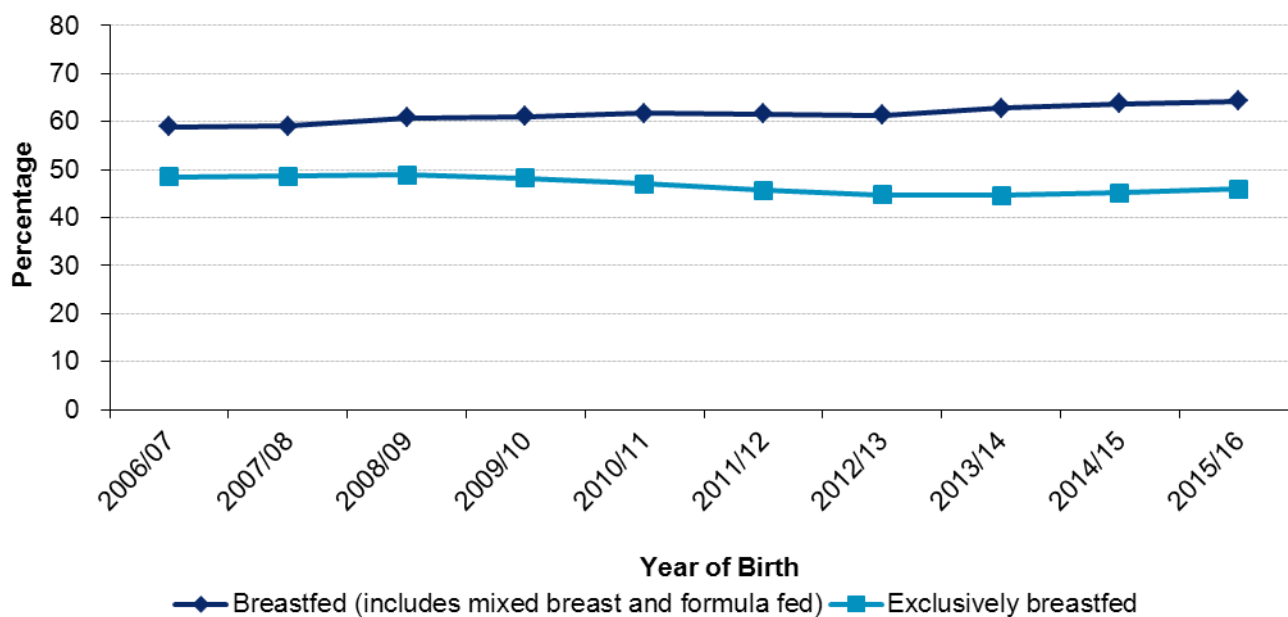
With this in place to ensure our core staff have the skills to universally support breastfeeding and relationship building, this year we are reviewing our wider support services with a view to developing a tiered service, providing the appropriate care at the appropriate time. We have already developed a plan for our peer support services looking to expand this service in 2017 and we have reviewed our provision of breastfeeding support groups with a view to providing additional support in the areas of highest need also during the coming year. Expanding this tier of additional need should enable us to review the provision of expert care tier in our breastfeeding clinics to ensure this is provided by the most skilled staff – linking in with the expected outcomes from the Scotland wide work on Infant Feeding Adviser practice.

During 2016 we brought our training for core staff up to meet the UNICEF requirements and are currently reviewing the update training for these groups as well as the initial training we intend to provide for neonatology. In addition we continue to provide training for GPs and nurseries and information for public and private organisations in the form of a Breastfeeding Friendly Award and are also developing a breast milk information pack for colleagues working with mothers with substance misuse issues. We have also reviewed the information supplied to parents as they introduce solid food to their babies and the staff that support them and will be assessing the impact of this in the coming year.

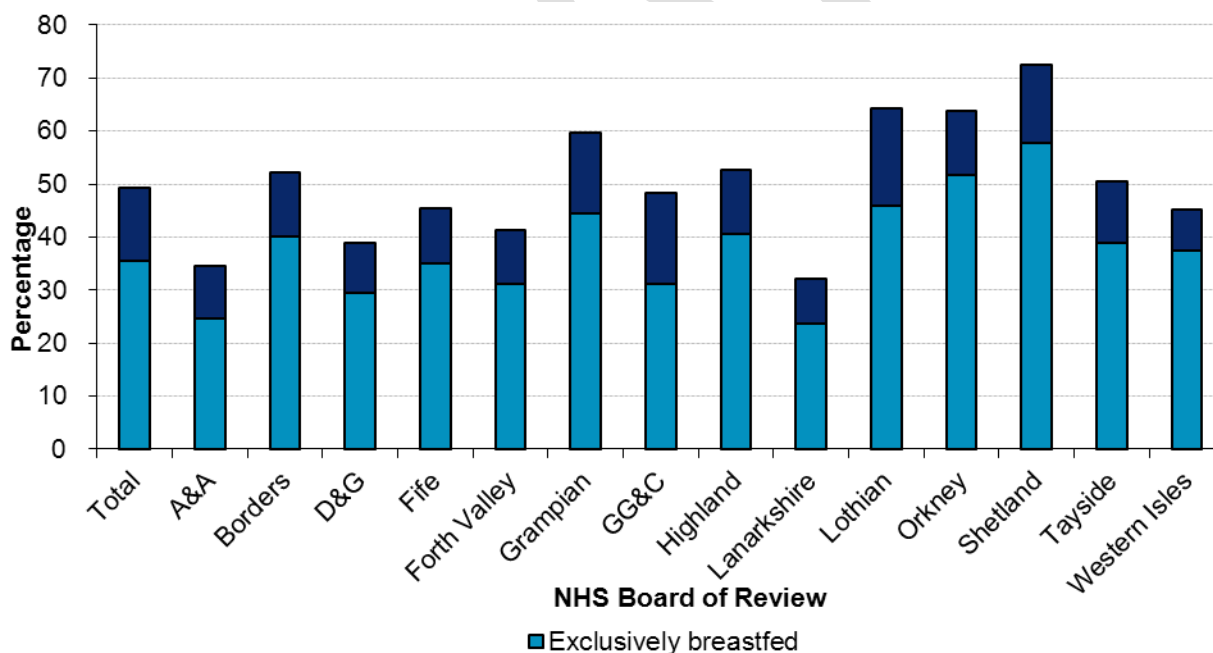
Breast Feeding Rates

Breast feeding is a key measure that is recorded by maternity, health visiting and family nursing. The real time health and wellbeing outcomes and the preventative protection factors for future health are well evidenced; therefore the aim of NHS Lothian is to support women to consider this and to be supported to do this in a holistic way, whilst also supporting women fully regardless of their choice of feeding for their child. The uptake of breast feeding is seen in the national first visit recorded statistics. In Lothian, this overall percentage has been relatively static over the last 10 years.

NHS Lothian First Visit Breast Feeding Rates 2006-2016

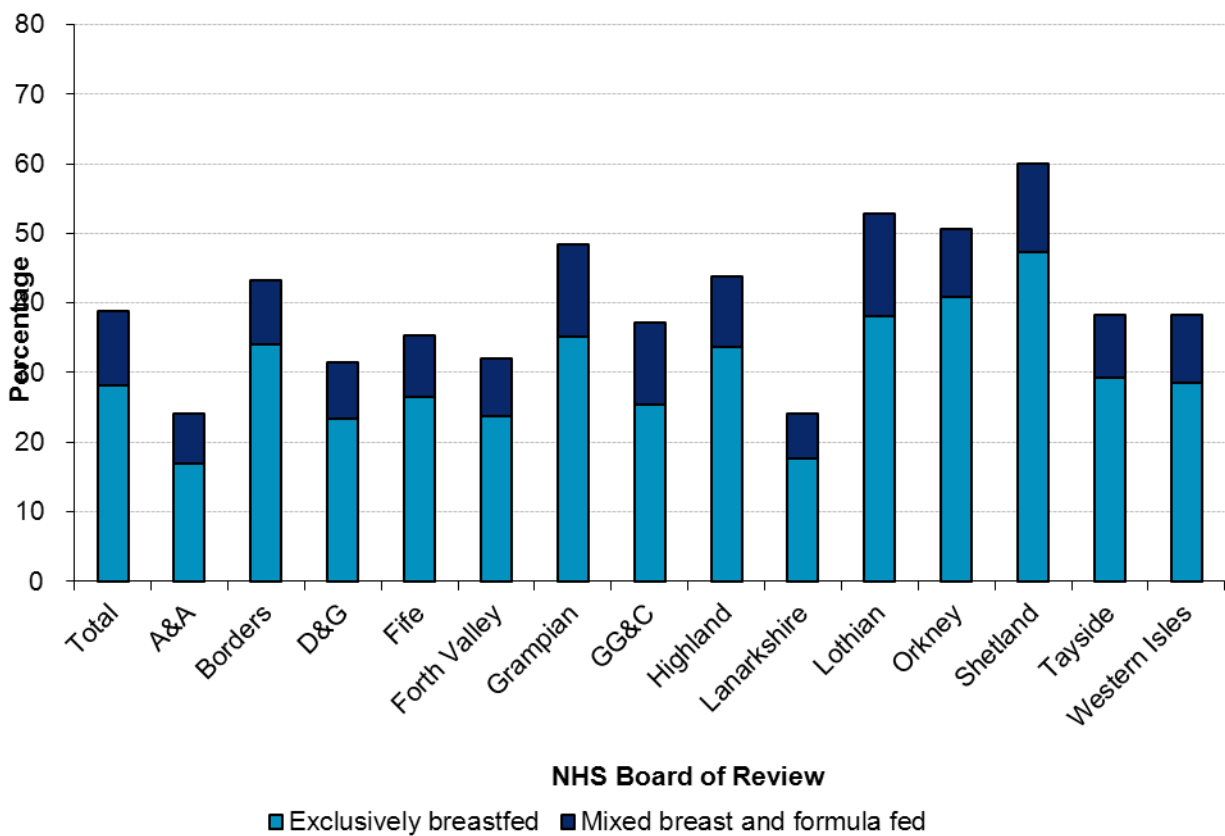
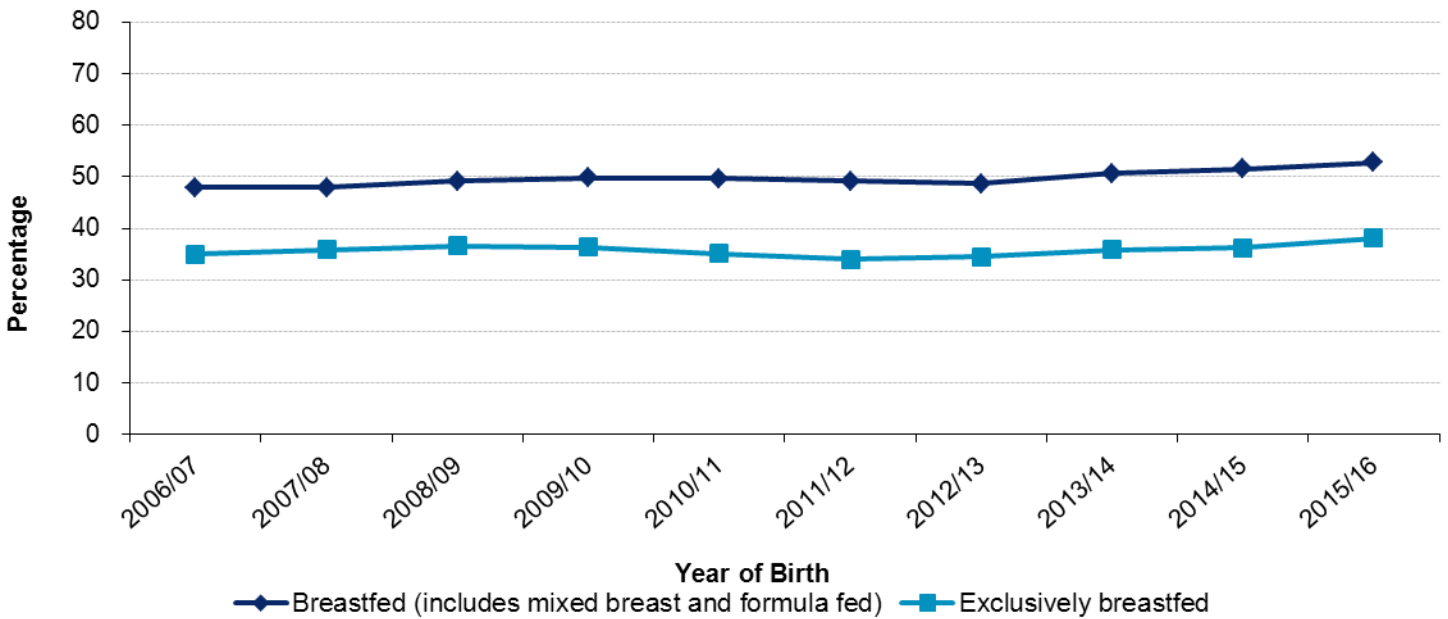


Overall, at first visit; 45.9% (35.5% Scotland) of Lothian women in 2015-16 were exclusively breast feeding; with 64.3% (49.3% Scotland) mixed feeding. Therefore, Lothian has the second highest exclusively breast fed rate in Scotland (and the highest mainland area) for 2015-16 data:



In all areas of Scotland, the rates drop by 6-8 weeks of age, and this is linked to many factors that are a mix of maternal, family, neonatal and social pressures. NHS Lothian wants to support all women well in the post natal period and beyond and continuity of carer, advice and support is fundamental to this. The new maternity and neonatal care strategy for Scotland with the aim of a primary midwife and the new universal pathway pre-birth to preschool should have a positive impact on this support and continuity, and therefore we will be keen to observe if this lifts the NHS Lothian figures over the next 5-10 years.

NHS Lothian Rates at 6-8 weeks of age in 2015/16



Roll Out of Universal Vitamins to All Pregnant Women

NHS Lothian will provide universal vitamins for pregnant women as announced for the whole of Scotland from 1 April 2017. We are working with community midwife teams and pharmacies to prepare for this change which will include communication and distribution storage.

3.5.6 Physical Activity

NHS Lothian will continue to support the delivery of the Scottish Government strategy Lets make Scotland Active 2003-2022 through;

Interventions

- Identifying training needs and provide training opportunities to NHS Lothian staff and partners working within local communities in relation to Physical Activity and support the Learning Disabilities MCN in activities that promote increased access to physical activity for people with learning disabilities in Lothian.
- Encouraging increased physical activity levels amongst NHS staff through activities designed to support staff to increase their level of physical activity, organisation wide campaigns and active travel initiatives
- Supporting interventions in the community that aim to address inequalities in diet and physical activity through increased knowledge, confidence and skills.

Supporting delivery of Scottish Government Active Scotland Outcomes Framework (to be published in 2017)

- Working with our local authority partners to support the development of Physical Activity & Sport strategies that aim to address Health Inequalities and promote increasing physical activity amongst the population in support of the Active Scotland Outcomes Framework.
- Working with primary and secondary care and leisure service providers in each of the four Local Authority areas towards increasing the effectiveness of exercise based referral initiatives that support people with specific health conditions within the population to become more physically active.

Embed the national physical activity pathway in all appropriate clinical settings by 2019

- Identify a cohort of staff with whom to develop a pilot training/support programme aimed at increasing knowledge and awareness of the national physical activity recommendations as well as of the role of physical activity in supporting positive health outcomes. Look to upscale relevant aspects of this to appropriate staff.

3.5.7 Health Promoting Health Service (HPHS)

The Chief Medical Officer Letter 19 (2015) is transformative in its mission to bring preventative action to the fore and actively change the culture of hospitals to help support this. It tasks NHS Boards to continue to drive forward the HPHS agenda, with particular emphasis on 3 key areas:

- 1) staff health & wellbeing,
- 2) a health promoting environment where healthier choices are the norm, and
- 3) person centred care with a focus on prevention, early intervention and addressing inequalities

Key actions outlined in the 2017-18 health promoting health service plan include:

- Increased emphasis on and commitment to staff health and wellbeing
- Increased work with multi-disciplinary staff groups to enhance and scale up current efforts across Lothian to support Health and Social Care Partnership services to promote the HPHS agenda.
- Work towards embedding HPHS ethos into all policies, strategies and services.

- Further work to ensure that all services are designed and staff trained and supported to deliver HPHS activities and measure impact.
- Increased emphasis on the promotion of Physical Activity amongst staff and the population more generally through improved links with council services.
- Increasing the amount of active travel amongst staff and active improving the advertising of public travel options to NHS Lothian premises.
- Work towards the Healthcare Retail Standard Lothian wide and liaising with PFI partners about the retail offer at the Royal Infirmary of Edinburgh.
- Work towards the attainment of the Healthy Working Lives programme across NHS Lothian.

Healthy Working Lives

In 2017-18, we will link re-design of Healthy Working Lives, in response to the reduction in funding, to align more closely with action required to implement the Scottish Government Health Works Strategy across Lothian. This focuses on reducing health inequalities among people of working age by addressing workplace health and health in the workplace with a particular emphasis on people on low wages, in insecure employment and inexperienced employers. The Lothian and Borders HUB will continue to focus on small and medium enterprises and on working with them to minimise health inequalities. Training and support is given to those interested in the Award to support policy development and on specific health topics. Examples include training on substance use and on Mentally Healthy Workplace for managers in statutory, private and community sectors.

3.6 RESEARCH AND DEVELOPMENT (R&D)

The Lothian R&D office will continue to implement the current R&D strategy, with the mission of improving health through excellence and innovation in clinical research. The objectives will remain in line with national Chief Scientist Office (CSO) priorities, but reflect strengths of Lothian and our aspiration to further support and grow local talent and initiatives.

3.6.1 Academic and Clinical Centre Office for Research and Development

1. The Academic and Clinical Central Office for Research and Development (ACCORD) office will continue to provide efficient high quality Research Governance for studies at all stages of the research pathway. This will include supporting the Lothian Research Ethics Committee. Contracting of all forms of research will ensure best value for Lothian in engaging with commercial partners, while ensuring Lothian remains attractive to a broad portfolio of commercial entities.
2. ACCORD will ensure that investment made by CSO is used effectively to promote and deliver efficient high quality research outputs. Specifically:
 - a. NHS Research Scotland (NRS) networks and specialty groups will be supported to deliver eligibly funded portfolio research, to maximise the number of studies and numbers of patients enrolled in eligibly funded research.
 - b. The portfolio of eligibly funded research will be underpinned by NRS Service Support Funding through pharmacy, other support services, and research staff to enable patient recruitment and retention.

- c. ACCORD will provide support to networks and specialty groups hosted by NHS Lothian through the leads and ensuring allocated funds are used to maximise activity across Scotland.
 - d. NRS Researcher Support Funding will be used to support NHS employed research active clinicians through protected research time, and support negotiations with clinical managers to maximise the value of this protected time.
 - e. Strategic investments in areas that are delivering a significant portfolio of research will continue, for example through support for research coordinators and managers. These include areas of high clinical pressure, for example emergency medicine, anaesthesia, acute medicine, and critical care, where R&D activity is substantial and contributes to staff morale and retention in addition to important outputs that benefit clinical service.
3. ACCORD will continue to support research active clinicians through the NRS fellowship scheme, and monitor the progress of these fellowships.
4. ACCORD will continue to support and champion the development of Nursing, Midwifery and Allied Health Professional careers by working closely with local Higher Education Institutes (HEIs) to develop novel models to support research careers that combine clinical roles with academic activity to maximise the impact of individuals. In addition, ACCORD will strongly support NMAHPs to compete for NRS fellowships, and facilitate their embedding in established groups, including the CSO networks and local areas of research strength.
5. ACCORD will continue to promote and provide resource to partner with Scottish patients and the public by:
 - a. Promoting and supporting the SHARE registry, and its use for research.
 - b. Developing generic and disease- or clinical area-specific patient/public engagement groups to support the development, conduct, and evaluation of research projects. Where relevant efforts will be made to support researchers to engage with patients/public during grant preparation to maximise the chance of successful application.
6. ACCORD will invest time and effort to ensure strategic areas of local and national importance are significantly advanced, namely:
 - a. The development of the NHS Research Scotland Biorepository, and associated initiatives, in collaboration with University partners and other Boards.
 - b. The development of eHealth infrastructure and transparent processes, to ensure that healthcare data is accessible to Lothian researchers, and wider projects through the NRS Lothian and national safe havens. Specifically, ACCORD will establish transparent pathways, governance, processes and procedures to enable clinicians and researchers to propose projects using NHSL data and be supported through the approvals process. ACCORD will implement these processes to support any major local or national initiatives involving data linkage, for example in relation to tissue banking.

7. ACCORD will develop a strategy to grow the commercial activity undertaken within NHS Lothian. For example:
 - a. Major groupings will be encouraged and supported to increase their commercial portfolio, supported by the infrastructure investment made by ACCORD (in research managers and coordinators).
 - b. Pro-actively connect industry with potential local PIs, working closely with the NRS Industry Liaison Manager to identify new commercial opportunities and pipelines.
 - c. Utilise the NRS fellows to champion commercial activity in key areas
 - d. Provide strong support in contracting, engaging with PIs to ensure that contracts represent best value to NHSL
 - e. Seek overarching or programmatic investment from industry and Life Sciences for collaborative research programme, in collaboration with the University of Edinburgh and other HEIs

8. ACCORD will act as a coordinating and central point in facilitating connection between clinicians with challenges and engineers, physical scientists, computer scientists, and other areas of science to maximise the opportunity for novel discovery and development to provide solutions to healthcare challenges. This will be achieved by closer interaction between NHS Lothian and HEIs, to accelerate new ideas and their translation into clinically useful products.

3.6.2 Nursing, Midwifery and Allied Health Professional (NMAHP) Research

NHS Lothian will :

- Seek to build on existing progress to establish Lothian as a centre of excellence for NMAHP research, as it is for medical research.
- Promote research as a core activity for the NMAHP professions thereby supporting the wider improvement agenda to achieve safer, more effective, efficient, productive, and person-centred care.

14,000 of the 26,000 employees of NHS Lothian are NMAHPs and therefore have a central and hugely significant role in the delivery of care across the whole spectrum of health and social care services. Currently 44 (0.3%) of these are research-trained to postgraduate level or are in training, of whom 14 (0.09%) occupy substantive posts with a significant research component. The Department of Health in England and Association of UK University Hospitals has recently established the ambition that by 2030 1% of all NMAHP roles will be clinical academic (note that in the medical workforce nationally this currently stands at 5%).

The Board will build on foundations which have been established in recent years:

- Collaborative NMAHP Research Strategy with local Higher Education Institute (HEI) partners – University of Edinburgh (UoE), Edinburgh Napier University (ENU) and Queen Margaret University Edinburgh (QMU)
- Clinical Academic Research Careers (CARC) scheme - £1.3m joint investment by NHS Lothian, UoE, ENU, QMU, NES and Alzheimer's Scotland across 5 sites since 2011
- Clinical Academic Homes – honorary contractual arrangements supporting clinical research focussed activity and capacity development across the service and academic boundary

- Research Futures – approximately £100k invested by NHS Lothian and Edinburgh & Lothian Health Foundation to support postgraduate research degree study expenses.

In 2017/18 we will:

- Establish a new 5 year NMAHP Research Strategy 2017-2022 jointly with local HEI partners
- Build a business case for a programme of NMAHP-led multidisciplinary, health services research focussing on NHS Lothian priority areas (e.g. integration of health and social care, dementia, health inequalities, service redesign) which incorporates a platform to support sustainable NMAHP clinical academic research career pathways and ensures even greater synergy with the Board's approach to QI.
- Commission collaborative research studies at postgraduate degree level with our HEI partners which address a number of key service questions
- Work closely with Research & Development Director and Head of Medical School (UoE) to optimise learning from Edinburgh Clinical Academic Training model in the further development of NMAHP clinical academic career pathways.
- Work with other health boards regionally to establish NHS Lothian as a national test area for NMAHP research career models
- With HEI partners vigorously pursue the establishment of a number of joint NMAHP clinical-academic posts at senior level e.g. Associate Professor/Nurse Consultant.
- Continue to encourage suitably qualified NMAHPs to apply for an NRS Career Researcher Fellowship which support up to 0.2WTE backfill for protected research time in job plans.

4. LOCAL DELIVERY PLAN (LDP) STANDARDS

NHS Lothian will continue to monitor and report performance against delivery of the 2017/18 LDP standards through the appropriate local and national systems. Submission of monthly performance reports for review and action will be via the Corporate Management Team. NHS Lothian Committees and Board will oversee the scrutiny and assurance of performance. Performance against the delivery of the LDP standards will be maintained through executive lead directors, committees and local management groups.

Commentary is provided below on current performance and actions to support improvements in delivery of the 2017/18 LDP standards and to mitigate the impact of risks.

People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase) 31 days from decision to treat (95%) 62 days from urgent referral with suspicion of cancer (95%). Early diagnosis and treatment improves outcomes.

NHS Lothian's performance over time against this target has been consistently above the all Scotland position and has followed a continued upwards trajectory in detection of stage 1 combined cases. NHS Lothian has increased the percentage of breast, colorectal and lung cancers (combined) detected at stage 1 by 19.9% from the baseline years of 2010 & 2011 to the final reporting period of 2014 & 2015. Scotland as a whole saw an increase of 8.0% in the same period. In NHS Lothian over the 2014 & 2015 period 27.1% of breast, colorectal and lung cancers (combined) were detected at stage 1 compared with 25.1% for Scotland as a whole. NHS Lothian delivered the second highest percentage improvement of all the mainland Boards.

NHS Lothian will update data after June 2017, when ISD will release national annual figures. Following the outcome from Scottish Government on the outcome from the Board's cancer implementation submission we will give an update on funding.

Impact on colorectal performance across all Boards will be subject to the conclusion of the bowel screening QoF (March 2015).

In January 2017 performance showed 81.3% against a target of 95%, 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).

Planned actions to support improvement are summarised below:-

- Introduction of daily review meeting with Urology and Colorectal trackers with management support
- Increase in access to urology first Outpatient appointment
- Change to administration process – allow cancer trackers within urology access rights to book patients direct into OP appointment
- Identification of 'bottle necks' in pathway to target potential improvement and redesign work
- Additional private sector capacity being introduced for urology/colorectal/GI

- Introduction of 0.5wte Cancer waiting times service role to provide increase in scrutiny, support and training for trackers
- Implementation of Robotic Prostatectomy

Additional senior management scrutiny of cancer performance and structure is also being undertaken. Specialty review meetings have taken place in January with the WGH site Director and individual tumour sites for Head and Neck, Colorectal, Urology and Upper GI to clarify governance arrangements and identify pathway issues associated with the current performance. This review forms part of ongoing additional management scrutiny for cancer services.

People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support (PDS). Enable people to understand and adjust to a diagnosis, connect better and plan for future care

ISD have published data against the above standard for the first time on 24th January 2017. Data is reported at NHS Health Board level only against 2 elements of the standard. Performance against the Standard as a whole is also reported. The data reflects diagnosis on the year 2014/15.

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

As of 2014-15, 25% of New Diagnosed Incidences of Dementia were referred to PDS and 64% of 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.

Lothian Integrated Joint Boards (IJB) Actions Planned for improvement:-

- Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.
- Improve recording of diagnosis in TRAK.
- Procedures agreed and implemented with local teams
- Routine reports to feedback performance to teams in place

Further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area was published on 24th Jan 2017. ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia was published on 24th Jan 2017.

12 weeks Treatment Time Guarantee (TTG 100%). Inpatient & Day Case (IPDC)
In January 2017, 1,434 individuals were waiting over 12 weeks for inpatient and day case treatment. The use of independent sector ceased from the 1st April 2016; internal capacity is unable to fully cover this previous activity which will impact on performance. Details of Demand, Capacity, Activity and Queue (DCAQ) work including efficiency improvements that we are undertaking are described below:

- Detailed review of Acute Services' available capacity and demand undertaken to

inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue exercise has examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties. Work has now moved from data collection and analysis to performance improvement monitoring. Actual activity against core capacity now implemented.

- Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams to improve theatre efficiency.
- Theatre matrix meetings established on all sites. Facilitates optimum use of sessions through 'pick up' of cancelled lists due to leave and optimise use of hours within sessions. Service review of all booked theatre lists one week in advance to ensure optimum booking and theatre efficiency.
- Establish extent to which specialties plan routine elective patients requiring to be preoperatively assessed are appointed no later than week 4 of their journey – ensure consistent approach is taken.
- Development of trajectories and detailed actions maximising internal capacity;
- New trajectories build up from, DCAQ work. Process endorsed by SG early May. Trajectories now developed until End March 2017.

18 weeks Referral to Treatment (RTT 90%).

In January 2017, 79.2% against a standard target of 90% of NHS Lothian planned/elective patients commence treatment within 18 weeks of referral.

The use of the independent sector ceased from 1st of April 2016. However funding has been agreed till March 2017, to target and support those specialities with the longest waiting times; internal capacity remains unable to fully cover this previous activity which will impact on overall RTT performance. Details of DCAQ work including efficiency improvements that we are undertaking are described below:-

- Pursue significant programmes of work to improve efficiency and reduce patient waits for IP and OP access: Theatre Improvement Programme; Demand and Capacity Programme, and Outpatient Redesign Programme.
- Ensuring clinic outcome data is completed
- Develop a monthly report that details by speciality and clinician clinic outcome completeness, supporting targeting improvement actions

12 weeks for first outpatient appointment (95% with stretch 100%)

Shorter waits can lead to earlier diagnosis and better outcomes for many patients as well as reducing unnecessary worry and uncertainty for patients and their relatives.

As of January 2017, 67.2% (19,016) against a standard target of 95% patients were waiting over 12 weeks for their first outpatient appointment at a consultant-led clinic. This includes referrals from all sources.

To ensure patients are informed about their pathway they are now sent a letter when they are added to an outpatient waiting list. These letters acknowledge receipt of the referral, explain that some services have waits longer than 12 weeks and provide contact details for the appropriate booking office so the patient can access more information if required.

The outpatient letters are sent to most specialties where there is a 12 week target in place. They are not currently sent if the patient has been referred to Allied Health Professional led specialties such as physiotherapy, to diagnostics such as Radiology or to Mental Health services. This is to avoid confusion for patients as there are different waiting times targets in place in these areas. These letters started to be sent in March 2017

The software issue impacting on reporting at the Dental Institute has been effectively addressed. Patients there are now included, with updated figures presented from March 2016.

Use of independent sector ceased from April 1 2016; internal capacity is unable to fully cover this previous activity which will impact on performance. Use of independent Sector recommenced in November 2016 and is in place until March 2017. Details of DCAQ work including efficiency improvements that we are undertaking are described below:-

- Review of Acute Services' available capacity and demand undertaken to inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue (DCAQ) exercise examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties.
- Move from data collection and analysis to performance monitoring and improvement trajectories.
- Cessation of independent sector capacity from April 2016, factored into DCAQ work
- Independent sector engagement for additional 'See and treat@ capacity recommenced in November 2016.

In line with the National Towards Our Vision for 2020 Delivering Outpatient Integration Together Programme. Aim of the programme is manage flow through consistently and sustainably delivering a suite of changes.

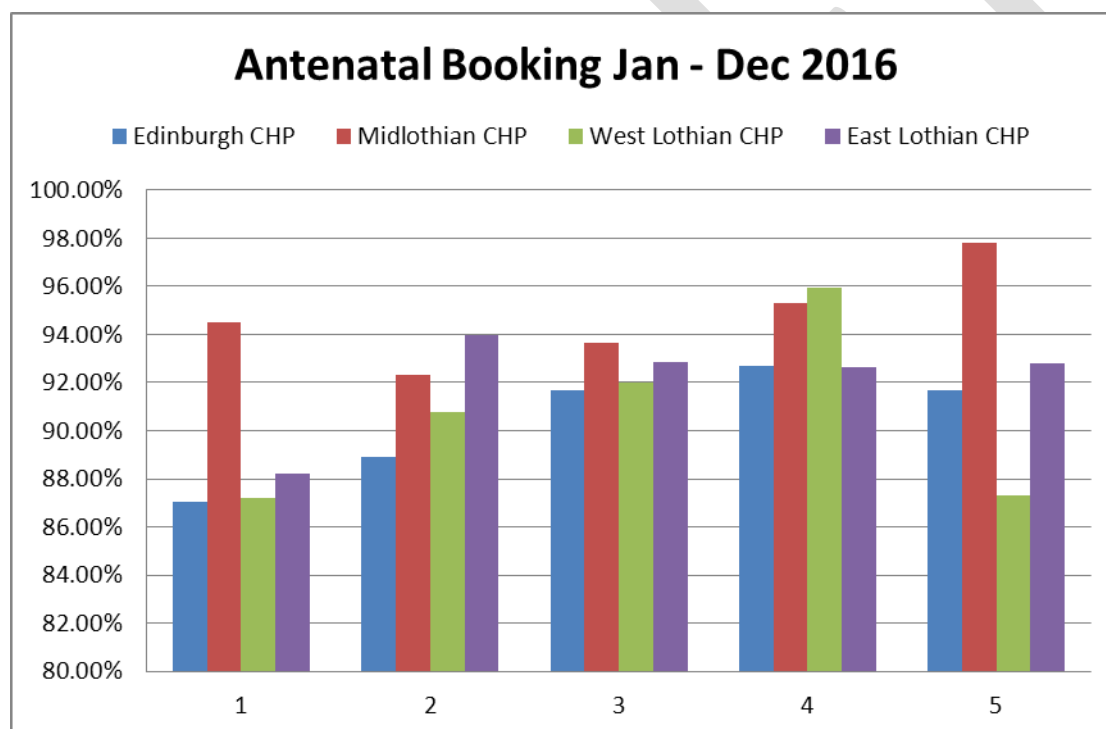
Progress following work streams;

- Advice Only – Allows clinician to provide advice as an alternative to an outpatient appointment where appropriate and safe to do so.
- Accommodation Matrix – 'At a glance' view of physical clinic space which is used by Outpatient Service Manager and Clinical Service Managers to identify available staffed clinic space and facilitate clinic reconfiguration without additional resource, thus increasing capacity for both new and review patients.
- Return Patient List – Demand for return patients will be captured. Allowing return patients to be seen at clinically appropriate times. Capacity can be planned in advance; rescheduled return appointment through cancellation will decrease, protecting new patient slots.
- Template Harmonisation – process of reviewing clinic templates to ensure they reflect current practice and demand
- Review of the Refhelp service for GPs focusing on key specialties under significant pressure. GP and Specialist engagement in the review.
- Detail on waits per specialty to be made available to GPs so they are aware of length of wait prior to referring.
- Engagement with 'Leonardo' to progress 100 day project on primary and secondary care collaboration on future role of outpatients.

- 'The Modern Outpatient, a collaborative Approach' has been launched by SG and its implementation is being progressed through Outpatient Strategic Board.
- Clinical Board established to progress development of plan for 'Consultant to Consultant' referrals, establishing clear expectations for referral of patient to outpatients and review and progression of Refhelp.
- Develop business case for implementation of patient focussed booking.
- Independent sector capacity for see and treat patients has been switched on at Spire Healthcare.
- Re-engagement with Medinet for Adult and Paediatric ENT and Dermatology

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation. Antenatal access supports improvements in breast feeding rates and other important health behaviours.

In December 2016, NHS Lothian met the performance target, 88.8% of pregnant women in each SIMD quintile had booked for antenatal care by the 12th week of gestation against an 80% performance target.



*80% is zero in the above chart (HEAT target = 80%)

- NHS Lothian is above 80% for all SIMD quintiles in Lothian
- We are aiming to maintain and improve on our good results by continuing to implement our good practice and use improvement methodology
- Community Midwifery Services receive statistics monthly from centralised booking and this keeps us on target
- A quarterly centralised booking meeting is a way of continuously improving our processes and to ensure that the information that we are distributing is current. This is done in conjunction with Health Promotion Services and contains relevant public

health reminders and so this becomes a way to spread relevant public health messages (e.g. Flu vaccinations)

- As part of early intervention and prevention strategies, midwives undertake the following risk assessments at booking visit (7-10 weeks) These include:
 - Routine Enquiry for Gender based violence
 - CO monitoring/smoking
 - Alcohol brief intervention

Early booking compliments the pending new strategy for maternity and neonatal care; maternal and infant nutrition work; the new universal pathway pre-birth to preschool, FNP support for teenage mothers, GIRFEC and the Children and Young People (Scotland) Act aims.

Eligible patients commence IVF treatment within 12 months (90%). Shorter waiting times across Scotland will lead to improved outcomes for patients.

In December 2016, 100% of eligible patients commenced IVF treatment within 12 months thus exceeding the standard. NHS Lothian anticipates exceeding this standard in 2017-18.

18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%). Early action is more likely to result in full recovery and improve wider social development outcomes

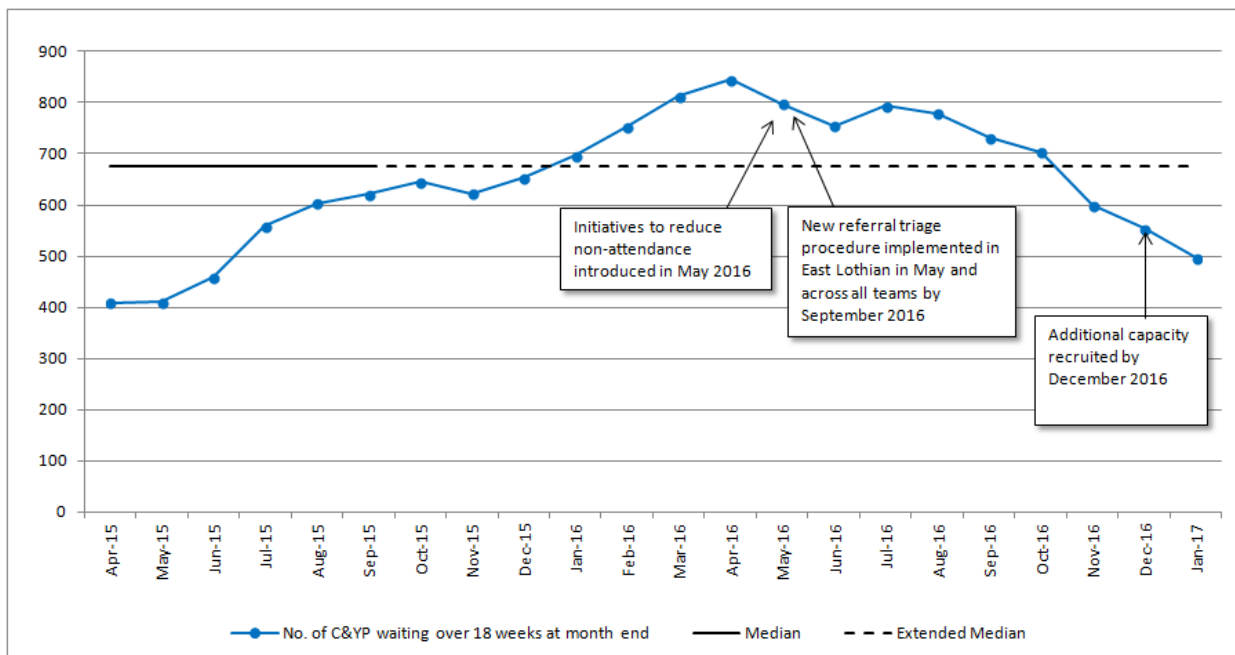
In January 2017 the performance showed a 42.4% against a target of 90% of patients meeting the target.

While there are a number of different specialist teams, the bulk of activity is managed via the outpatient teams with the majority of long waits on the generic waiting list.

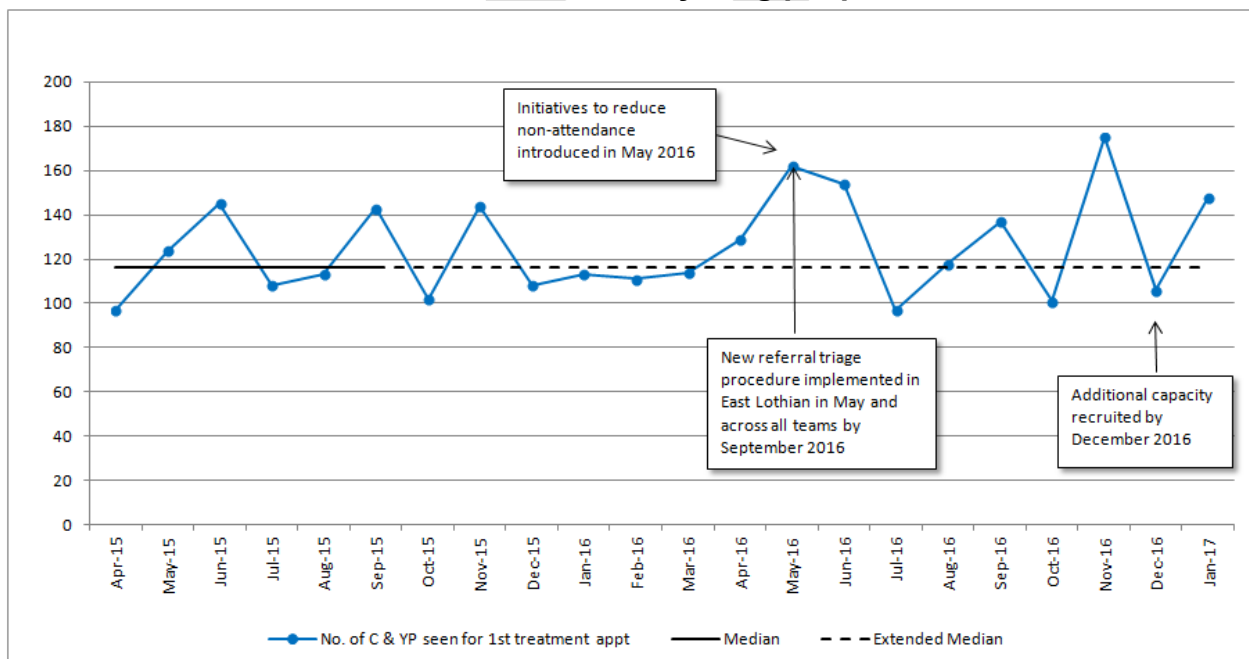
The CAMHS Recovery Plan was developed and implemented from September 2018. It covers the period of one academic year only and has 3 main strands designed to increase the number of patients treated and reduce long waits.

- Change in Link Worker Capacity Building Time
- Reduction in CHOICE assessment clinics
- Recruitment of additional staff

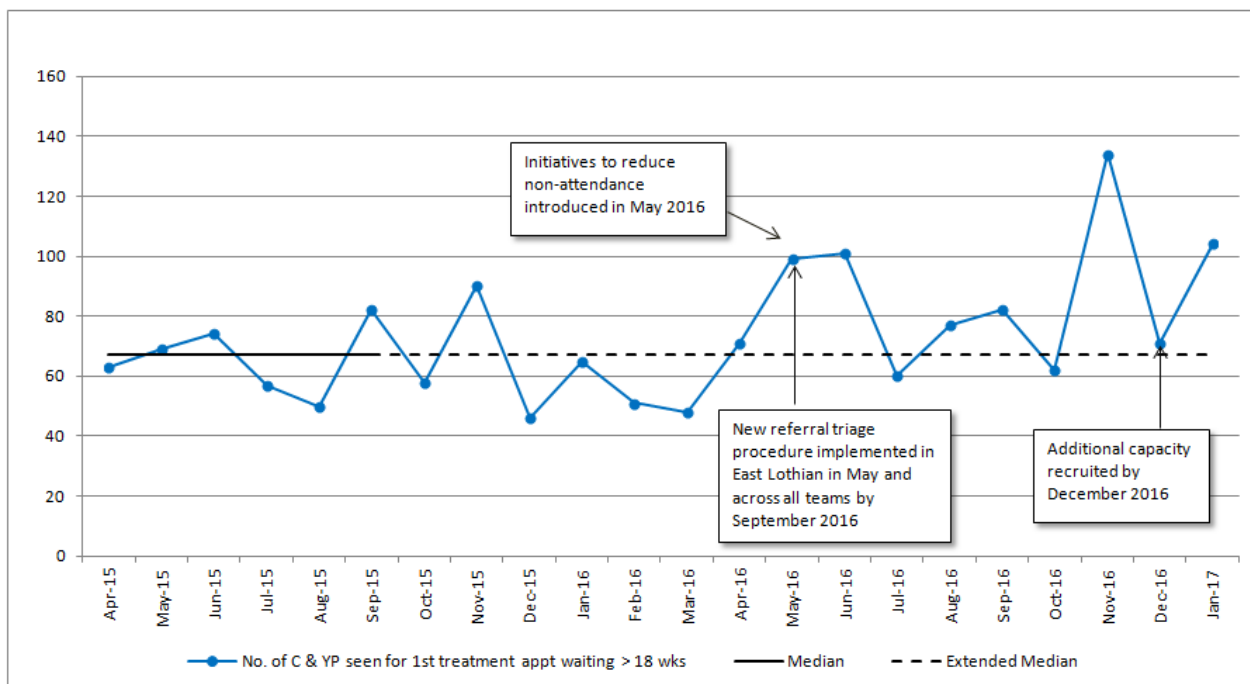
All Generic Teams - Number of children and young people waiting over 18 weeks



All Generic Teams - Number of children and young people seen for 1st treatment



All Generic Teams - Number of children and young people seen for 1st treatment waiting over 18 weeks when seen



18 weeks referral to treatment for Psychological Therapies (90%).

Timely access to healthcare is a key measure of quality and that applies equally to mental health services.

The 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.

In January 2017 65.2% of NHS Lothian patients were achieving the above target.

An additional 12 WTE psychologists are required to clear the queue of patients waiting. "Building Capacity" allocation has been agreed at 10.5 WTE Clinical staff for Adult mental Health General Services to be recruited on a permanent basis.

- 9.5 WTE Clinical Staff have been recruited to as of October 2016.
- WTE Band 8a remains to be recruited to.
- 0.8 WTE band 7 has been recruited to CFS service from these funds.

Actions planned to improve compliance with the LDP standard includes:

- Updated Service Improvement plans for each service / team delivering psychological therapies.
- A single prioritised amendments / additions work-plan for TRAK with named analytical, data and system support staff from clinical services, e-health and planning.

- Development of a single implementation plan for the introduction of Patient Focused Booking across all service delivering psychological therapies.
- Development of a single implementation plan for the introduction of Text Reminder system across all service delivering psychological therapies.
- Agreement of norms per WTE for direct clinical contact (appointments) based on banding and role across teams delivering psychological Therapies. Improved reporting of expected versus actual activity.
- Amendment of the Meridian work allocation tool within Psychological Therapies in Edinburgh only for job planning with nurses and AHP delivering formal Psychological Therapies within REAS.
- Completion of updated DCAQ for all general adult services.
- Completion of remaining DCAQ for all services / teams whose data is recorded and reported from TRAK.
- Introduction of Lothian-wide Group Programme funded by Mental Innovation funding.

Clostridium difficile infections per 1000 occupied bed days (0.32) SAB infections per 1000 acute occupied bed days (0.24). NHS Boards area expected to improve SAB infection rates during 2017/18. Research is underway to develop a new SAB standard.

In January 2017, performance was 0.31 SAB infections per 1000 acute occupied bed day against a target of 0.24. The actions to support improvement in SAB infection are outlined below:

- Development of more detailed action plan in conjunction with Quality Improvement.
- Infection Prevention and Control to improve quality of information reported to clinical and senior teams in relation to SAB.
- Additional resources to support education and clinical practice to work with clinical teams in the reduction of invasive device related SABs.
- Quality Improvement and education of all staff involved in the care of invasive devices is essential to ensure safe practice.
- The two staff appointed must deliver local education to improve practice in areas with highest incidence of device related infection.
- Through education and patient safety ensure all levels of staff involved in insertion, maintenance and use of invasive lines deliver safe and effective practice and demonstrate competency and compliance in use of asepsis.
- Essential all medical staff as well as nursing staff are appropriately trained and competent in the handling of lines.
- Shared learning and practices from areas where invasive lines infection rates are low should be developed through quality improvement teams.
- A review of skin preparation products to ensure the correct product CA2CSKIN is being utilised supported by updated communication and education.
- Standardise transparent dressings utilised for invasive vascular devices to ensure compliance with best guidelines
- Establish a quality improvement project to consider the efficacy and benefit of using antimicrobial lock solutions e.g. Taurolock.
- Catheter care should be reviewed and catheter use needs to be discouraged when not absolutely necessary and access to alternatives explored.
- Roll out of SPSP CAUTI Bundle to areas reporting catheter associated infections using the Pareto charts to prioritise implementation.

- Improve compliance with National MRSA Screening Clinical Risk Assessment ensuring decolonisation/suppression therapy is implemented where clinically indicated.
- Evaluate the impact of routine decolonisation to reduce the incidence of Hickman and PortaCath related SAB should be considered with a view to implementation in other units with high central line use.
- Review of blood culture sampling practice and education for front door areas
- Test of Change within Emergency Department at the RIE on the effectiveness of grab bag approach to blood culture sampling. Grab bags would contain all equipment required for safe sampling and a reminder message outlining what is best practice within the pack.
- Ensure education of all staff undertaking blood culture to ensure competency and safe practice.
- Review blood culture contamination rates as a standing item discussed weekly at ward safety briefs and at departmental M&M meetings, Ensure feedback and education of staff with poor technique, reducing the risk of contaminated samples.
- Introduction of the Visual Phlebitis scoring as part of the patient safety bundle.
- Raise awareness of risks associated with unsafe injection practices with People Who Inject Drugs (PWIDs).
- Frontline clinical teams to ensure opportunities for education to PWIDs when presenting within acute setting.

Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%). Services for people are recovery focused good quality and can be accessed when and where they are needed.

In July -September 2016 85.4% of clients will achieve the above standard against a target standard of 90%.

The Substance Misuse Directorate (SMD) is continuing to use the productivity work to maximise capacity in local services. Actions to improve performance are summarised below;-

Discussions are ongoing with the three ADPs and four IJBs about what the likely available funds for the remainder of this financial year and next will look like significant reductions are still expected which will impact on ability to deliver 3 week target.

The review of residential services is ongoing and the impact on services will be addressed as part of this review.

The Lothian Substance Misuse Collaborative, the three ADPs and the four IJBs are working to take proposals forward to each organisation's Board to highlight what is required to meet the access target in each area and ensure sustainable services. ADPs are drawing together risk assessments on the impact on service delivery of the 23% reduction in ADP funding and these will be agreed through local IJB governance structures.

In addition NHS Lothian, the ADPs and the Health and Social Care Partnerships have agreed to progress the recommendations from a piece of commissioned work completed by McMillan Rome. The report and proposed next steps have been circulated to service leads. The Lothian Wide Substance Misuse Collaborative Group has set up several task groups to

progress the detail of each recommendation. This was further discussed and refined at November Collaborative Meeting and leads identified.

Initial outcomes were discussed in December and further work is ongoing to identify risks and mitigations to each task. Savings have been identified but not to the level of 23% required.

Proposals and the impacts of these proposals are now going through governance processed CMT and the four partnerships. During February and March.

Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

In December 2016, NHS Lothian met the target. 16,831 alcohol brief interventions were delivered against an annual target of 9,757. ABI National Guidance from the Scottish Government 2017- 18 sets NHS Lothian ABI delivery target 9,757.

NHS Lothian will meet the new ABI delivery target in the priority settings and will report accurate data quarterly to Information Services Division (ISD) by submitting further demographic data e.g. age gender, postcode. Further data will be obtained and evaluated around hard to reach groups where deprivation is greatest.

It is expected that at least 80% of delivery will continue to be in the priority settings. The remainder will be delivered in wider settings in accordance with the national guidance.

It is expected that NHS Lothian will exceed the target as illustrated in previous years outlined below.

Phase 1 – HEAT Target 2008-2011

- Outcome: NHS Lothian delivered 29,884 ABIs which represents 127% of the target (23,594)

Phase 2 –HEAT Target 2011-2012

- Outcome: NHS Lothian delivered 17,093 ABI's which represents 172% of the target (9,938)

Phase 3- HEAT Standard 2012-2013

- Outcome: NHS Lothian delivered 18,275 ABI's which represents 184% of the target (9,938)

Phase 4 –HEAT Standard 2013-2014

- Outcome: NHS Lothian delivered 23,735 ABI's which represents 239% of the target (9,938).

Phase 5 – HEAT Standard 2014-2015

- Outcome: NHS Lothian delivered 24,388 ABIs which represents 244% of the target (9,938).

Phase 6 – HEAT Standard 2015-16

- Outcome NHS Lothian delivered 28,972 ABI's which represents 294 % of the target (9757)

Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas. Enabling people at risk of health inequalities to make better choices and positive steps toward better health.

NHS Lothian will sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas by providing an accessible cessation service in our most deprived communities, targeting key community facilities and assets.

At September 2016, 454 successful quit attempts were achieved in Quarter 1 and 2 2016 (April to September) which accounts for 31% of the overall 2016-17 target.

Smokefree Lothian's mission remains to provide an effective cessation service to hospital patients, both acute and mental health, pregnant women and their families and supporting Smokefree Prisons providing a cessation service in both Lothian Prisons.

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For 2017-18 we have reviewed the quit targets and have started planning the delivery of a 'Shared Care Model' across NHS Lothian. The aim will not only be to promote a more effective patient care model but to also increase the performance of NHS Lothian's Smokefree Pharmacies. It is expected this Shared Care Model will lead to an additional increase in successful smoking quits of circa 10% to be delivered through pharmacies.

Actions planned to improve performance include:

The core NHS service is entirely funded from a Scottish Government allocation. The service remains in the process of significant redesign to meet reductions in budget including a reduction in the Scottish Government allocation. As a consequence there has been disruption to staffing levels.

A new service manager took up post In December soon to take forward further improvements and will help optimise the outcomes the service can achieve against reduced funding.

The New Service Manager and Consultant in Pharmaceutical Public Health established a Smokefree Lothian Working Group, they agreed to target low performing Pharmacies and review training and resources, including administrative support from Smokefree staff. Discussions are taking place about a future shared care model 17/18.

48 hour access or advance booking to an appropriate member of the GP team (90%). Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients.

Following the removal of the 48 hour access indicators in the Quality Outcomes Framework (QOF) for 2015-2016 there is no longer local monitoring of 48 hour access to GP services. Access is instead assessed through the two-yearly and centrally delivered National Health and Care Experience Survey.

Results from National Health and Care Experience Survey

	2009/10	2011/12	2013/14	2015/16
48-hour GP/HCP access	90.0%	84.0%	85.0%	85.0%
Advance booking	77.0%	80.0%	77.0%	75.0%

The most recent report shows declining satisfaction with access. This correlates with the increase in GP practices in Lothian experiencing difficulty in recruiting and retaining staff (a phenomenon being experienced across Scotland) and the introduction by some practices of restrictions on new patient registrations. There is unlikely to be any significant improvement in this position until the new GP contract is introduced in autumn 2017.

Sickness absence (4%) A refreshed Promoting Attendance Partnership Information Network Policy will be published in 2015.

In December 2017 5.30% of NHS Lothian staff hours have been lost to staff sickness time against a standard target of 4%.

Actions planned to improve staff hours lost are outlined below:-

- Attendance Management Training Sessions continue to be held.
- Master Classes have also been held to assist managers in dealing with difficult conversations at work in the context of staff absence.
- Targeted support has been put in place for absence hotspots i.e. Nursing Bands 1-5 and A&C Bands 1-4.
- Absence Review Panels have taken place to review how absence cases are being handled and provide further advice and guidance.
- An Absence Dashboard available to all managers has been set up to facilitate effective performance monitoring.
- As part of the Efficiency and Productivity Group a sickness absence project has been set up to focus on what could be put in place to assist with an improvement in absence levels. This will initially be focussed on the RIE but any successful improvements will be rolled out across NHS Lothian.
- An Internal Audit of Absence Management has recently taken place. The overall summary was that there are appropriate controls in place to manage sickness absence within the organisation with only a few control issues to be addressed which will now be taken forward.
- A paper was taken to the Staff Governance Committee and the Lothian Partnership Forum in January 2017, and agreement reached that a Health and Wellbeing Strategy should be developed over the next 6 months to focus on trying to prevent absence by addressing the health and wellbeing of staff.

Outlined above are some of the actions that are being undertaken to support managers currently with this task. The sickness absence assurance levels will also be discussed and reviewed at the Staff Governance Committee in March 2017.

4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%). High correlation between emergency departments with 4 hour wait performance between 95 and 98% and elimination of long waits in A&E which result in poorer outcomes for patients

In January 2017 performance against the 4 hour target was 92.8% set against the standard target 95%. 93.5% Year to date, 93.2% Month to date Inclusive of WGH (10.02.17) (Increase of 0.4 % and 2.6% respectively since Jan reporting)

Winter planning is well embedded and rolled out across the system. Additional bids included to support patient flow across the system, for example extra pharmacy support to the discharge lounges

Investment in virtual ward models of care such as HAH, H2H and D2 Assess, across the partnerships and acute system are in place and the number of teams has increased in number to support care provision at home.

Local Service Improvement teams are taking forward a number of diverse improvement activities including daily dynamic discharge and a check chase challenge approach to planning discharge from hospital

Edinburgh locality model continues to evolve; focusing on admission avoidance and ensuring timely discharge from hospital.

Weekly teleconference with the IJB Chief Officers and COO and acute teams to discuss pressures and performance with a view to enacting actions to support mitigation of risk continues

Key actions to support improvements associated with the 4 hour target include:

- Deliver on Lothian's winter plan that included reducing elective bed pressures in January to support unscheduled capacity, enhancing weekend services and strengthening services that manage increased winter demand and support flow. The plan builds on the need for whole system working across acute, primary and social care services. Working with Integrated Health Boards is assisting with the promotion of care at home services and shifting away from hospital admission being considered as the 'default' position.
- Focus on care in the community models is evidenced such as HAH virtual wards and H2H support for patients requiring POC
- Implement national 6 essential actions unscheduled care toolkit on all three acute sites. These are integral to planning and delivery unscheduled care services, including winter.
- Implement recommendations from the Deloitte report around Frailty pathways and Length of Stay.
- Implement SEFAL (Safe Effective Flow across Lothian) work stream shifting discharge curve to earlier in the day and avoiding more unnecessary admissions.
- Referred to the Flow Centre for short.

Performance is better to date than last year at this time but monitoring of sustainability is ongoing. All acute sites experiencing high acuity of patient workload impacting on the resource at the front door areas as the patients are stabilised. There is a vigilant focus on prevention of crowding in the assessment areas and a strong senior team presence 7 days on the RIE (largest site) has been effective in supporting the site in anticipating and proactively managing the complex situations which can present.

Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement. Sound financial planning and management are fundamental to effective delivery of services.

NHS Lothian continues to assess the financial plan for 2017-18 with the aim of achieving a balanced position. Work is on going to support business units in the delivery of financial recovery plans to meet the challenge of closing the financial gap.

The LDP Standards are intended to provide assurance on sustaining delivery which will only be achieved by evolving services in line with the 2020 vision. The Scottish Government will continue to review the LDP Standards to ensure that their definitions are consistent with changes in service delivery through the 2020 vision.

5.0 PATIENT EXPERIENCE AND SATETY

5.1 Patient Experience

Tell us Ten Things - “Tell us Ten Things” (TTT) was a local patient experience survey programme previously based within the Universities Hospital Services. We reviewed the questions at the end of 2015 against best practice and aligned with the “5 must do elements” of the national Person Centred Health and Care Programme:

- What matters to you?
- Who matters to you?
- What information do you need?
- Nothing about me without me
- Personalised contact

During this last year we have been working hard with the clinical teams across the organisation to improve our response rate, thus giving as many of the patients the opportunity to give us their feedback on the care they have received. We are also looking to see how volunteers can assist us with this. The results are shared at every Healthcare Governance Committee and through our regular reporting function to NHS Lothian Board.

Patient Opinion – The Head of Patient Experience responds to all postings on Patient Opinion (PO), thanking people for sharing their feedback with us and sharing this with the staff concerned. Where the feedback is less positive / critical we invite the person to make contact with the Patient Experience Team so that we can ask a few more details and look into their concerns. More recently, a number of frontline clinical staff have requested access to the PO system so that they can respond directly to the person.

New Model Complaints Handling Procedure - We have been working hard to prepare for the implementation of the new model CHP ahead of its implementation on April 2017. We have been hosting a number of staff awareness sessions across all the clinical management teams and have updated our complaints policy which is currently being consulted upon. Whilst we see the April date for implementation as important we believe that this will be a longer term programme of work with the staff and this will be a key priority for us for the year ahead. In addition to this we have working with our partners in the 4 local authorities to see how we can improve our process for those complaints that cross the health and social care boundaries.

Involving People Meaningfully in Service Design and Improvement (including using the Our Voice framework).

NHS Lothian recognises that involving patients, carers and the public is a very important part of improving the quality of its services and to this end has made it a requirement of NHS Lothian Board and its committees, that papers proposing service change, improvement or policy set how service users and public have been involved and the outcome of the involvement. NHS Lothian looks forward to working with Our Voice local peer network to explore how they can contribute to the development of services and how national learning from the Our Voice can inform local service improvement.

5.2 Patient Safety Programme

NHS Lothian in collaboration with the Lothian Health and Social Care Partnerships will be focussing on the following priorities during 2017-18 which are aligned to the Scottish Patient Safety Programme Core Themes.

- Sustain improvements in falls and the delivery of the safety essentials
- Deliver a programme of safety walk rounds across primary and secondary care
- Improve the management of deteriorating patients in acute hospitals and mental health wards
- Improve the management of Sepsis in acute hospitals and continue to be a Health Improvement Scotland pilot site for management of Sepsis in a primary care
- Improve the medicines reconciliation at front door acute hospitals
- Improve the prevention and management of pressure ulcers
- Contribute to the reduction in *Staphylococcus aureus* Bacteraemia (SABs) through reliable PVC/CVC insertion and maintenance

Management of Healthcare Associated Infections

Clostridium difficile infections (CDI) incidence per 1000 occupied bed days (0.32)

Staphylococcus aureus Bacteraemia (SAB) infections incidence per 1000 acute occupied bed days (0.24).

The current LDP notes that HAI LDP standards are not changed and are carried forward from 2016/17 the requirements note there is research underway to develop a new SAB standard.

Discussions are taking place at a national level in relating to hospital associated infections.

1. There is a proposal for changes in denominator data which could impact on the actual final LDP requirements for SAB and CDI in 2017-18.
2. Additional LDP standards' being discussed at various national meetings with representatives from SGHD and this includes a reduction in *E.coli* Bacteraemia (ECB) for which surveillance became mandatory in April 2016.
3. Health Protection Scotland also intend to implement a change to the categorisation of cases of *C. difficile* which will no longer be divided into two categories by age (e.g. 15-64 years and over 65 years) but will all be reported as age over 15 years. Also the categories of Hospital Acquired and Healthcare associated are being merged into one category of Healthcare Associated *C. difficile* infection. This will result in some change in the categorisation and reporting of NHS Lothian's data nationally.

Caveat: At the time of preparing this action plan the information on revised and any additional LDP requirements was not available. The meeting between the Health Minister and the HAI Policy Unit to discuss proposals is not scheduled until late February 2017. Therefore this action plan is subject to change depending on the outcomes of these discussions.

Delivery and Improvement

Risk	Management of Risk
<p>There is a risk of harm to patients through routine and essential clinical interventions</p>	<ul style="list-style-type: none"> • The application of care bundles related to Healthcare Associated Infection, for example for insertion and maintenance of central venous lines, peripheral venous cannulae and urinary tract catheters assist in reducing the risk of bacteraemia. • Targeted work to reduce blood culture contamination rates and thereby possibly avoid unnecessary further investigation of bloodstream infection and possible unnecessary antimicrobial exposure. • Compliance with antimicrobial prescribing guidelines to reduce the risk of healthcare associated Clostridium difficile infection (CDI) and avoid selecting antimicrobial resistance.
<p>There is a potential risk to patients through poor knowledge of staff regarding best practice relating to prevention and control of infection</p>	<ul style="list-style-type: none"> • All staff should have an HAI objective within their annual work plan and linked practice development activity in their personal development plan. • The HAI Education Strategy is currently under review pending launch of new national training packages, and is available on the intranet • The National Infection Control Manual is available on the intranet and supplemented by 7 day access to a duty IPCN service for advice and guidance. • 7 day access to advice about infection control also requires out of hours input from microbiologists and virologists • The National manual only covers 3 chapters of generic advice but doesn't cover specific common infection and our local manual requires review to ensure up to date guidance regarding common issues like MRSA management or MDR Gram negative management which creates a risk as staff do not have access to information regarding how to apply best practice in such situations.
<p>Poor compliance with standard and transmission based precautions can increase the risk of acquisition and transmission of infection.</p>	<ul style="list-style-type: none"> • Clinical teams undertake a scheduled programme of audit of SICPs compliance. • Senior Charge Nurses and Clinical Nurse Managers are responsible for taking remedial action in relation to suboptimal audit results; including formulating structured improvement action plans as appropriate. Progress with these should be monitored by site Infection Control Committees. • The Infection Prevention & Control Team undertake regular informal and formal quality assurance audits of SICPs and TBPs. There is regular ward based review of patients with known infections due to alert organisms.

Risk	Management of Risk
<p>Failure of local ownership/leadership and corrective action regarding suboptimal performance relating to SICPs compliance can lead to acquisition of healthcare associated infections and can impede identification of lessons to learn and areas to improve when HAIs occur.</p>	<ul style="list-style-type: none"> • Local ownership by site and clinical teams of improvement action plans and support of the implementation of wider HAI related strategies is critical, and must continue to be strengthened further, particularly through site based infection control committees providing such a site HAI governance structure and forum for discussion. • Aggregated data (e.g. <i>C. difficile</i> incidence) to facilitate wider performance monitoring and management across a range of measures is provided to key governance and management committees on a monthly and quarterly basis. This includes progress with local trajectories for LDP targets. • Key data are collated and reported monthly to site & ward level to allow local clinical and management teams with support from the Infection Prevention and Control Team (IPCT) and others to target improvement actions to further reduce HAI. Reports are freely available on the IPCT intranet page. • Data is presented using a variety of methods including Pareto charts and Statistical Process charts to facilitate meaningful local analysis, and target interventions towards the areas of highest risk. • Local Site Infection Control Committees are responsible for guiding local ownership and action to support interventions for local reductions in HAI. Oversight and governance is provided by the NHS Lothian Infection Committee. • Root Cause analysis (RCA) of SABs that are considered healthcare associated is undertaken by clinical teams with support from IPCT within two working days. RCA can identify intrinsic and extrinsic risk factors may have contributed to acquisition of infection. • The IPCT in conjunction with medical staff from microbiology conduct a detailed monthly review of all SABs to identify emerging themes or issues which can guide SAB prevention quality improvement strategies, education and practice development within the local department/service. • Clinical Teams will continue to engage with Scottish Patient Safety Programme in the use of care bundles and improvement methodology.

Risk	Management of Risk
<p>There is a risk a focus on acute and in-patient services could miss opportunities for prevention and control within other healthcare contact settings including clinics, GP practices as well as care homes</p>	<ul style="list-style-type: none"> • A risk based and proportionate approach is taken to providing IPCT support in NHS Lothian based on case distribution, acuity and risk. The microbiologists in NHS Lothian aim to review all patients with CDI and SAB within 24 hours of diagnosis and in collaboration with the IPCT retrospectively review the management and outcomes and surveillance categorisation of all CDI toxin positive lab tests and patients with SAB on a monthly basis. This allows identification of key issues and themes for improvement action, and includes all NHS Lothian healthcare premises and GP practices. • The IPCT analysis includes a review of all healthcare contact and treatment in the preceding 12 weeks. Where a potential or actual risk factor for acquisition is identified, action should be taken by the relevant healthcare department to investigate and address if there are issues of suboptimal healthcare delivery which may have contributed to HAI acquisition. • Where issues arise relating to health and social care provision (e.g. Care Homes) the IPCT liaise with the Health Protection Team work to ensure that appropriate advice, education or action is taken in response to the case. • The IPCT support other working groups and programmes including the Scottish Patient Safety Programme, Vulnerable Groups Steering Group, Care Assurance Standards project board to implement wider preventative measures to reduce the risk of HAI acquisition e.g. prevention of pressure sores, optimum management of diabetic ulcers, implementation of PVC care bundles. • In collaboration with the Health Protection Team, the IPCT work with primary care, health and social care partners, to optimise early intervention in the community when an HAI is identified in order to reduce the risk of further HAI acquisition.

Staphylococcus aureus Bacteraemia

NHS Lothian will work to continue to reduce the incidence of *Staphylococcus aureus* Bacteraemia (Meticillin Resistant *Staphylococcus aureus* /Meticillin Sensitive *Staphylococcus aureus*). This involves a multi-disciplinary team approach to the prevention on *Staphylococcus aureus* Bacteraemia with a delivery and improvement action plan outlining the following actions:

No	Improvement Plans for 2017-18	Expected Date of Completion
1	<p>Infection Prevention and Control to improve the quality of information reported to clinical and senior management teams in relation to SAB through the development of Tableaux dashboards</p> <p>Responsible Person(s): Head of Service Infection Prevention and Control, Tableaux Leads</p>	June 2017
2	<p>Using enhanced surveillance data, the IPCT will work collaboratively with key clinical teams e.g. diabetic services and renal services; to develop and deliver appropriate interventions to reduce the risk of SAB in high risk patient groups.</p> <p>Responsible Person(s): Lead IPCN, Clinical Scientist, Lead ICD and clinical representative</p>	Sept 2017
3	<p>Raise awareness of national HIS/SAPG guidance regarding best practice regarding clinical management of SAB.</p> <p>Responsible Person(s): Local IPCN teams, Clinical Scientist, medical infection specialists</p>	March 2018
4	<p>To work to ensure that all clinical staff (medical, nursing and allied health professionals) receives appropriate education and training and can demonstrate competency relating to the insertion, maintenance and use of vascular access devices and other invasive devices.</p> <p>Responsible Person(s): Head of Education and Employment / Patient Safety Programme Manager / Associate Medical Directors / Associate Nurse Directors / Senior Charge Nurse / Consultants</p>	Dec 2017
5	<p>Establish membership and terms of reference for a revised Community and Integrated Joint Board Infection Control Committee to ensure appropriate oversight and action relating to HAI matters across all service providers.</p> <p>Responsible Person(s): Head of Services, HAI Executive Lead , IJB programme Leads</p>	March 2018
6	<p>Through introduction of CRA on TRAK improve compliance with National MRSA Screening Clinical Risk Assessment facilitating appropriate placement and that decolonisation/suppression therapy is implemented where clinically indicated prior to procedures and admission. Nursing staff undertaking MRSA screening should be encouraged to complete the NES screening and MRSA education packages.</p> <p>Responsible Person(s): Associate Nurse Directors /</p>	Nov 2017

	Senior Charge Nurse. Infection Doctors, Senior Charge Nurses	
7	Development of the Infection Services web pages to provide easier access to clinical teams to information, policies and guidance documents Responsible Person(s): NIS SLWG led by Chair of AMT	Dec 2017
8	SPSP to promote and embed the use of Visual Infusion Phlebitis (VIP) scoring as part of the PVC care bundle. Responsible Person(s): Patient Safety Programme Manager / Senior Charge Nurses	March 2018
9	Integrate mortality review of all HAI related SAB deaths into the Severe Adverse Events reporting structure to optimise wider improvement and organisational learning. Responsible Person(s): Patient Safety Programme Manager / Senior Charge Nurses	August 2017
10	Strengthen membership of local IPC Committees to increase local ownership of data and corresponding actions for improvement Responsible Person(s): Site Associate Medical Directors	October 2017
11	Development of supplementary chapters to the Infection Control Manual for organism specific guidance. Responsible Person(s): Lead Nurse Infection Prevention and Control, Infection Prevention and Control Team. Infection Control Doctor	October 2017

Clostridium Difficile Infection

NHS Lothian will continue to work to reduce the incidence of *Clostridium difficile* infection. This involves a multi-disciplinary team approach to the prevention of *Clostridium difficile* infection with a delivery and improvement action plan outlining the following actions:

No	Improvement Plans for 2017-18	Expected Date of Completion
1	Strengthen membership of local IPC Committees to increase local ownership of data and corresponding actions for improvement Responsible Person(s): Site Associate Medical Directors	October 2017
2	AMT to establish a mechanism for identifying specialties or prescribers that consistently deviate from policy prescribing and have a forum for discussing the reasons why, resulting either in a revision of the policy acknowledging a legitimate reason for deviation or alteration in prescribing behaviour to comply with the existing policy. Responsible Person(s): Chair Antimicrobial Management Team	July 2017

3	<p>Improved Antimicrobial Stewardship CDI preventative strategies depend on effective antimicrobial stewardship, and management of other risk factors for CDI such as prescription of proton pump inhibitors (PPI).</p> <p>Antimicrobial Management Team to ensure that site, specialty and ward level data is shared with areas of high antimicrobial use, and/or use of antimicrobials associated with high risk of subsequent CDI. These reports will also be freely available on NIS web pages.</p> <p>Antimicrobial Pharmacists, and site/service Associate Medical Directors supported by the Antimicrobial team will lead review of prescribing practices, with access to the expertise of NHS Lothian infection specialists and promote education regarding best practice e.g. Scottish Antimicrobial Programme Guidance and NICE guidance as appropriate or other novel strategies to reduce the use of high risk antimicrobials.</p> <p>Regular performance monitoring reports with regard to antimicrobial consumption, resistance and adverse events associated with key antimicrobial groups to be made available to acute services CMG and NHS Lothian Infection Control Committee.</p> <p>Site and ward level reports to be developed and shared with local practitioners and directly and on the AMT Intranet page.</p> <p>Consideration be given to the wider roll out of the frail elderly restricted antimicrobial prescribing guidelines that has been piloted in St John's Hospital</p> <p>Review of surgical prophylaxis policies Responsible Person(s): Clinical Teams / Antimicrobial Management Team / Associate Medical Directors</p>	Sept. 2017
4	<p>Continued implementation of the strategy for primary care 4C prescribing authorised and supported by the medical director for primary care. Responsible Person(s): Antimicrobial Management Team / Associate Medical Directors / Medical Director for Primary Care /GP Sub Committee</p>	December 2017
5	<p>Staff undertaking administration of antimicrobials should be encouraged to complete the NES Antimicrobial stewardship education package. Responsible Person(s): Associate Nurse Directors / Associate Medical Directors Senior Charge nurses</p>	March 2017

6	Implementation of the Lothian loose stool policy and monitoring of compliance with this. Responsible Person(s): Geographical Lead Infection Prevention and Control Nurses / Associate Nurse Directors	May 2017
7	Promote prompt clinical assessment of patients with loose stool in line with HPS CDI clinical management guidance Responsible Person(s): Site Microbiologists or Consultant leading site Infection Rounds	May 2017
8	Infection Prevention and Control to improve quality of information reported to clinical and senior management teams in relation to CDI through the development of Tableaux dashboards Responsible Person(s): IPCT Clinical Scientist / Head of Infection Prevention and Control Services.	October 2017
9	Integrate mortality review of all HAI related CDI deaths into the Severe Adverse Events reporting structure to optimise wider improvement and organisational learning. Responsible Person(s): Lead Nurse IPCT, Clinical Governance and Clinical Management Group	June 2017
10	Establish membership and terms of reference for a revised Community and Integrated Joint Board Infection Control Committee to ensure appropriate oversight and action relating to HAI matters across all service providers Responsible Person(s): HAI Executive Lead, Head of Infection Prevention and Control Services, Chair CHP ICC and IJB Chief Nurses	March 2018
11	Improve dialogue with GPs regarding patients' testing CDI toxin positive in the community to assess whether they meet the HPS surveillance case definition before reporting to HPS as cases of CDI. Responsible Person(s): IPCT Clinical Scientist/ Microbiologists	March 2018

6. FINANCIAL PLAN 2017-18 to 2019-20

6.1 Financial Context

The financial outlook sets out a challenging position for 2017-18. The assessment of the 2017-18 financial position is based on the current forecast outturn, anticipated growth and assumptions around additional resources available. This is within the context of Lothian's population increasing, growing older and presenting with more complex needs requiring community and hospital support.

NHS Lothian's 2017-18 Financial Plan continues to strengthen the link between business unit plans and the delivery of financial balance, through the development of individual forecasts and specific action plans at Business Unit level. The financial planning process has also sought to recognise the Board's changing role in relation to the preparation of budgets for Integrated Joint Boards. As part of this process the Board will be considering the impact on performance associated clinical risk. It is also considering the requirement to develop a longer term financial strategy to support and deliver significant transformation and redesign of services.

NHS Lothian's 2017-18 financial position shows a financial gap for next year. An update of the additional 2017-18 costs and a review of available in year flexibility to support the position in conjunction with quarterly reviews between Finance and Service leads has resulted in refinement of figures to the Board to show a reduced gap of £22.4m.

Table 1 sets out the position reached to date on the financial plan. This is an improved position from that reported previously, and reflects the removal of any provision for the use of the Independent sector for activity next year. In addition, further resources of £13m have been added into the Plan, largely sourced from residual reserves, and these two elements represent the core drivers of the reduction in the gap as shown below. This means that all reserves have now been released to support the position.

Table 1 Financial Plan Summary

	April Board £000's
Baseline Carry Forward Pressures	(30,888)
Additional Costs, Growth, Uplifts & Commitments	(54,538)
Total Projected 17/18 Costs	(85,426)
Total 17/18 Additional Resources	37,510
Financial Gap Before Recovery Actions	(47,916)
Financial Recovery Actions Identified	25,540
Financial Plan Gap	(22,376)

The total projected additional costs for 2017-18 now equates to £85.4m. This represents £30.8m of baseline carry forward pressures and £54.5m of additional growth, uplifts and commitments. These additional costs are summarised in table 2 and 3 below.

Table 2 Summary of Baseline Carry Forward Pressures

Baseline and Carry Forward Pressures	£000's
16/17 GP Prescribing	8,553
Recurring C/F Unmet Efficiency Targets	6,837
Junior Medical Costs	4,500
Nursing Pressures	6,000
Waiting List Initiatives	2,000
Net Non-Pay Pressures	2,998
Total Baseline & C/F Pressures	30,888

Table 3 Additional Costs and Uplifts Identified

Projected Costs, Uplifts & Commitments	£000's
1% Pay Uplift	10,532
Apprenticeship Levy	3,624
Discretionary Points	1,084
2% General Non-Pay Uplift	4,850
Investment in Primary Care Services	2,000
8% Acute Medicine Growth	8,005
GP Prescribing Growth	10,507
Agreed Business Cases	1,744
Other Policy Changes	1,770
Service Pressures / Demographic Growth	10,422
Total Projected Costs	54,538

Key drivers of both the baseline carry forward and additional projected costs are explained in more detail below.

Junior Doctors

The financial plan includes forecast overspend of c. £4.5m on junior doctors. The forecast overspend position for 2016-17 is driven by rotas requiring an additional 70 whole time equivalents above the number of training grades to provide a safe level of cover. For 2017-18 a Project Board to be chaired by the Medical Director will be established with a remit to develop plans in relation to rota requirements, recruitment, reporting, monitoring and systems of internal control in with the aim of reducing the level of junior doctor expenditure.

Primary Care and Hospital drugs

The Financial Plan provides further funding of £8.5m to support GP Prescribing in 2017/18. This level of additional investment will result in the budget matching the 2016/17 outturn expenditure level. Funding will be aligned to ensure each partnership budget is consistent with this year's outturn position.

The anticipated GP prescribing growth in 2017/18 is currently estimated at £10.5m with an estimated £5.5m off-patent and community pharmacy contract tariff efficiencies to offset this growth. Table 4 shows the split of expected net growth in prescribing by Partnership, updated to reflect data at period 9 of this financial year.

Table 4 2017/18 Prescribing Analysis

	Funding to				
	Match	Revised	Estimated	Net	Net
	16/17	Total	Efficiencies	Growth	Growth
	Outturn	Growth	£000's	£000's	%
	£000's	£000's	£000's	£000's	%
East Lothian	£1,880	£1,253	£(711)	£542	2.6%
Mid Lothian	£1,352	£1,038	£(642)	£396	2.2%
Edinburgh	£2,098	£5,435	£(2,805)	£2,630	3.3%
West Lothian	£3,223	£2,782	£(1,342)	£1,440	3.9%
Total	£8,553	£10,507	£(5,500)	£5,007	3.2%

In order to mitigate the £5m net pressure, separate funding of £2m has been set aside to support a quality approach to prescribing to support the reduction in waste and unwarranted variation, although the savings are not currently shown in the plan from this quality initiative.

Acute Hospital Medicines also continues to feature as a significant growth area with estimates of almost £8m growth for 2017-18. Further work on acute medicines will be taken forward by the Medical Director through the leadership of the Effective Prescribing programme and this will be monitored through the Sustainability and Value work stream.

Service Pressures

There are a wide range of service pressures across the system, relating to issues of sustainability, demography, clinical priorities or policy decisions for which there is no funding source. Financial recovery plans are largely focussed on efficiency savings but require to consider opportunities to manage expenditure pressures either through looking at different service models, quality improvement opportunities or by considering the prioritisation of resources.

6.2 Unmet Efficiency Savings

At the start of 2016-17, a total efficiency gap value of nearly £13m was identified. Moving into the new financial year, this gap has been worked down to £6.8m.

Further work will be required over the next 12 months to manage this legacy gap down.

6.3 Waiting List Initiatives

The financial plan maintains provision for waiting list initiatives and the use of Golden Jubilee Hospital during 2017-18, as noted above, however the financial plan does not include any provision for the independent sector to address further capacity pressures including population and demographic growth on waiting times. Whilst plans will be developed to mitigate this demand and associated clinical risk, the impact on performance requires to be considered by the Board. A scheduled meeting with the Scottish Government to discuss the Boards approach to the management of performance will also be a key consideration for the Board.

6.4 Available Resources

Table 1 identified £37.5m of additional resource available to offset the £85.4m of additional costs discussed above. Table 5 shows the composition of the available resources along with the planned application of that resource. This is an increase of £13.1m from the value previously presented to the Board, with a significant proportion of these funds available on a non-recurring basis only. Recognising the increasing risk arising from the extent of recurring deficit the Finance & Resources Committee will be considering an initial outline of a longer term financial strategy of transformational change and major service and pathway redesign in order to achieve both a sustainable financial and operational future.

Table 5 Funding Source and Application

Funding Sources	Rec £m	Non- Rec £m	Total £m	Application
Base Uplift (0.4%)	5.4		5.4	£10.4m pay uplift
ODEL Benefit	5.0		5.0	£10.4m pay uplift
Year End Mgt		10.0	10.0	Acute & GP Prescribing
Additional DEL		4.0	4.0	Acute & GP Prescribing
Previously Identified Additional Resources	10.4	14.0	24.4	
Reserves	10.0		10.0	Held pending Review
Year End Management		3.1	3.1	GP Prescribing
Total Additional Resources	20.4	17.1	37.5	

The 2016/17 financial plan approved £33.3m of pressures funded from non-recurrent sources. The additional £19m 2017/18 NRAC funding received has been applied in conjunction with 2016/17 NRAC and recurring reserves to make good these funding arrangements recurrently in 2017/18 as shown in Table 6 below.

Table 6 Funding Source and Application

Funding Sources	Rec £m	Non- Rec £m	Total £m	Application
NRAC 16/17	6.0		6.0	Baseline Pressures, making good the 16/17 Financial Plan Allocations recurringly
NRAC 17/18	19.0		19.0	
Reserves	8.3		8.3	
NRAC & Recurring Reserves	33.3		33.3	

6.5 Financial Recovery Plans

In order to achieve a balanced financial plan, business units have continued to develop and review financial recovery actions, with £25.5m of actions identified to date. Of these, £4.7m are classified as being high financial risk as shown in table 7 below.

Table 7 Financial Recovery Plans By Financial Risk Rating

Financial Recovery Plan Summary	Financial Risk Rating			
	High Risk	Medium Risk	Low Risk	Grand Total
	£000's	£000's	£000's	£000's
Clinical Productivity	308	1,283	114	1,705
Drugs & Prescribing	1,014	6,812	25	7,851
Estates & Facilities	672	652	5,910	7,235
Procurement	40	1,065	32	1,137
Support Services	708	1,535	277	2,520
Workforce	1,971	2,990	131	5,092
FRP Total	4,713	14,337	6,489	25,540

6.6 Sustainability and Value

The Scottish Government has challenged all Boards to produce detailed plans to minimise waste, reduce variation and to standardise and share in order to deliver and drive efficiencies underpinned by principles of Sustainability and Value. The main key areas of review are:

- Implementation of the Effective Prescribing programme;
- A quality and cost assessed improvement plan to respond to Productive Opportunities identified from benchmarked performance:
- Reducing medical and nursing agency and locum expenditure as part of a national drive to reduce this spend by at least 25% in-year;
- Implementation of opportunities identified by the national Shared Services

Programme

NHS Lothian, in response to this challenge, will take the existing Efficiency and Productivity programme of work and realign these to ensure the Sustainability and Value key areas outlined above are being addressed. This work will also incorporate a resource evaluation of programmes being taken forward through the Quality Improvement Programme. Monitoring and evaluating the impact of plans will be essential.

6.7 Closing the Gap

NHS Lothian has a statutory financial requirement to deliver financial balance and the Plan describes a gap of over £22m at this stage. In terms of closing the gap, consideration has been given to a number of opportunities:

- Efficiency Savings – As noted above, the efficiency savings plan is currently projecting savings of circa £25m, of which almost £5m is high risk. In recent years achievement of savings in Lothian has been limited to this level, and there is a very low expectation that further efficiency savings will be delivered locally. Therefore additional savings are not anticipated to close the gap.
- Prescribing – Further opportunities for cost reductions may still exist within GP and Acute Prescribing, both of which anticipate significant growth next year. For GP Prescribing, an additional £2m of investment has been prioritised to support cost effective prescribing. The ambition is that this investment will prevent further growth in spend next year, reducing the cost gap of circa £5m. Additional funding of £8m has been set aside in the plan to meet the additional costs anticipated in acute drugs. There may be opportunities to curtail expenditure within this area, particularly through the Effective Prescribing programme highlighted earlier.
- NRAC – Despite additional NRAC funding of £19m for 2017/18, NHS Lothian remains £12m behind its NRAC parity figure in the new financial year. The shortfall against parity has existed since the introduction of the NRAC formula almost a decade ago, and this has resulted in Lothian being required to source non-recurrent solutions on an annual basis to achieve balance. The Board will continue to have dialogue with the SG to establish opportunities for additional NRAC funding in-year, recognising the historical shortfall against allocations received.
- The Health & Social Care delivery plan requires that IJBs plan for a reduction of 10% to unscheduled care bed days, representing circa 400,000 bed days across NHS Scotland. Applying an NRAC share to this figure, Lothian partners would be required to deliver a saving of around 60,000 bed days, equating to an indicative cost of £13.2m (based on direct and support services costs for Liberton hospital). As at end February the daily census identified 323 social care delays across the region, of which 41 were related to Mental Health services. The impact of this degree of delays includes boarding into elective and day beds within acute hospitals, resulting in poorer quality of care for patients and cancellation of surgical activity and increased costs. Budget allocations to Integrated Joint Boards will

reflect the expectation that this performance indicator will deliver financial benefit in their share of the set aside budget.

6.8 Integrated Joint Board 2017-18 Allocations

The NHS Lothian Board requires to establish budgets for the delegated functions of the Integrated Joint Boards for 2017/18. This latest iteration of the financial plan, once agreed, will form the basis of a formal allocation of budgets to each of the Boards. The next course of action required will be to engage in discussion with each IJB to agree directions and actions that will aid the reduction of the financial gap for their Boards and NHS Lothian. The directions will also require to outline how each Integrated Joint Board will work with NHS Lothian to deliver the 10% unscheduled care bed day reduction discussed previously.

Additional funding is anticipated under the heading of transformational change, impacting favourably on Primary Care and Mental Health Services, in line with the national strategy of shifting the balance of care. This resource will have a positive impact on the resources available to IJBs.

6.9 Next Steps

Recognising the Board's statutory obligation to achieve financial balance, there is further discussion required in relation to reducing the level of financial pressure presented within the 2017/18 Financial Plan.

Already taken into consideration is the achievement of £25m of financial recovery plans across Business Units. The ability to generate further savings beyond this level will be difficult to achieve but Business Units must continue to seek every opportunity for cost reduction and will look for Board approval and support in doing so. The Sustainability and Value programme will require to deliver significant additional benefits in order to increase the level of efficiencies close to the 5% target suggest by the Scottish Government.

Following the presentation of this update, the Director of Finance will send budget allocation letters to each of the Integrated Joint Boards with the request to formulate plans in relation to achieving the 10% unscheduled bed day reduction and issue directions that will improve the forecast financial gap for 2017/18.

Discussions are taking place within the region to develop a regional financial plan and Local Development Plan for the Scottish Governments September deadline. The development of this plan may highlight the potential for benefits from regional working.

6.10 Key Risks

Whilst every effort has been made to ensure all likely additional costs and national, regional and local priorities for investment have been incorporated into the financial plan at this time, there remain a number of inherent uncertainties and associated risks. The financial planning process is an on-going and iterative cycle, and it is not

possible to fully identify all financial risks facing individual service areas, nor the wider organisation at this stage.

A number of risks require to be considered by the Board:

- Consolidation of the individual Business Unit recovery plans do not give the required level of assurance that a balanced financial plan is achievable;
- Continued management of the financial exposure on elective and unscheduled care capacity pressures including delayed discharges;
- Availability of SGHSCD funding for both nationally funded programmes & initiatives and services funded annually on a non-recurring basis;
- Revenue impact of the capital investment programme including transitional or double running costs not yet identified, and development costs required to support all projects.

7.0 WORKFORCE PLANNING

7.1 Everyone Matters: 2020 Workforce Vision

NHS Lothian Everyone Matters: 2020 Workforce Vision 2017-18 Implementation Plan to support national priorities relating to Healthy Organisational Culture,

Sustainable Workforce, Capable Workforce, Workforce to Deliver Integrated Services and Effective Leadership and Management is detailed below.

NHS Lothian Everyone Matters Implementation Plan – 2017-18

Actions for 2017-18	
<p>Ensure delivery of their iMatter implementation plans, involve staff in decision making and take meaningful action on staff experience for all staff. (Healthy Organisational Culture).</p>	<ul style="list-style-type: none"> • Achieve full implementation of iMatter by July 2017 • Establish Staff Engagement and Experience Programme Board to provide leadership and strategic direction for staff engagement within NHS Lothian and through a number of initiatives seek to improve staff engagement and experience within the organisation. • Scope the development of a framework for staff engagement and experience, which transitions NHS Lothian to becoming a listening organisation, changing our communication approach from ‘telling’ to ‘sharing, listening, responding, empowering and enabling’ and supports our Cultural Development Strategy. <p>Take forward the recommendations associated with the NHS Lothian Internal Audit Report relating to Organisational Culture</p> <ul style="list-style-type: none"> • Organisational Culture Action Plans - consider the most appropriate mechanisms for overseeing the on-going work across the organisation on embedding our values • Leadership Style - consider review and realignment of corporate management team arrangements and portfolios and thereafter as part of the annual objective setting process. • Leadership Style - discuss the merits of a further 360 degree feedback exercise in the context of the wider discussions on realigning leadership portfolios and development plans • Re-establishing Trust and Confidence - remind managers of the importance of conducting exit interviews and explore technological solutions to simplify current manual process • Change of Leadership Style - CMT session to consider how we can further develop our approach to distributed leadership and improving organisational culture (what can the executive team do, to demonstrate that they are living the values and how is this communicated) • Change of Leadership Style - use the iMatter programme to undertake a focused piece of work on what staff would like to see done differently on key areas such as managing performance and leadership visibility
<p>Take action to promote the health, wellbeing and resilience of the workforce, to</p>	<ul style="list-style-type: none"> • Develop our Health and Well Being Strategy to enable services to take a holistic approach to the management of sickness absence, recognising the demographics of the workforce. • Continue to develop information on HR Online including links to NHS Scotland Working Longer information and resources.

<p>ensure that all staff are able to play an active role throughout their careers and are aware of the support available to them. (Sustainable)</p>	<ul style="list-style-type: none"> • Implement tests of change re absence management practice and process improvement to support efficiency. • Develop collaborative processes with OHS to increase effective management of absence. • Further develop absence data on tableau dashboard to improve accessibility of information.
<p>Build confidence and competence among staff in using technology to make decisions and deliver care by encouraging active participation in learning. (Capable)</p>	<ul style="list-style-type: none"> • eHealth continue to offer a range of course to support staff in the use of clinical and non-clinical systems. <p>Specifically within our Diagnostic Services we will:</p> <ul style="list-style-type: none"> • Continue to develop knowledge and skills for new technology and update training via procurement arrangements with provider companies. • Continue to support all grades of staff to work within the competency frameworks associated with Laboratories UKAS accreditation. • Support staff to maintain CPD for the HCPC registration
<p>Work across boundaries (between professions, between primary and secondary care, between sectors and so on) to share good practice in learning and development, evidence-informed practice and organisational development. (Capable)</p>	<ul style="list-style-type: none"> • Through the NHS Lothian Clinical Change Forum and Quality improvement Academy continue to foster the opportunities for shared learning development across primary, secondary and social care. • Collaborate with local Board Workforce Planning specialists / committees across the South East of Scotland Region to support delivery of the Regional Transformation Plan and promote a 'once for the region' approach where appropriate. • Establish regional relationships with HR & OD counterparts and look for areas for collaboration including supporting the Shared Service programmes and the 'once for Scotland' ethos ensuring that our own staff are fully engaged and supported through the changes.
<p>Working with partners, develop workforce planning capacity and capability in the</p>	<ul style="list-style-type: none"> • Establish a Workforce Planning and Development Programme Board, which takes a 'whole system' multi-professional approach and overview of workforce planning and development. • Scope all workforce development activity and capacity • Build organisational capacity and capability to deliver effective workforce planning and development both locally and regionally.

<p>integrated setting. (Workforce to Deliver Integrated Services)</p>	<ul style="list-style-type: none"> • Support the development of integrated workforce plans in IJB’s using an agreed workforce planning methodology for integrated services based on the “Six Steps” framework. • Jointly develop the data set required to inform workforce planning in the integrated setting. • Support Primary Care Services by developing a framework of the workforce options that provides alternatives to the current delivery models • Understand and support the implementation of the national Workforce Planning and Development Plan for workforce planning, succession planning and appraisal. • Continue to support our Health and Social Care Partnerships with the implementation of integrated organisational structures and support local senior leadership teams to develop together. • Continue to deliver <i>Playing to your strengths</i> leadership development across 4 partnerships • Design and deliver workforce planning training and support resources for managers of integrated services. • Roll-out team development toolkit for integrated teams. • Identify opportunities for collaboration in learning & development
<p>Implement the new development programme for board-level leadership and talent management. (Effective Leadership and Management)</p>	<ul style="list-style-type: none"> • Awaiting development programme for board-level leadership and talent management from Scottish Government.

7.2 Health and Social Care Partnerships Workforce Plans

Midlothian

The Midlothian partnership will produce a Midlothian Health and Social Care Partnership Workforce Plan in line with Midlothian Integration Joint Board and Scottish Government requirements. This will enable an integrated approach to the recruitment, retention and skills development of a health and social care workforce. This will include confirming the range and scope of the redesign of roles for the future, incorporating the roles the voluntary and private sector play in delivering services and support.

To support Organisational Development within Midlothian, a range of programmes will be delivered to support integration including leadership and team development. There will be a specific focus upon the development of a Locality approach supported by the national Collaborative Leadership Programme.

Edinburgh

During 2017-18, the Edinburgh partnership will take forward the development and implementation of their plan 'Transforming the Primary Care Workforce in Edinburgh' to support the re-establishment of a stable, effective and flexible multi-professional workforce.

7.3 Other Workforce Planning Actions

A number of areas of action relating to workforce planning and development in Lothian include:

Medical Cover in Paediatrics

The Paediatric Programme Board established in August 2016 has been overseeing the implementation of the Royal College of Paediatrics and Child Health Review of Medical Paediatric inpatient services in Lothian. Following agreement to a redesigned workforce model, 6 out of 8 new consultant posts have been appointed to, working between St John's Hospital Children's Ward and RHSC and further interviews are taking place in March 2017. The existing St John's Paediatrician team agreed to staff the out of hours rota themselves while this recruitment got underway. Discussions about the longer term input of this team are on-going. 2 Trainee Advanced Paediatric Nurse Practitioners have also been appointed, again to work between St John's and RHSC.

Implementation of School Nursing Pathway in Lothian – Commencing in 2017-18

In response to this requirement Scottish Government issued CEL 13 (2013): Public Health Nursing, Future Focus. A School Nursing Group was established as a sub group of the National Children's Young People and Families Nursing Advisory Group, commissioned by Scottish Executive Nurse Directors (SEND).

The School Nursing Group developed a suite of recommendations to SEND group in July 2015 and has further refined nine identified care pathways since that time. These 9 areas are the priority areas that school nurses shall work within, delivering a more individual and caseload based approach to care. The 9 areas are: emotional health and wellbeing; substance misuse; child protections; domestic abuse; looked after children; homelessness; youth justice; young carers; transitions.

The School Nursing Group and SEND have also approved the roles and tasks that school nursing services will not deliver in the new role. The largest role being removal of the delivery of immunisations.

'Setting the Direction': The CNO review of Education (2013) provides a key policy driver for the refocusing of education for School Nursing. Strategic aim 1 focused on a consistent collaborative approach to post registration and post graduate education and to this end NHS Education for Scotland and the Higher Education Institutes agreed that 3 of the 5 providers would provide the new masters level 11 courses for School Nursing (QMU for South East Scotland). The new course commences for the first time in its new format at end of January 2017 and covers the 9 pathways in the new model, and the refreshed role of home visiting and working with families.

Testing of the revised school nursing model began in November 2015 within 2 early adopter sites in NHS Tayside and NHS Dumfries and Galloway. The Scottish Government commissioned the Scottish Research Centre for Public Health (SRCPH) to undertake an initial exploratory study of the early adopter sites. In addition, Children in Scotland were commissioned to work in partnerships with Boards to undertake consultation with children and young people in education, which will include collation of data on service access and vulnerability.

No Scottish Government funds have been identified for this work, and at present the expectation is that Boards will re-design current work force and skill mix teams to meet the new workforce requirements.

ISD data in December 2015 showed that there was 358.1 wte nurses (between band 3 to 8a) working within School Nursing in Scotland, with 140.6 wte listed as band 6, but with only 71.65wte of these holding the SCPHN qualification.

Scoping carried out by the national school nursing group in May 2016 showed that NHS Lothian had 4 SCPHN qualified nurses working within the Pan Lothian service (3 of these in clinical practice, 1 as band 7 service development manager). This showed Lothian to have the lowest ratio of qualified school nurses to school age population ratios by a significant amount. 2 full time (1 term time, 1 full year) and 1 part time (term time) for a population of 130,117 (age 5-18 years; 2016 population figures).

Using 2016 CHI data, there are 130,117 children and young people aged from 5-18 years. A full overview is shown within appendix 2. Key statistics are:

- Of the 130,117 children and young people aged between 5-18 years, 107,136 are accounted for being in school, leaving the balance of 23,081 for those who have left school between the ages of 16-18.
- 58.5% are aged 5-12 years, and 41.5% are 13-18 years
- 23.3% are in the most deprived quintile (SIMD1) – but with wide variation in this across the 4 CPP areas – 10.2% in East Lothian; 20.7% in Mid Lothian; 30.2% in West Lothian; 24.1% in Edinburgh City.
- 10,208 are educated in the independent school setting, which represents 9.5% of the Lothian children known to still be in school age education.
- 100 children are known to be home schooled in Lothian (as registered with LA's)
- 403 children are within local authority special school settings (who have complex needs and have dedicated community children's nursing input at the schools)

Number of Local Authority School Settings per Community Planning Partnership Area

	Edinburgh City	East	Mid	West
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LA Primaries	93	35	34	69
LA Secondary's	29	6	6	11
Complex Needs	2	0	1	?5

The clinical workforce within the generic School Nursing Service summarised below.

	Band 7	Band 6 (TT)	Band 6 (AY)	Band 5 (TT)	Band 5 (AY)	Band 3 (TT)	Band 3 (AY)
Edinburgh.	1(1)	0	3.62	7.53	8.04	13.54	0.53
West Lothian	0	3.81 (2)	0	0.66	1.73	0	0
East & Mid Lothian	0	0	2 (1)	11.44	0	3.37	0.8
Lothian	1(1)	3.81 (2)	5.62 (1)	19.63	9.77	16.91	1.33
		3.46 (AY equivalent)		17.84 (AY equivalent)		15.37 (AY equivalent)	

TT – Term Time

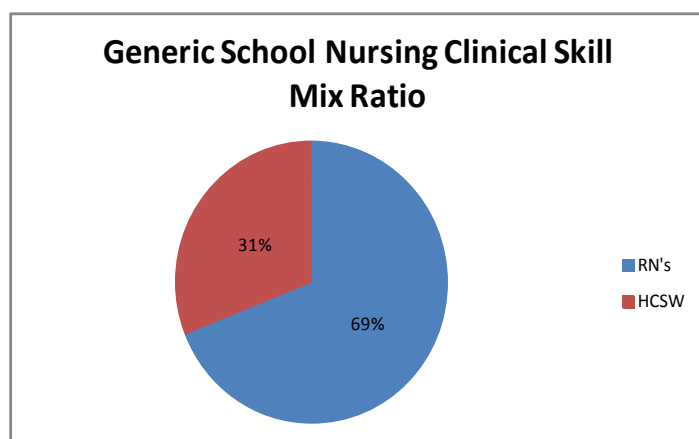
AY – All Year

The numbers outlined in brackets relate to wte staff who are Specialist Community Public Health Nurses (SCPHN) qualified and registered on the third part of the Nursing and Midwifery Council register.

RN qualified: 39.83wte

Clinical RN's: 38.83 wte (36.69 wte all year equivalent)

HCSW: 18.24 wte (16.7 all year equivalent)



Age Profile of existing generic school nursing workforce (2016):

Cost Centre Name	25	30	35	40	45	50	55	60	Grand Total	% over5
School Nursing	29	34	39	44	49	54	59	64	18	55.56

Service B3										
School Nursing										
Service B5	3	3	6	4	6	8	3	1	34	35.29
School Nursing										
Service B6					2	5	3	3	13	84.62
Grand Total	3	4	7	5	13	19	8	6	65	50.77

The change from the current model of school nursing team delivery to the new model will require large service redesign across a number of parts of NHS Lothian delivery. A school nursing pathway steering group has commenced and an implementation plan being focused to look at deliverables in 2017-18. The key focus for this year will be to shift immunisation delivery for secondary schools to the community vaccination team model; this will free time for the nurses to start to work on the 9 pathway areas, which should also help reduce CAMHS referrals for school age children for tier 1 and 2 support.

Board Meeting
 5 April 2017

Executive Director, Nursing, Midwifery and Allied Health Professionals

NHS Lothian 2017-18 Corporate Objectives

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

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

<ul style="list-style-type: none"> The Board is recommended to agree the 2017-18 Corporate Objectives 	2.1
<ul style="list-style-type: none"> The Chief Executive and Corporate Directors agree measures and timelines for objectives for which they are accountable 	2.3
<ul style="list-style-type: none"> A report against the objectives will be brought back to the Board at a mid point in the year and at the end of the year. 	2.5
<ul style="list-style-type: none"> The objectives have been developed to support achievement of the Scottish Government 2020 vision and NHS Lothian’s mission and are aligned to the Scottish Government Health and Social Care Delivery Plan and NHS Lothian’s 2017-18 Local Delivery Plan 	3.1 3.3
<ul style="list-style-type: none"> There are six 2017-18 Corporate Objectives: <ol style="list-style-type: none"> Engagement and Development of Staff Improve Quality, Safety and Experience across the Organisation Protect and Improve the Health of Our Population Achieve Greater Financial Sustainability and Value Improve Patient Pathways and Shift the Balance of Care Work with Partner Boards to Develop a Regional Health and Social Care Plan for the East of Scotland 	3.2

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NHS Lothian

Board Meeting
5 April 2017

Executive Director, Nursing, Midwifery and Allied Health Professionals

NHS Lothian 2017-18 Corporate Objectives

1 Purpose of the Report

- 1.1 The purpose of this report is to recommend that the Board approves the 2017-18 Corporate Objectives.

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

2 Recommendations

- 2.1 Agree the 2017-18 Corporate Objectives (Appendix 1)
- 2.2 Support the dissemination of the Corporate Objectives throughout the Corporate Management Team and the wider organisation to inform the personal objective setting process and to assist individuals to understand their personal contribution to the objectives of NHS Lothian.
- 2.3 Through the action set out above individual and collective measures and timelines will be agreed with the Chief Executive for Corporate Directors in relation to those objectives which they are accountable for.
- 2.4 Update reports associated with delivery of the Corporate Objectives will be undertaken through regular update papers to the Board and Committees of the Board relating to, for example, performance standards, financial and workforce plans, quality programme, patient safety programme, patient experience and Health Promoting Health Service.
- 2.5 A report against the objectives will be brought at a mid point in the year and at the end of the year the Board, with the aim to provide information and assurance against performance and to assist in setting objectives for 2018-19.

3 Discussion of Key Issues

- 3.1 The NHS Lothian Corporate Objectives for 2017-18 have been developed to support achievement of the Scottish Government 2020 Vision, NHS Lothian's mission to improve the health of the population, improve the quality of healthcare and to achieve valued and financial sustainability and reflect NHS Lothian's values of care and compassion, dignity and respect, quality, teamwork and openness, honesty and responsibility.

3.2 The 2017-18 Corporate Objectives incorporate six key objectives relating to:

- 1) Support the engagement and development of our staff through leadership and behaviours
- 2) Improve quality, safety and experience across the organisation
- 3) Protect and improve the health of our population
- 4) Achieve greater financial sustainability and value
- 5) Improve patient pathways and shift the balance of care
- 6) Work with partner boards to develop a Regional Health and Social Care Delivery Plan for the East of Scotland

3.3 The detailed actions within the six corporate objectives address the main areas of focus and action as outlined in the Scottish Government Health and Social Care Delivery Plan¹ published in December 2016 and the NHS Lothian 2017-18 Local Delivery Plan, which is separately on the agenda for approval by the Board on 5 April 2017. The objectives also reflect key strategic planning activities, financial and workforce plans and include reference to the requirements outlined by the Scottish Government relating to integration performance measures (unplanned admissions, occupied bed days for unscheduled care, A&E performance, delayed discharges, end of life care and balance of spend across institutional and community services).

4 Key Risks

4.1 There are no new risks arising from this report.

5 Risk Register

5.1 As indicated in section 4.1, there are no new risks associated with this report for inclusion on the corporate risk register. The major risks relate to achieving financial targets and workforce plans, delivery of waiting times and other Local Delivery Plan Standards, whole system performance measures including the integration performance measures outlined in section 3.3.

6 Impact on Inequality, Including Health Inequalities

6.1 This report does not propose any new policy or service change. Specific actions and change programmes either have been or will be subject to equality impact assessment.

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

7.1 The Corporate Objectives are drawn from national and local improvement priorities and plans which have been developed with involvement of stakeholders and locally these have been developed with the input of all corporate directors.

8 Resource Implications

8.1 There are no new resource implications associated with the corporate objectives.

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22 March 2017
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¹ <http://www.gov.scot/Resource/0051/00511950.pdf>

List of Appendices

Appendix 1: NHS Lothian 2017-18 Corporate Objectives



2017-18 CORPORATE OBJECTIVES

NHS Lothian - Mission, Vision, Values and Objectives

Our Vision

By 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions supported through House of Care and Realistic Healthcare approaches

There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

Our Mission

- improving the health of the population,
- improving the quality of healthcare and
- achieving value and financial sustainability.

Better health, better care, better value

Our Values

- Care and Compassion
- Dignity and Respect
- Quality
- Teamwork
- Openness, Honesty and Responsibility

Our Objectives

Support the Engagement and Development of Our Staff through Leadership and Behaviours

Improve Quality, Safety and Experience across the Organisation

**Protect and
Improve the
Health of our
Population**

**Achieve
Greater
Financial
Sustainability
and Value**

**Improve Patient
pathways and
Shift the
Balance of Care**

**Work with Partner
Boards to Develop a
Regional Health and
Social Care Delivery
Plan for the East of
Scotland.**

We will work in collaboration with our four Health and Social Care Partnerships to delivery our objectives and moves us closer to achieving our vision.

1. Support the Engagement and Development of Our Staff through Leadership and Behaviours

- Promote a leadership culture which encourages distributed clinical leadership and empowers staff to innovate and experiment to deliver transformational improvement
- Implement the Clinical Change Forum programme to support on-going clinical engagement and drive quality through peer recognition
- Improve leadership visibility through face to face contact and digital communication channels
- Continue to embed our NHS Lothian values in our interactions with our patients and each other and measure our success through patient and staff feedback
- Achieve full roll out of iMatter – the continuous improvement model to measure and improve staff experience and embed the use of staff exit interviews to build our picture of staff experience
- Support staff to raise concerns safely (for example through datix, with their line managers, through their trade unions, seeking advice from the independent alert line or through our Whistleblowing Policy), by publicising how to do this, training our managers and listening.
- Strengthen our workforce planning and development capability and capacity and work with partners to support delivery of the National Workforce Plan at local and regional levels.
- Develop workforce plans to support the delivery of the NHS Scotland Health and Social Care Delivery Plan (December 2017)
- Develop a Health and Wellbeing Strategy to support a healthy organisational culture and build staff resilience
- Offer team and leadership development programmes to ensure leaders and managers have the necessary skills to drive forward the transformational agenda , work across boundaries and harness the talents of our staff

2. Improve Quality, Safety and Experience Across the Organisation

Quality

- Using the NHS Lothian Quality Management System to deliver improvement programmes across the primary and secondary care.
- Develop the NHS Lothian Quality Academy to increase the capacity within teams to manage continuous quality improvement.
- Nurture and embed the core values and approach associated with Realistic Healthcare through creating meaningful opportunities for patients to understand their condition, all treatment options and how each will impact upon them and giving 'Permission' for clinicians and patients to agree to a treatment plan that meets the individual patient's needs.
- Incorporation of the principles of realistic healthcare as a core component of medical education
- Continue the development of infrastructure to support a range of Quality Programmes that reduced wasteful variation and improve patients' experience of care.
- Deliver the national 'what matters to me' and 'must do with me' programmes, supporting patients, families and carers and enabling clinical teams to listen and understand with compassion
- Continue the development of the Quality Academy to build capability of all staff (leaders to front line workforce) in confidently managing and improving the quality of our services.

Safety

- Deliver a programme of safety visits across primary and secondary care
- Medicines - utilise the NHS Scotland Hospital Electronic Prescribing and Medicines Administration Framework (**HEPMA**) to improve patient safety through reduction in drug errors
- Patient Safety Programme
 - Sustain improvements in falls and the delivery of the safety essentials
 - Deliver a programme of safety walk rounds across primary and secondary care
 - Improve the management of deteriorating patients in acute hospitals and mental health wards
 - Improve the management of Sepsis in acute hospitals and continue to be a Health Improvement Scotland pilot site for management of Sepsis in a primary care
 - Improve the medicines reconciliation at front door acute hospitals
 - Improve the prevention and management of pressure ulcers
 - Contribute to the reduction in SABs through reliable PVC/CVC insertion and maintenance.

Experience

- Measure people's experiences of care or support through a range of tools including complaints, the Care Assurance System, 'real time' and 'right time' feedback and Patient Opinion and demonstrate how we are using this to improve services.
- Deliver revised policy and culture in respect of hospital visiting times
- Implement the new model NHS Complaints Handling Procedure to support consistently person-centred complaints handling.
- Involve people meaningfully in service design and improvement including using the Our Voice framework
- Ensure performance trajectories relating to the 2017-18 Local Delivery Plan (LDP) Standards are maintained and delivered within available resources and in line with peer performance

3. Protect and Improve the Health of Our Population

- Deliver improved uptake in all childhood and adult immunisation programmes
- Deliver smoking prevention, protection and cessation services to reduce smoking rates at 12 weeks post quit, in the 40% SMID areas and enforce smoke-free hospital grounds
- Develop an implementation for 'A Vision for a More Active Scotland' (to be published in 2017) including actions to address inequalities in physical activity and the roll out of the national physical activity
- Implement Getting It Right For Every Child (GIRFEC)
- Implement the maternal and infant nutrition framework including the roll out of universal vitamins to all pregnant women by 2017 and a competency framework to promote and support breastfeeding
- Deliver a programme to promote better mental health amongst children and young people through implementing the GIRFEC principles and implementation of the universal Health Visitor pathway
- Develop Clinical Quality Programmes to improve population health, reduction of inequalities and improved access to healthcare for disadvantaged groups in society
- Refresh the NHS Lothian Oral Health Plan to support delivery of the Scottish Oral Health Plan due for publication in 2017

4. Achieve Greater Financial Sustainability and Value

- Develop a three year financial plan setting out plans for investment and reform to ensure the best use of available resources and return NHS Lothian to recurring balance.
- Deploy, test and embed financial tools, within Clinical Quality Programmes to demonstrate cost savings and avoidances through reduction of waste and unwarranted variation.
- Deliver recurring efficiency and productivity savings of circa 2% and circa 4% non-recurring appropriate cost efficiencies
- Develop and implement an effective prescribing programme
- Deliver the 2017/18 capital investment programme including the commissioning of the RHSC & DCN development opening in spring 2018, the three partnership centres and phase 2 of the Royal Edinburgh Hospital Redevelopment.
- Work with the Scottish Government on the future capital investment programme including the re-provision of the Princes Alexandra Eye Pavilion, Edinburgh Cancer Centre and the proposed Diagnostic and Treatment Centres.
- Deliver a longer term Medical equipment strategy integrated with eHealth and data management
- Complete the business case for new digital telephony system

5. Improve patient pathways and shift the balance of care

- Redesign the shape of service provision across hospital, care home and community settings to reduce inappropriate use of hospital services and release funding to be invested in the community
- Deliver a 10% reduction in unscheduled bed days through the implementation of plans to reduce admissions and to ensure the timely discharge of patients from hospital.
- Double the palliative and end of life provision in the community and expand the use of Key Information Summaries to reduce the number of people dying in a hospital setting.
- Increase capacity within the adult social care sector through reform of the national care home contract, social care workforce issues, new models of care and support in home care.
- Create an innovation support programme to increase our capacity, capability and culture for radical experimentation and innovation across the organisation
- Develop secure, resilient and effective Information management system infrastructure
- Incrementally over the next three years as funding is increased:
 - Support the implementation of the new GMS contract
 - Develop the primary care group being led by NHS Lothian's Medical Director
 - Continue to support GP recruitment and retention initiatives
 - Increase the number of Advance Nurse Practitioners (14 in training) and Nurse Practitioners
 - Support implementation of quality clusters
 - Ensure we have the additional 40 Health Visitors trained
 - Ensure we have an additional 15 District Nurses trained
- Additional investment of £2m for primary care and an additional £2m innovation to support development of cost effective prescribing

- Take forward recommendations from the Review of Maternity and Neonatal Services
- Roll out the unscheduled care six essential actions across the whole of acute care (improve time of day discharge, increasing weekend emergency discharges, more effective use of electronic information, enhance patient's journey through the hospital system and back to the community without delay)
- Reduce unnecessary attendances and referrals to outpatient services through a structured improvement programme
- Develop and implement performance plans to manage outpatient and treatment time guarantee pressures to support delivery of the projected capacity requirements

6. To work with partner boards to develop a Regional Health and Social Care Delivery Plan for the East of Scotland

- With South East Scotland NHS Boards and Integration Joint Boards, outline an East of Scotland Regional Health and Social Care Delivery Plan by August 2017. The plan will focus on areas of critical issue which require regional collaboration and redesign to enable service sustainability, quality and safety at lower cost.

Our local delivery plan sets out in detail the actions we will take to deliver our objectives and measure our success.

SUMMARY PAPER: QUALITY AND PERFORMANCE IMPROVEMENT

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

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

<ul style="list-style-type: none">that performance on 12 measures considered across the Board, including those relating to the Hospital Scorecard, are currently met with 23 not met. It is not possible to assess performance on dementia post-diagnostic support;	5.1
<ul style="list-style-type: none">Committees have commenced their programme of assurance. To date, 14 have been considered with significant, moderate and limited assurance reached on 2, 6 and 6 instances respectively. On no occasion was 'no assurance' concluded.	5.2

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27th March 2017
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NHS Lothian

Board Meeting
5 April 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. 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 accept:
 - 2.1.1 that performance on 12 measures considered across the Board, including those relating to the Hospital Scorecard, are currently met with 23 not met. It is not yet possible to assess performance on dementia post-diagnostic support; and
 - 2.1.2 that Board Committees have commenced their programme of assurance. To date, 14 measures have been considered with significant, moderate and limited assurance reached on 2, 6 and 6 instances respectively. On no occasion was 'no assurance' concluded.

3 Process

- 3.1 This paper draws together those measures agreed by the Board from across the performance and quality spectrum. Where an expectation has not been achieved, a completed proforma has been provided by the responsible director to allow the issue to be explored in more depth by providing an explanation of current performance and a timescale for improvement as well as detailing underlying actions.
- 3.2 Each measure has been aligned to a nominated board committee for the purposes of assurance. The finalised list is shown in Table A and those committees are now seeking to answer the following question when considering proforma or Directors' reports;

“What assurance do you take that the actions described will deliver the outcomes you require within an acceptable timescale?”

3.3 A common grading approach has been agreed by Committee Chairs and is summarised, alongside possible actions, in Table B.

Table A – Alignment of Measures to Board Committee

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

Table B – Adopted Assurance Gradings

Definition	Most likely course of action by the Board or committee
<p>LEVEL – SIGNIFICANT</p> <p>The Board can take reasonable assurance that the system of control achieves or will achieve the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.</p> <p>Examples of when significant assurance can be taken are:</p> <ul style="list-style-type: none"> • 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. 	<p>If there are no issues at all, the Board or committee may not require a further report until the next scheduled periodic review of the subject, or if circumstances materially change.</p> <p>In the event of there being any residual actions to address, the Board or committee may ask for assurance that they have been completed at a later date agreed with the relevant director, or it may not require that assurance.</p>
<p>LEVEL – MODERATE</p> <p>The Board can take reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.</p> <p>Moderate assurance can be taken where:</p> <ul style="list-style-type: none"> • 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 	<p>The Board or committee will ask the director to provide assurance at an agreed later date that the remedial actions have been completed. The timescale for this assurance will depend on the level of residual risk.</p> <p>If the actions arise from a review conducted by an independent source (e.g. internal audit, or an external regulator), the committee may prefer to take assurance from that source’s follow-up process, rather than require the director to produce an additional report.</p>
<p>LEVEL – LIMITED</p> <p>The Board can take some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk which requires action to be taken.</p> <p>Examples of when limited assurance can be taken are:</p> <ul style="list-style-type: none"> • 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 been 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. 	<p>The Board or committee will ask the director to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved.</p>
<p>LEVEL – NONE</p> <p>The Board cannot take any assurance from the information that has been provided. There remains a significant amount of residual risk.</p>	<p>The Board or committee will ask the director to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved.</p> <p>Additionally the chair of the meeting will notify the Chief Executive of the issue.</p>
<p>NOT ASSESSED YET</p> <p>This simply means that the Board or committee has not received a report on the subject as yet. In order to cover all aspects of its remit, the Board or committee should agree a forward schedule of when reports on each subject should be received (perhaps within their statement of assurance needs), recognising the relative significance and risk of each subject.</p>	

4 Notable Updates

- 4.1 There are a number of recent changes and data issues across the measures reported through the Quality and Performance Improvement Reporting Process. These are reported below.

Change in Director Responsibility

- 4.2 In keeping with placing the quality agenda at the core of the organisation, the Chief Quality Officer took over responsibility for the quality and performance improvement reporting at the start of March and will oversee its continuing development. This is the first instance when the Board has received the report since this change.

Board Committees' Assurance Process

- 4.3 The Board is now receiving a summary of the assurance levels attained by both Healthcare Governance and Acute Hospital Committees with dates for these board committees in 2017 having been aligned as far as possible with meetings of the Board itself to support timely passage of assurance levels attained. Arrangements for the Staff Governance Committee and their oversight of Staff Absence are in train. Areas where a level of assurance has been reached are summarised in Table C.
- 4.4 Following discussion at the Board and its committees, a programme of assurance is under development to set out a timetable for establishing assurance levels for Quality and Performance Improvement measures both across the Board and the health board management structure. The draft programme is in the process of being shared with Chairs of Board Committees.

Engagement Process

- 4.5 The reporting team has shared a work-plan covering 2017 in response to points raised at the engagement events and workshops in the latter part of last year. As a result committee members should expect ongoing development of proforma over this period as implementation occurs. A copy of the work-plan is available on request to those who have not received it as an event attendee.
- 4.6 Additional events occurred with those in the acute structure in March 2017. Further are planned in Spring following the initial report from Harry Burns' national review into targets and indicators for health and social care, when the dashboard under development will also be showcased.

5 Recent Performance

- 5.1 Against the measures considered, most recent information demonstrates that NHS Lothian met 12 of the 36 measures considered, whilst 23 were not met. As detailed above, it is not possible to make an assessment on Dementia Post-Diagnostic Support.
- 5.2 Board committees have concluded levels of assurance for those areas that they have considered to date. These assessments are set out both in Table 1 and in the

individual proforma for the measure. Table C below sets out the assessments by board committee. To date, 14 have been considered with significant, moderate and limited assurance being reached on 2, 6 and 6 instances respectively. On no occasion was 'no assurance' concluded;

Table C – Assessed Levels of Assurance

			Assurance Level				
			Not yet assessed	None	Limited	Moderate	Significant
Board	Met	12	-	-	-	-	-
	Not Met	23	-	-	-	-	-
Acute Hospitals Committee	Met	8	8	0	0	0	0
	Not Met	10	5	0	3	2	0
Healthcare Governance Committee	Met	4	3	0	0	0	1
	Not Met	12	4	0	3	4	1
Staff Governance Committee	Met	0	-	-	-	-	-
	Not Met	1	-	-	-	-	-

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)	Safe	Quality	Acute Hospitals (AHC)	To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0.95 per 1,000 discharges (median)	1.85 (median)	Feb 17 (Mthly)	DF	
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)	0.18 (median)	Feb 17 (Mthly)	DF	
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)		LDP	HGC	Significant	Mar 17	Met		Better	Sep 16 (Quarterly)	0.32 (max) (<=262)	0.27 (rate) 201 (incidences)	Feb 17 (Mthly)	DF	
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)		LDP	HGC	Moderate	Mar 17	Not Met	No Change	Equal	Sep 16 (Quarterly)	0.24 (max) (<=184)	0.30 (rate) 220 (incidences)	Feb 17 (Mthly)	DF	
Hospital Standardised Mortality Ratios (HSMR) (within limits)		Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	1 All sites within HS Limits	NHS L 0.87 RIE 0.86 SJH 0.74 WGH 0.76	Sep 16 (Qtrly)	DF	
48 Hour GP Access – access to healthcare prof	Timely	LDP	HGC	TBC	TBC	Not Met	Improving	Worse	2015/16	90% (min)	85.0%	2015/16	DS	
48 Hour GP Access – GP appt		LDP	HGC	TBC	TBC	Not Met	Deteriorating	Worse	2015/16	90% (min)	75.0%	2015/16	DS	
Four hour Unscheduled Care (% <=4 hrs)		LDP	AHC	Moderate	Feb 17	Not Met	Improving	Better	Jan 17 (Monthly)	95.0% stretch to 98.0%	93.2%	Feb 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	2015/16	9,757 (Annual) 2,440 (Quarter 1)	0	Mar 17 (Qtrly)	AMcM	
CAMHS ¹⁰ (<=18 w ks)		LDP	HGC	Limited	Mar 17	Not Met	Deteriorating	Worse	Dec 16 (Quarterly)	90.0% (min)	48.4%	Feb 17 (Mthly)	AMcM	
Cancer (<=31-day) (% treated)		LDP	AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Sep 16 (Quarterly)	95.0% (min)	90.6%	Feb 17 (Mthly)	JC	
Cancer (<=62-day) (% treated)		LDP	AHC	To be reviewed	To be reviewed	Not Met	Improving	Better	Sep 16 (Quarterly)	95.0% (min)	88.7%	Feb 17 (Mthly)	JC	
Diagnostics (<=6 w ks) - Gastroenterology/ Urology Diagnostics			AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Dec 16 (At month end)	0 (max)	2,231		Feb 17 (Mthly)	JC
Diagnostics (<=6 w ks) - Radiology														
Diagnostics (<=6 w ks) – Vascular Labs														
Drug & Alcohol Waiting Times (% <=3 w ks)		LDP	HGC	Limited	Mar 17	Not Met	Improving	Worse	Sep 16 (Quarterly)	90.0% (min)	85.4%	Sep 16 (Qtrly)	AMcM	
IPDC Treatment Time Guarantee (<=12 w ks)		LDP	AHC	Limited	Feb 17	Not Met	Deteriorating	Better	Dec 16 (Quarterly)	0 (max)	1,497	Feb 17 (Mthly)	JC	
IVF (% <=12 months)		LDP	AHC	TBC	TBC	Met		Worse	Dec 16 (Quarterly)	90.0% (min)	100.0%	Jan 17 (Mthly)	JC	
Outpatients (<=12 w weeks)		LDP	AHC	Limited	Feb 17	Not Met	Improving	Worse	Dec 16 (At month end)	95.0% (min)	68.4% 17,967	Feb 17 (Mthly)	JC	
Psychological Therapies (% <=18 w ks)		LDP	HGC	Moderate	Nov 16	Not Met	Deteriorating	Worse	Dec 16 (Quarterly)	90.0% (min)	66.1%	Feb 17 (Mthly)	JF	
Referral to Treatment (% <=18 w ks)		LDP	AHC	Limited	Feb 17	Not Met	Deteriorating	Worse	Dec 16 (Monthly)	90.0% (min)	79.3%	Feb 17 (Mthly)	JC	
Stroke Bundle (% receiving)		Quality	AHC	Moderate	Nov 16	Not Met	Improving	Not Applicable	Not Applicable	80.0% (min)	72.8%	Jan 17 (Mthly)	JC	
Surveillance Endoscopy (past due date)			AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0 (max)	4,523	Feb 17 (Mthly)	JC	
Delayed Discharges (>3 days) – East Lothian IJB		Effective		HGC	To be reviewed	To be reviewed	Not Met	Improving	Worse	Jan 17 (Monthly)	0 (max)	230	Feb 17 (Mthly)	DS
Delayed Discharges (>3 days) – Edinburgh IJB			RMG											
Delayed Discharges (>3 days) – Midlothian IJB	EM													
Delayed Discharges (>3 days) – West Lothian IJB	JF													
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days	Efficient	Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	All NHS L Sites (RIE; SJH & WGH), Within Hospital Scorecard Limits	NHS L 26.28 RIE 34.09 SJH 25.50 WGH 21.70	Apr - Jun 16 (Qtrly)	DF	
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met	48.67 61.11 41.82 54.44				DF			
Hospital Scorecard – Standardised Medical Readmission rate within 7 days		Quality	AHC	TBC	TBC	Met	57.96 54.70 81.82 58.29				DF			
Hospital Scorecard – Standardised Medical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met	123.17 127.42 155.21 116.43				DF			
Hospital Scorecard – Average Surgical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met	0.95 0.93 0.89 1.01				DF			
Hospital Scorecard – Average Medical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met	1.17 0.90 1.26 1.34				DF			
Staff Sickness Absence Levels (<=4%)	LDP	Staff Governance	To be reviewed (not yet provided to Board Committee)	To be reviewed (not yet provided to Board Committee)	Not Met	Deteriorating	Better	2015/16	4.0% (max)	5.45%	Jan 17 (Mthly)	JB		
Early Access to Antenatal Care (% <=12 w ks)	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 ¹² quintile	88.8%	Dec 16 (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	294 (min for this quarter)	235	Sep 16 (Qtrly)	AKM	
Complaints - 3-Day (%<=3-day)	Person-Centred	Quality	HGC	Moderate	Nov 16	Not Met	Deteriorating	Worse	2015/16	100.0%	85.0%	Jan 17 (Mthly)	AMcM	
Complaints - 20-Day (% <=20-day)		Quality	HGC	Moderate	Nov 16	Not Met	Improving	Worse	2015/16	80.0% (min)	78.0%	Jan 17 (Mthly)	AMcM	
Detect Cancer Early (% diagnosed)		LDP	HGC	Significant	Nov 16	Not Met	Improving	Better	2014 & 2015 (Combined Calendar Years)	29.0% (min)	27.1%	2014 & 2015 (Combined Calendar)	AKM	
Dementia – East Lothian IJB		LDP	HGC	To be reviewed	To be reviewed	TBC ¹³	Not Applicable	Part 1. Worse; Part 2. Worse	2014/15	TBC ¹³ (exptd diag rate + 1 Year (min) PDS)	Part 1: 25% Part 2: 64%	2014/15 (TBC)	DS	
Dementia – Edinburgh IJB		LDP	HGC			TBC ¹³							RMG	
Dementia – Midlothian IJB	LDP	HGC	TBC ¹³			EM								
Dementia – West Lothian IJB	LDP	HGC	TBC ¹³			JF								
Patient Experience (9.0/10 – Overall Experience)	Quality	HGC	Limited	Nov 16	Not Met	Deteriorating	Not Applicable	Not Applicable	9 (out of 10)	8.64	Jan 17 (Mthly)	AMcM		

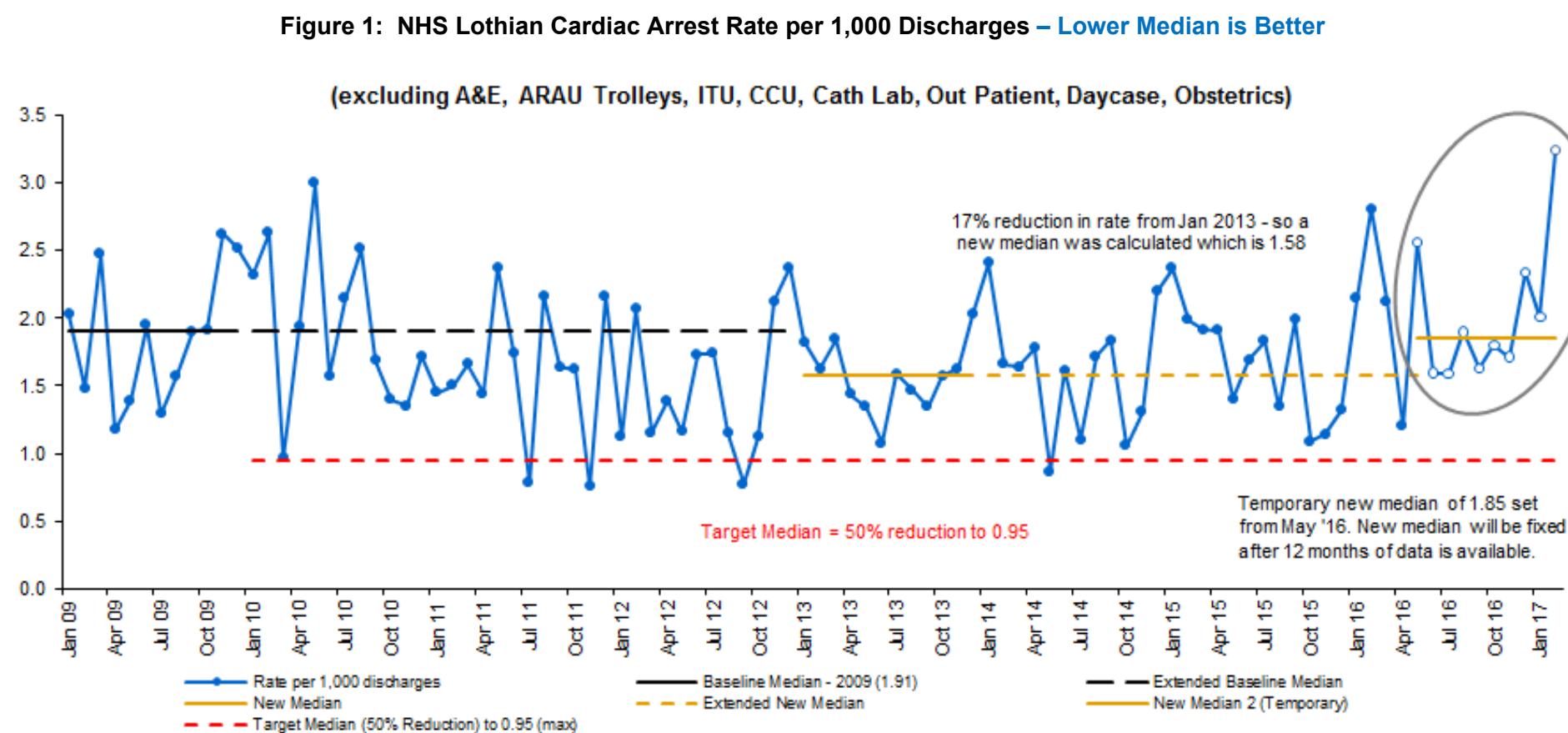
Notes

- Much of this reporting uses management information and is therefore subject to change
- 6 Domains of Healthcare Quality <http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html>
- 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.
- Performance Against Target/Standard – describes where Latest Performance meets or does not meet Target.
- 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. HAI measures use HIS run chart assessment to ascertain trend. (Black cells indicate that a Standard is 'Met' so a Trend is not available).
- 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.
- 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.
- Data Updated since Last Report – Current performance figure, and/or Trend and/or Published NHS Lothian vs. Scotland items updated, where applicable on proformas, since last report.
- Proforma Narrative Updated Since Last Report – Trajectories and/or Action Plans and/or Comments updated since last report
- 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
- SIMD - Scottish Index of Multiple Deprivation, <http://www.gov.scot/Topics/Statistics/SIMD>
- 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" <https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Report.pdf>. Please also see relevant IJB level Proforma below (in Section 6 Exception Proformas).

6 Exceptions Proformas (for Areas where Performance Target/Standard is 'Not Met', or 'TBC')

Cardiac Arrest												
Healthcare Quality Domain: Safe												
For reporting at April 2017 meetings												
Target/Standard: <ul style="list-style-type: none"> 50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2017 from February 2013 (1.91 per 1,000) baseline. 												
Responsible Director[s]: Medical Director												
NHS Lothian Performance:-												
Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0.95 per 1,000 (median; max)	1.85 per 1,000 (median)	Feb 17	2222 Database	Yes	Yes	DF
Summary for Committee to note or agree NHS Lothian has achieved a 3% reduction and the median is 1.85 against the Scottish median of 1.61 and across Scotland the reduction has been 17%. The HCG committee have approved a review of the management of deteriorating patients in March 17 with an improvement plan based on finding going to the July 17 meeting to inform assurance.												

Recent Performance – 17% against Standard



Timescale for Improvement

HIS evaluating improvement goal.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Local cardiac arrest reviews using a structured tool and development of the database.	December 2016	Organisational learning & identification of themes for targeted improvements and a sustained reduction in cardiac arrests. MDT engagement to identify themes & actions for improvement	Changes in process and increase the days between cardiac arrest in a number of wards with 6 of the pilot wards achieving greater than 300 days between.	Pilot initiated and exploring best practice from other boards. Cardiac Arrest feedback being provided to teams to inform improvement plans. Review of unplanned admissions to ICU being undertaken and feedback to individual consultants to inform Deteriorating Patient Project Plan.
Aim: 95% of people with physiological deterioration in acute care will have a structured response. Implementation of the Structured Response Tool (in conjunction with education within Deteriorating Patient work-stream).	April 2016	The tool has demonstrated that it supports reliable communication, decision making and management of deteriorating patients by clinical teams, as well as enabling learning from events which informs the improvement process	Testing in surgery RIE & oncology has demonstrated improved early recognition and appropriate management of deterioration with improved documentation. Considering adoption of structured response tool within the context of paper-lite and based on service feedback.	Rolled out April/May 2016 as part of NEWS implementation for acute sites. Monthly monitoring and reporting to the service. Complete for NEWS. Further testing of structured response tool taking place in Oncology, Stroke Medicine and Surgery. Testing paper-lite response at Acute Receiving Unit at WGH.
NEWS chart implementation. (In conjunction with Deteriorating Patient work-stream & Education team). NEWS is evidence based to be sensitive to early physiological deterioration and to trigger an appropriate graded response with a reduction in cardiac arrests and mortality. NEWS replaces the current SEWS chart.	April 2016	Adopting the National standardised chart which is used in all Boards including SAS in Scotland to reduce variation and improve communication. Linked to the Structured Response Tool to support timely identification & management of deterioration by facilitating accurate recording of observations with appropriate early escalation & graded response.	Alignment with national approach. Ensures consistency for patients moving across Boards. Provides greater sensitivity and support for patients deteriorating.	Rolled out in April/May 2016 for Acute sites – complete. Planning rollout in inpatient sites in Primary Care. <ul style="list-style-type: none"> Royal Edinburgh Hospital – complete Astley Ainslie Hospital –12th Sept - complete Murray Park –5th Sept - complete HBCCC –28th Sept - complete
Implementation of sepsis screening and management using NEWS, sepsis boxes, education, training and simulation.	Dec 2016	To improve the recognition and management of sepsis to reduce mortality from sepsis. As part of our scoping work in 2015 70% of patients in NHS Lothian who deteriorated had sepsis.	ISD % unadjusted sepsis mortality has shown a statistically significant reduction in RIE from 28% to 15%, SJH has remained stable but there has been an increase at WGH from 10% -13% however it is well below the Scottish median of 21% and WGH has a low HSMR	SEPSIS bundle rollout continues and plans in place to further test, implement and monitor. NHS Lothian has been chosen as a national pilot for SEPSIS management in primary care working with Lothian Unscheduled Care Service. Second national learning session was in November – has place in testing phase.
In NHS Lothian pilot areas >80% of patients have advanced conditions and are at risk of deterioration and dying & 51% of cohort died within 12 months. Development of anticipatory care planning with patients and families nearing the end of their lives to discuss potential future deterioration & facilitate shared decision making with reliable documentation. This is informed by policy context and baseline data including cardiac arrest reviews which demonstrate need for 'upstream' engagement with patients & families. Prototyping of a structured review and testing implementation is taking place. Evolving themes include the need for concurrent MDT communication skills education & patient/carer engagement in the testing & implementation.	Prototyping phase with September 2016	<ul style="list-style-type: none"> Avoidance of cardiopulmonary resuscitation for patients who either do not want or will not have a good outcome to CPR; Person centred decision making and optimal engagement with patients and families with effective communication of these decisions; Clear communication of plan for deterioration to facilitate a bespoke Structured Response in the event of deterioration; Timely transition to end of life care; Support appropriate identification of patients with anticipatory care planning needs; Closely linked with Deteriorating patient work-stream and the development of the Structured Response Tool. 	Data from small tests in 8 MoE/Stroke wards (c.200 patients) demonstrate sustained improvement in documented discussions with patients & their families regarding future wishes & plan for further deterioration.(>80% of patients have documented AnCP/future wishes discussion). In test areas data demonstrates improved access to Key Information Summary on admission & improved AnCP information within discharge documentation.	Prototyping testing with input from AnCP forum including expert palliative care, primary & secondary care input. Next steps include MDT communication skills workshops and test of structured review tool within MAU & an oncology ward. December 2016
Exploring electronic observation systems including electronic track & trigger.	Dec 2016	NHS Fife has demonstrated a reduction in Cardiac arrests since implementation of track & trigger system as one aspect of their improvement programme.	Timely access to data to inform improvement. With respect to response to deterioration at a ward level	Bought hardware, e.g. monitors. Exploring how it interfaces with TRAK to provide timely data to the service. This will require investment and needs to be assessed against other interventions to manage deteriorating patients through the deteriorating patient working group.

Comments

Reasons for Current Performance

The Cardiac Arrest rate for the three major acute hospitals is low, and below the Scottish rate. All three sites are approximately the same rate and do not give cause for concern. The HIS 50% reduction from our low baseline rate by December 2017 was ambitious and we now predict that our cardiac arrest rate could be reduced by a further 10% by 2020 using the current approach. In order for us to achieve this, identification and management of deterioration and greater numbers of earlier anticipatory care plans will need to be in place reliably in the above plans across all three acute sites. A review of current status of the Deteriorating Patient work stream using a range of data from Cardiac Arrest reviews, admission to Intensive Care plus learning from other boards is being drawn together to support future improvement plans and goal setting. A paper setting out the scope of the review was approved by the March 2017 Healthcare Governance Committee. The July 2017 committee will set out recommendations to further improve the management of the Deteriorating Patient and identify further areas for reduction in the overall rate, based on the findings of the review.

Healthcare Acquired Infection – *Staphylococcus aureus* Bacteraemia (SAB)

Healthcare Quality Domain: Safe

For reporting at April 2017 meetings

Target/Standard: NHS Boards' rate of *Staphylococcus aureus* Bacteraemia (including MRSA) (SAB) cases are 0.24 or less per 1,000 acute occupied bed days.

Responsible Director[s]: Medical Director

NHS Lothian Performance:-

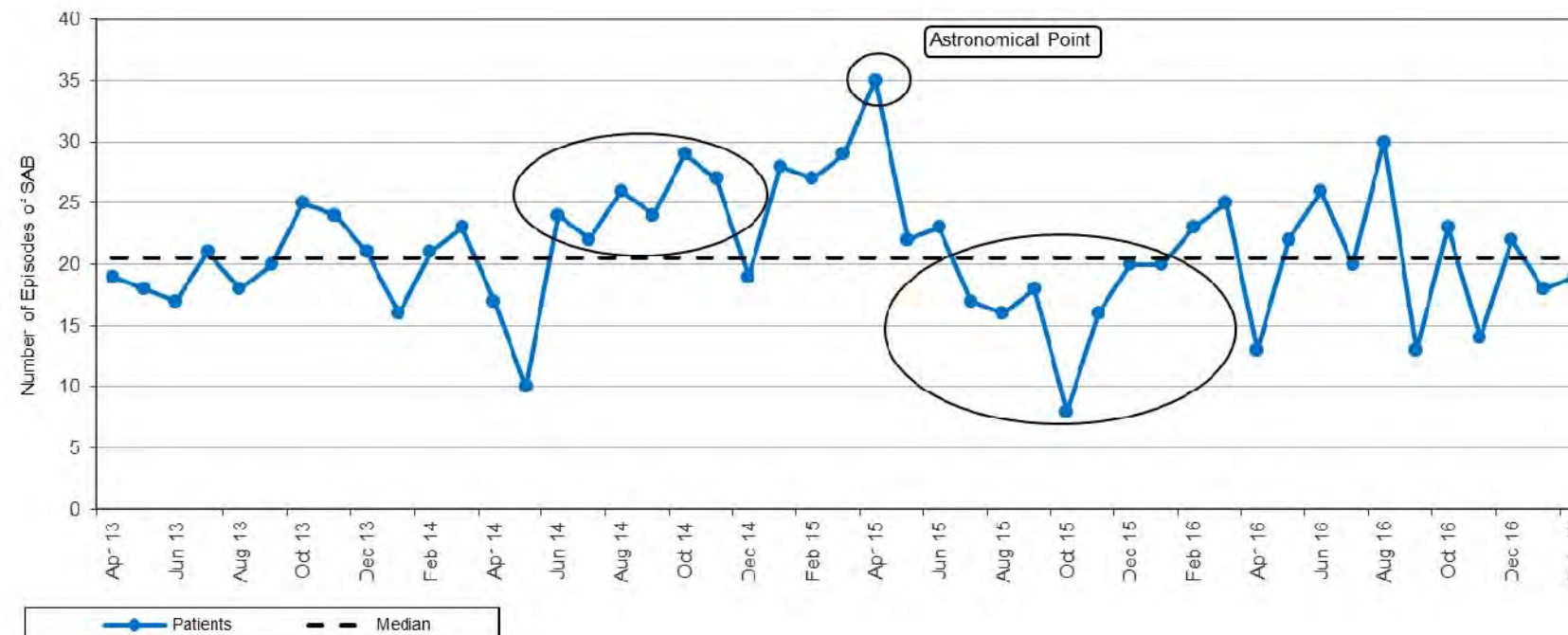
Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Moderate	Mar 17	Not Met	No Change	Equal	Jul – Sep 16	0.24 (max) (<184)	0.30 (220)	Feb 17	Infection Prevention and Control Team	Yes	Yes	TG

Summary for Committee to note or agree

- Performance target is for reporting year 1st April 2016 - 31st March 2017 incl. The reported rate above is based on 11 months of data.
- SAB incidence across NHS Lothian remains within the current warning limits but has not demonstrated sustained improvement. NHS Lothian has not achieved the Local Delivery Plan target for 2016/17 having breached the number of incidences to achieve the target.
- Health Protection Scotland published quarter 3 data (July – September 16), indicated NHS Lothian *S. aureus* bacteraemia incidence (predominantly due to MSSA bacteraemia), rate of 0.33 was the same as the overall NHS Scotland *Staphylococcus aureus* Bacteraemia incidence.

Recent Performance – Rates against Standard

Figure 1: SABs progress against Local Delivery Plan – NHS Lothian – Number of SAB Episodes per Month Source: Infection Prevention and Control Team



Timescale for Improvement The trends and patterns will be monitored and remedial actions taken as required

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
<p>Development of more detailed action plan in conjunction with Quality Improvement.</p> <p>Responsible Person(s): Lead Infection Prevention and Control Nurse/Patient Safety Programme Manager / Clinical Management Group</p>	February 2016	<p>A multidisciplinary approach is essential to the prevention of <i>Staphylococcus aureus</i> Bacteraemia. The detailed action plan includes contributions from clinical teams if this is to be effective.</p> <p>All staff involved in insertion, maintenance and interventions utilising invasive lines have a role to play in prevention of healthcare associated infections.</p>		Complete
<p>Infection Prevention and Control to improve quality of information reported to clinical and senior teams in relation to SAB.</p> <p>Responsible Person(s): Head of Service Infection Prevention and Control</p>	First report issued Dec. 2015	<p>Previous reporting only reported the number of SABs in each area, enhanced surveillance aims to identify source.</p> <p>Feedback from enhanced surveillance will engage clinical teams more in the review of cases which has previously predominately been undertaken by Infection Control. A multidisciplinary approach is better able to differentiate between preventable and non preventable infection</p> <p>Enhanced surveillance will raise awareness of cause/ source in order that clinical teams can target local actions to reduce healthcare associated SABs such as those related to invasive devices.</p> <p>Through multidisciplinary discussion the number of SAB categorised as "source unknown" should drop enabling more opportunities for intervention having identified the most likely source and reason for the bacteraemia.</p>	<p>Feedback from enhanced surveillance raises awareness of cause/ source in order that clinical teams can target local actions to reduce healthcare associated SABs such as those related to invasive devices.</p> <p>Report has been positively received by clinical teams</p>	Complete
<p>Additional resources to support education and clinical practice to work with clinical teams in the reduction of invasive device related SABs.</p> <p>Quality Improvement and education of all staff involved in the care of invasive devices is essential to ensure safe practice.</p> <p>The two staff appointed must deliver local education to improve practice in areas with highest incidence of device related infection.</p> <p>Responsible Person(s): Head of Education and Employment / Patient Safety Programme Manager / Practice Education Facilitator / Quality Improvement Facilitator</p>	<p>Staff appointed Nov. 2015</p> <p>Nov 2016</p>	<p>Temporary funding from Quality Improvement and Education Department has resourced 1 WTE each within their respective teams for 1 year</p>	<p>2 staff appointed on temporary contracts. They are undertaking review of current practice to support the development of targeted education at clinical level</p>	Staff appointments Complete
<p>Through education and patient safety ensure all levels of staff involved in insertion, maintenance and use of invasive lines deliver safe and effective practice and demonstrate competency and compliance in use of asepsis.</p> <p>Essential all medical staff as well as nursing staff are appropriately trained and competent in the handling of lines.</p> <p>Responsible Person(s): Head of Education and Employment / Patient Safety Programme Manager / Associate Medical Directors / Associate Nurse Directors. / Senior Charge Nurse / Consultants</p>	Nov. 2016	<p>Evidence of education and improvement in the management of invasive lines.</p>	<p>Education is progressing. There is a focus on areas that have been identified within the enhanced SAB reviews as having device related SABs</p> <p>Multidisciplinary working group established at WGH to review and standardise education and training resources, competency frameworks and standard operating procedures for the insertion and maintenance of invasive devices.</p> <p>It is anticipated that once pilot work complete at WGH, this will be adopted across all sites as best practice.</p>	March 2017
<p>Shared learning and practices from areas where invasive lines infection rates are low should be developed through quality improvement teams.</p> <p>Responsible Person(s): Quality Improvement Teams</p>	Dec. 2016	<p>RIE ITU demonstrates extremely low line related infections and have consistently ensured education of staff to reduce and prevent incidents. Clinical areas should learn from areas where there is good practice.</p>	<p>The data is reported to local infection control committees and quality improvement teams to facilitate local actions</p>	Complete
<p>A review of skin preparation products to ensure the correct product CA2CSKIN is being utilised supported by updated communication and education.</p> <p>Responsible Person(s): Senior Charge Nurses /</p>	June 2016	<p>There remains confusion regarding which skin preparation product should be used. Lothian advocates the use of Clinell Alcoholic 2% Chlorhexidine wipes. It has been observed in practice that CA2C200 for equipment are being used in areas for use on skin and invasive devices removal rather than the correct CA2CSKIN</p>	<p>Practice of using antimicrobial lock solutions e.g. taurolock has been reviewed as part of epic3 guidelines as routine use of device is not advised. Use in clearly defined clinical areas maybe beneficial.</p>	Complete

<p>Consultants / Procurement / Stores Top Up</p> <p>Standardise transparent dressings utilised for invasive vascular devices to ensure compliance with best guidelines</p> <p>Establish a quality improvement project to consider the efficacy and benefit of using antimicrobial lock solutions e.g. taurolock.</p> <p>Responsible Person(s): Quality Improvement /Procurement</p>		<p>product. This may partly arise through too many products being made available at ward level to select from and thereby using the wrong product for the wrong purpose.</p>	<p>The appropriate dressing type is available to order or through top up. Clinical teams are responsible for ensuring that the appropriate dressings are used</p>	
<p>Catheter care should be reviewed and catheter use needs to be discouraged when not absolutely necessary and access to alternatives explored.</p> <p>Roll out of SPSP CAUTI Bundle to areas reporting catheter associated infections using the Pareto charts to prioritise implementation.</p> <p>Responsible Person(s): Patient Safety Programme Manager/Clinical Nurse Managers/Senior Charge Nurses</p>	<p>March 2017</p>	<p>The SPSP CAUTI reduction work has shown a reduction in the number of short term catheters inserted and the time to removal in the pilot ward at RIE. The catheter passport has been introduced across the board and catheter alternatives are being advocated. This would benefit SAB and E coli bacteraemia incidence.</p>	<p>The HPS initial report demonstrated that 7.9% of ECB had a urinary catheter as source. Urinary Catheters account for approximately 2% of SAB, therefore the impact of CAUTI Bundle may have limited impact on reduction of overall SAB incidence.</p> <p>It is anticipated that the inclusion of CAUTI as a key part of the Care Assurance Standards (CAS) project will improve use of the catheter passport and CAUTI bundles.</p>	
<p>Improve compliance with National MRSA Screening Clinical Risk Assessment ensuring decolonisation/suppression therapy is implemented where clinically indicated.</p> <p>Responsible Person(s): Lead Infection Prevention and Control Nurse / TRAK Management Board / Associate Nurse Directors / Senior Charge Nurse</p>	<p>April 2017</p>	<p>With the introduction of Paperlite System and the transition of nursing risk assessment documentation, infection control risk assessment which covers MRSA is covered within document highlighting patients who are admitted with MRSA which will automatically develop associated action plan which will direct patient to be isolation and transmission based precautions utilised. Whilst MRSA SABs are low it is important that we do not become compliant. Currently IPCT participating in research project carried out by Glasgow Caledonian University to identify barriers to screening compliance.</p>	<p>The upgrade to TRAK to include the HAI risk assessment has been completed. However the unintended consequence has disrupted the extract of information required for MRSA CRA which is submitted to HPS.</p> <p>Discussions with IT to address disruption in capability Previous IT issues now resolved, and MRSA CRA compliance data has been extracted and reported to HPS. Some improvement in compliance noted.</p>	
<p>Evaluate the impact of routine decolonisation to reduce the incidence of Hickman and PortaCath related SAB should be considered with a view to implementation in other units with high central line use.</p> <p>Responsible Person(s): Quality Improvement Teams / Clinical Teams / Microbiology</p>	<p>Oct 2016</p>	<p>Decolonisation is being used in the renal unit as a strategy to prevent dialysis line SAB and possibly could be used as a strategy to prevent Hickman line and PortaCath related SAB also.</p>	<p>A multidisciplinary SLWG is being established at WGH to address strategies to reduce a disproportionately higher incidence of line related SAB at WGH site. A range of strategies to reduce tunnelled line related SAB will be considered. Completion date has been amended to accommodate the additional work</p>	<p>Ongoing, needs to be rolled out to other sites (RIE, RHSC & SJH)</p>
<p>Review of blood culture sampling practice and education for front door areas</p> <p>Test of Change within Emergency Department at the RIE on the effectiveness of grab bag approach to blood culture sampling. Grab bags would contain all equipment required for safe sampling and a reminder message outlining what is best practice within the pack.</p> <p>Responsible Person(s): Clinical Nurse Manager / Clinical Lead RIE ED / All Medical Staff</p> <p>Ensure education of all staff undertaking blood culture to ensure competency and safe practice.</p> <p>Responsible Person(s): Clinical Lead / All Medical Staff / Clinical Nurse Manager / Phlebotomists</p> <p>Review blood culture contamination rates as a standing item discussed weekly at ward safety briefs and at departmental M&M meetings, Ensure feedback and education of staff with poor technique, reducing the risk of contaminated samples.</p> <p>Responsible Person(s): Clinical Lead / Clinical Nurse Manager</p>	<p>Oct. 2016</p>	<p>Improved quality of sampling reduces the risk of contamination. This contamination can be interpreted as infection, resulting in patients receiving additional treatment and extended stay and over reporting of actual infection rates.</p> <p>These interventions are designed to improve blood culture taking and reduce wastage of laboratory time and resource in working up contaminated samples. They are labour intensive to deliver and therefore this creates an additional cost.</p>		

<p>Introduction of the Visual Phlebitis scoring as part of the patient safety bundle.</p> <p>Responsible Person(s): Patient Safety Programme Manager / Senior Charge Nurses</p>	<p>March 2017</p>	<p>Early recognition of phlebitis can prompt staff to remove the cannula and reduce the risk of progression to SAB associated with Peripheral Vascular Cannulas (PVC). PVC is identified as one of the key preventable sources and reduction in these could support move to achieving of 0.24 rates in 2016/17.</p> <p>Episodes of venflon associated soft tissue infection are unacceptably common in Lothian. Optimal management of all invasive devices is essential. Where there is evidence of infection they should be removed and antimicrobial treatment commenced appropriately</p>	<p>Education and improvement work to support implementation of VIP continues across the acute hospital sites.</p>	
<p>Raise awareness of risks associated with unsafe injection practices with People Who Inject Drugs (PWIDs).</p> <p>Frontline clinical teams to ensure opportunities for education to PWIDs when presenting within acute setting.</p> <p>Responsible Person(s): Associate Medical Directors / Associate Nurse Directors</p>	<p>December 2016</p>	<p>In the current HEAT target year there have been 17 incidences where PWIDs have developed SAB as either direct or contributing factor from recreational use of IV drugs.</p> <p>Preventative strategy through harm reduction services to provide information leaflets written jointly by NHS Lothian staff and Scottish Drugs Forum, education regarding safe injecting, use of filters, skin preparation, optimising wound care within needle exchanges and outreach centres and buses.</p> <p>Identify PWID on admission to acute services and promote information leaflets as a preventative strategy. Provide information to PWID SAB patients prior to discharge to minimise risk of further SAB associated with injecting practice.</p>	<p>Selling of Novel Psychoactive Substances is illegal throughout the UK.</p> <p>Greater use of an educational leaflet on acute sites written jointly by NHS Lothian and Scottish Drugs Forum explaining how S aureus infections arise from drug injecting is being considered.</p>	
<p>Comments</p>				
<p>Reasons for Current Performance: Staphylococcus aureus bacteraemia is a serious condition with a reported mortality rate of about 30%. Published mandatory data shows that the analysis of longer term trends showed no national increase or decrease in the SAB rate. However, there was a decrease in the number of patients with MRSA and an increase in the number of patients with MSSA in Scotland. No NHS boards were above normal variation this quarter (SAB, MRSA or MSSA) when analysing long-term trends over the past three years.</p>				

48 Hour GP Access

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:

1. **At least 90%** of people should have 48-hour access to the appropriate healthcare professional (HCP);
2. **At least 90%** of people should be able to book an appointment with a GP more than 48 hours in advance.

Responsible Director[s]: Chief Officer – East Lothian IJB

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
TBC	TBC	HCP Access: Not Met	Improving	Worse	2015/16	90% (min)	85.0%	2015/16	National Health and Care Experience survey ¹ [proxy measure]	No	No	DS
TBC	TBC	GP Appt: Not Met	Deteriorating	Worse	2015/16	90% (min)	75.0%	2015/16	National Health and Care Experience survey [proxy measure]	No	No	DS

Summary for Committee to note or agree

- Following the removal of the 48 hour access indicators from the Quality Outcomes Framework (QOF) for 2015-2016 there is no longer local monitoring of 48 hour access to GP services. Access for NHS Lothian practices is instead assessed through the two-yearly and centrally delivered National Health and Care Experience survey. The survey results for 2015/16 do not directly address the issue of whether 90% has been achieved, but does provide useful information on satisfaction with access. The Healthcare Governance Committee received a report at its meeting on 26th July on this subject. The national report showed a declining positive % for satisfaction with overall arrangements for getting to see a doctor from 85% in 2011/12 to 73% in 2015/16. This is 1% higher than the Scotland figure. In contrast to the overall decline in satisfaction, satisfaction in getting to see or speak to a doctor or nurse within 2 days rose from 84% to 85%. However on most measures relating to this area there has been a decline in satisfaction.

Web link to full report: <http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16>

Recent Performance – Numbers against Standard

Table 1: Results from National Health and Care Experience Survey - Higher % is Better

	2009/10	2011/12	2013/14	2015/16
48-hour GP/HCP access	90.0%	84.0%	85.0%	85.0%
Advance booking	77.0%	80.0%	77.0%	75.0%

Timescale for Improvement

A trajectory has not been agreed with SGHD.

¹ <http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16>

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Summary of 15/16 survey results to next Board meeting.	August 2016	To provide an alternative source of data to describe any delays in access to Primary Care services.		

Comments**Reasons for Current Performance**

As 48 hour access to GP services no longer features in the Quality Outcomes Framework with the evolutionary change of the GP Contract, there is no longer any local monitoring of 48 hour access. Alternative, but not directly comparable data is available through the National Health and Care Experience survey. The most recent report shows declining satisfaction with access. This correlates with the increase in GP practices in Lothian experiencing difficulty in recruiting and retaining staff (a phenomenon being experienced across Scotland) and the introduction by some practices of restrictions on new patient registrations. There is unlikely to be any significant improvement in this position until the new GP contract is introduced in autumn 2017.

Four Hour Unscheduled Care

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard: 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%.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Moderate	Feb 2017	Not Met	Improving	Better	Jan 17	95.0% (min) - stretch to 98.0%	93.2%	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

93.9% Year to date, 95.5 % Month to date Inclusive of WGH (13.03.17)

Winter planning is well embedded and rolled out across the system. Additional bids included to support patient flow across the system, for example extra pharmacy support to the discharge lounges. Investment in virtual ward models of care such as HAH, H2H and D2 Assess, across the partnerships and acute system are in place and the number of teams has increased in number to support care provision at home.

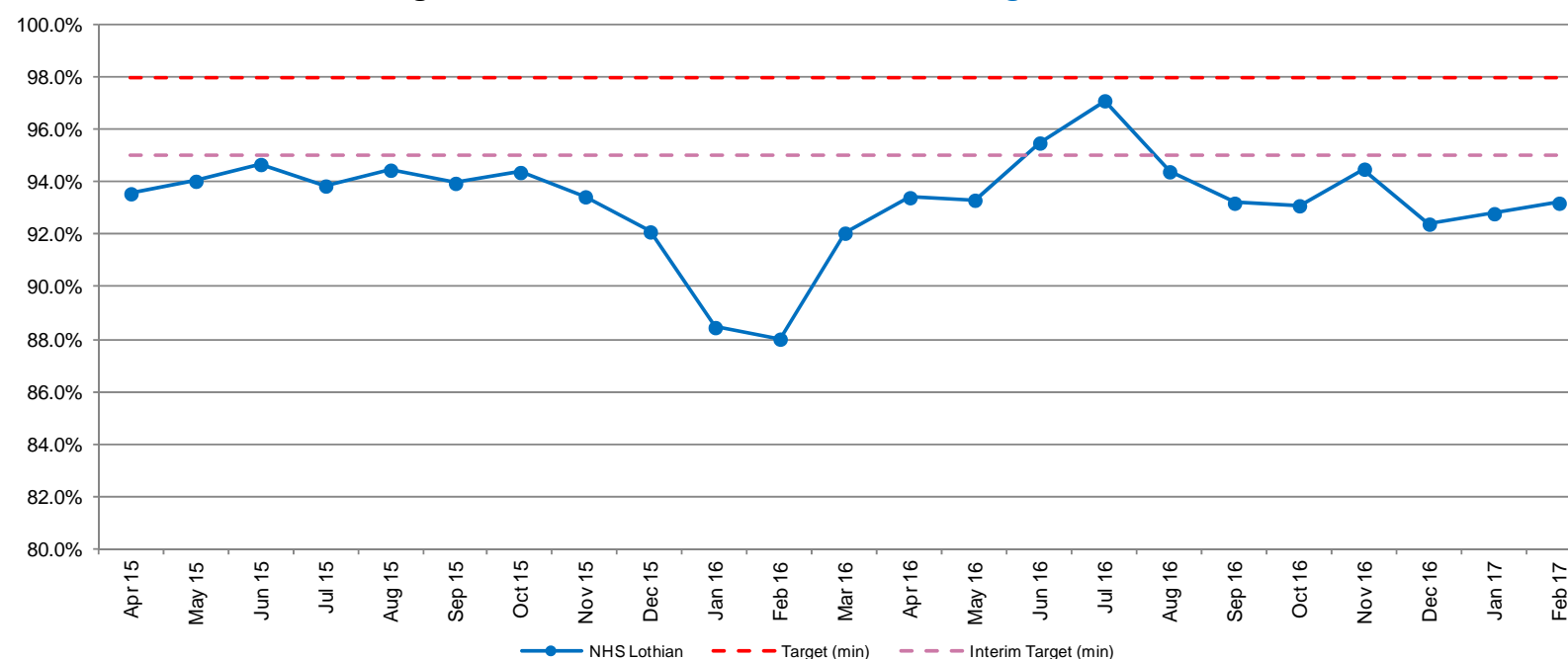
Local Service Improvement teams are taking forward a number of diverse improvement activities including daily dynamic discharge and a check chase challenge approach to planning discharge from hospital

Edinburgh Health and Social Care Partnership new locality model continues to evolve; focusing on admission avoidance and ensuring timely discharge from hospital.

Weekly teleconference with the IJB Chief Officers and COO and acute teams continues to discuss pressures and performance with a view to enacting actions to support mitigation of risk continues. UCC performance is high on NHS Lothian UCC Committee / Winter Programme Board Agenda

Recent Performance – Numbers over 4 hour standard

Figure 1: Trend in A&E Performance – Higher % is Better



Timescale for Improvement

Various actions for improvement with timescales outlined in table below.

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
<p>Deliver on Lothian's winter plan that included reducing elective bed pressures in January to support unscheduled capacity, enhancing weekend services and strengthening services that manage increased winter demand and support flow. The plan builds on the need for whole system working across acute, primary and social care services. Working with Integrated Health Boards is assisting with the promotion of care at home services and shifting the balance of care.</p> <p>Focus on care in the community models is evidenced such as HAH virtual wards and H2H support for patients requiring Packages of care or achievable hospital treatment within their own homes.(virtual ward)</p>	<ul style="list-style-type: none"> Winter funding now allocated and targeted at a number of flow improvement service developments. Weekly teleconference with the IJB and UCC Committee/winter programme board meet monthly and UCC performance is high on the agenda Revised plans discussed to support patient flow Recognition of interdependency re the reduction of delayed discharges and UCC performance is apparent Winter debrief templates distributed re specific funding allocated to specific services to support data re trends in performance supporting better outcomes. Full Debrief April 2017 	<p>Improved patient flow and improved 4-hour performance.</p>	<p>TBC as services are reviewed and embedded in.</p> <p>February Performance Month to date 2017 is 5.2 % better than this time last year</p> <p>Monitoring sustainability.</p>	<p>Winter planning progressing on each of the three acute sites. This includes a focus on early discharge through strengthening Discharge Hubs resources, reshaping how 'boarded' patients are cared for at RIE and WGH with senior nurses and clinicians allocated to this group. The development of a Winter ward at WGH. There is a focus on extending our virtual wards via HAH and increasing our hospital to home teams. The Winter plan also includes increasing Respiratory capacity system-wide, strengthening out of hours medical cover and a number of funded tests of change aimed at improving patient flow.</p> <p>Monitoring of good practise from winter planning continues as a feature to embed good practise into our services. Hence the stringent monitoring, updating of data and stringent debrief from each service delivery</p> <p>Extending some services to support the whole system to mitigate risk. For example GP led winter interim care ward and AHP posts to support integrated rehabilitation on acute site and community rehabilitation.</p>
<p>Implement national 6 essential actions unscheduled care toolkit on all three acute sites. These are integral to planning and delivery unscheduled care services, including winter.</p>	<ul style="list-style-type: none"> Programme initiation now complete Oct-16 Embedding S,G Methodology re In Out Balance and capacity requirements by speciality on our acute sites Methodology to be rolled out to downstream services in Health and Social Care Partnerships such as complex Rehabilitation for Brain Injury and Amputee where patients move on for transfer of care Commencing in April 2017 	<p>Improved 4-hour performance.</p> <ul style="list-style-type: none"> Proactive discharge planning Shifting the balance of care Reducing delays in transfer of care Reducing the high levels of Capacity on the Acute Sites 	<p>To date: Jan / Feb 2017 4-hour performance is 4.4 % and 5.2% higher respectively than in 2016</p>	<p>Service improvement teams established on all sites and focussing on rollout of Daily Dynamic Discharge (DDD) at RIE, WGH, and SJH since November and increasing pre-noon and over all discharge profiles across each of the sites.</p> <p>Roll out required across the whole system</p>
<p>Implement recommendations from the Deloitte report around Frailty pathways and Length of Stay.</p>	<ul style="list-style-type: none"> NHS Lothian Frailty Programme Board established August 2016 Performance reporting sub group since Oct-16. Extended to stakeholders from all sites and partnerships across the system 	<p>Improved admission avoidance and discharge. Improved 4-hour performance.</p>	<p>Programme Board currently scoping planned benefits</p> <p>Flow centre embedded in system and is sign posting to alternative pathways re clinics, HAH etc</p>	<p>Frailty Programme Board meets monthly. Work underway to develop Frailty Dashboard to evidence impact of improvement work.</p> <p>Focus on reducing delayed discharges across Lothian. Each health and social care partnership has trajectories in place to support taking their own patients out of hospital in a timely way. RIE has increased Geriatrician cover in the Acute Medical Unit to cover the whole unit from Nov-16.</p> <p>WGH has an interim care ward opened for winter which is GP led and will be extended for 3 months (June 2017)</p>
<p>Implement SEFAL (Safe Effective Flow across Lothian) work stream shifting discharge curve to earlier in the day and avoiding more unnecessary admissions. Referred to the Flow Centre for short.</p>	<ul style="list-style-type: none"> Flow Centre operational since summer 2016 Emergency Bed Bureau and transport services have amalgamated to reduce batching of attendances Out patients is part of this service too 	<p>Improved 4-hour performance</p> <p>Reduce Batching of Hospital Attendances</p> <p>Access to alternatives for</p>	<p>TBC re sustainability of performance over winter as new services are bedded in</p> <p>Worked well for the</p>	<p>Work between ED and Flow Centre underway to encourage Primary Care use of Centre. Advanced Nurse Triage service invested in for winter. This will give the GPs access to appropriate advice and signage to appropriate pathways for patients</p> <p>Work underway to encourage more GPs to use Flow</p>

	and is signposting appropriate patients to outpatient slots <ul style="list-style-type: none"> • Patients arriving at hospital earlier in the day a • Virtual ward area set up on TRAK to allow the Acute Sites to visualise number of patient expected and the arrival time 	assessment of patients	Hogmanay Plan Positive feedback apparent from GPS and Front door receiving units	Centre as referral route. GPS are using the flow centre well. Care home referrals from all localities are reviewed by the HAH teams to assist with prevention of attendances and admissions
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Comments

Reasons for Current Performance

Higher volume of unscheduled attendances throughout January / winter at peak times and an increase in acuity of patients which impacts on ability to maintain 4-hour performance. Delayed discharges still a pressure on capacity across the whole system. An Integrated approach is in place to try and alleviate this situation and mitigate risk. Performance is better to date than last year at this time but monitoring of sustainability is ongoing. All acute sites experiencing high acuity of patient workload impacting on the resource at the front door areas as the patients are stabilised. There is a vigilant focus on prevention of crowding in the assessment areas and a strong senior team presence 7 days on the RIE (largest site) has been effective in supporting the site in anticipating and proactively managing the complex situations which can present. An integrated approach to the importance of interdependency of all services to enhance performance is in place. The links to whole system flow and using the same methodology will assist in the sustainability of our systems to enhance patient outcomes.

Child & Adolescent Mental Health Services (CAMHS)

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

National Target/Standard:-

No child or young person will wait longer than 18 weeks from referral to treatment in a specialist CAMHS from December 2014. This target should be delivered for at least 90% of patients.

Responsible Director[s]: Nurse Director

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Mar 17	Not Met	Deteriorating	Worse	Dec 16 (Mthly)	90% (min)	48.4%	Feb 17	Management Information	Yes	Yes	AMcM

Summary for Committee to note or agree

Local Target/Standard:-

The CAMHS Recovery Plan has been in place since September 2016. This focuses on removing the longest waits from the waiting list for treatment. The figures to date demonstrate that the recovery plan is delivering as anticipated so far.

Achievement of the 18 week standard will not happen until the longest waits have been treated and removed from the waiting list. To date circa 300 longest waits have been treated/removed.

Recent Performance – Performance against 18 Week Standard

Figure 1: All Teams - Percentage of children and young people seen within 18 weeks for first treatment – Higher % is Better

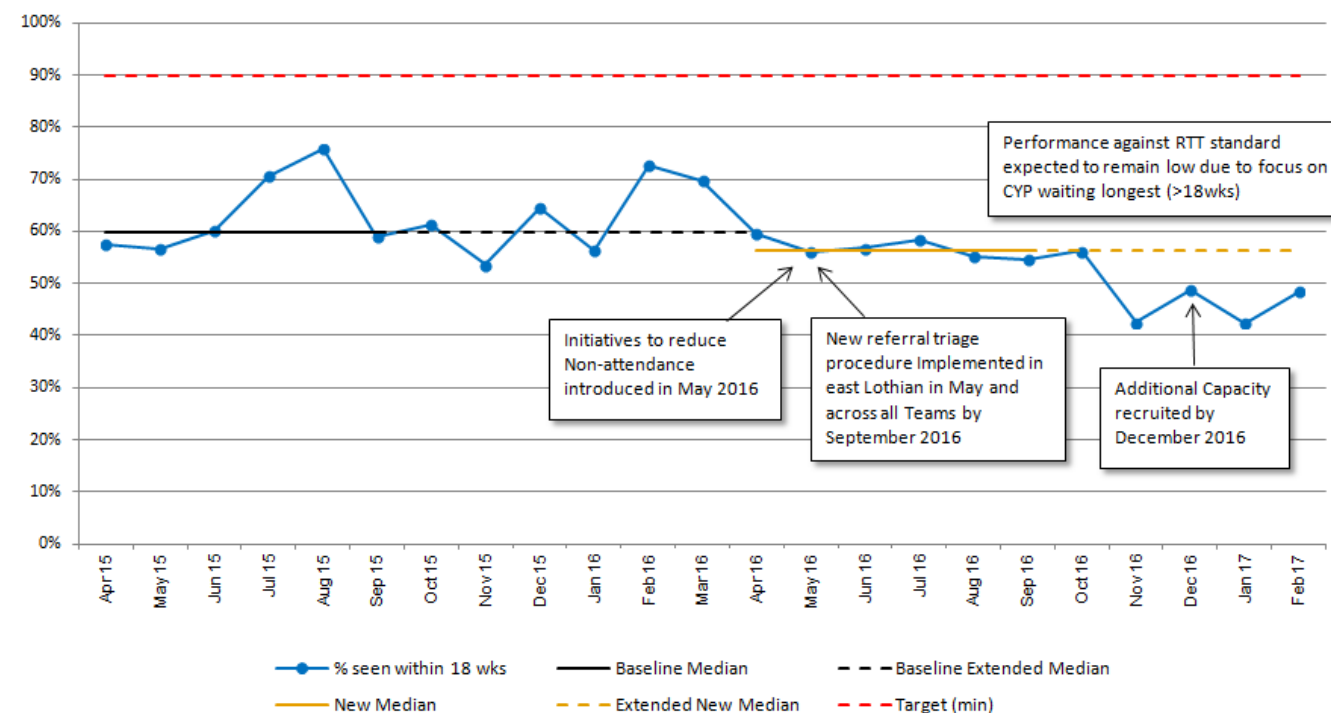


Figure 2: All Teams - Number of children and young people waiting over 18 weeks – Lower Count is Better

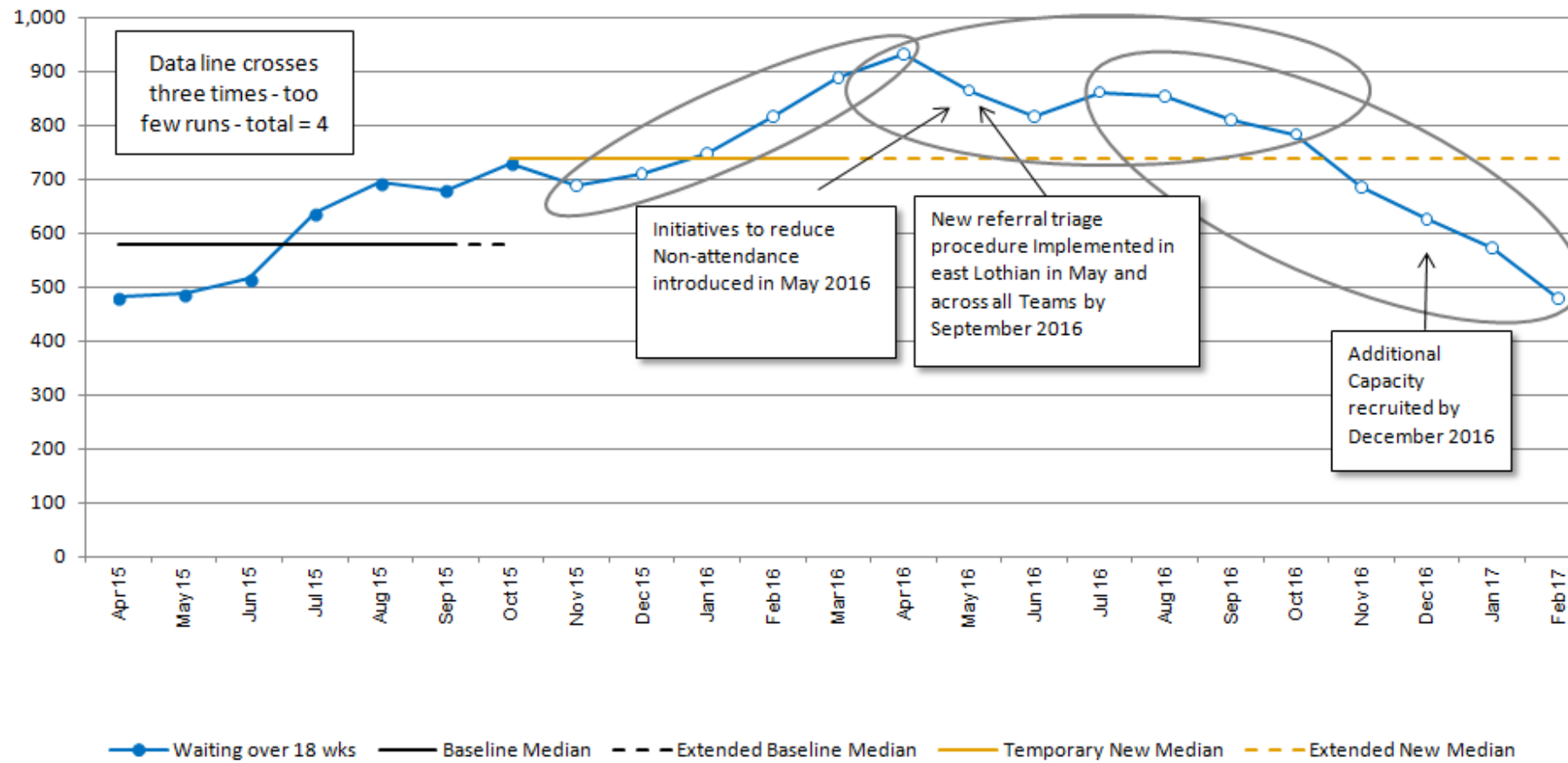


Figure 3: Generic Teams - Number of children and young people seen for 1st treatment – Higher Count is Better

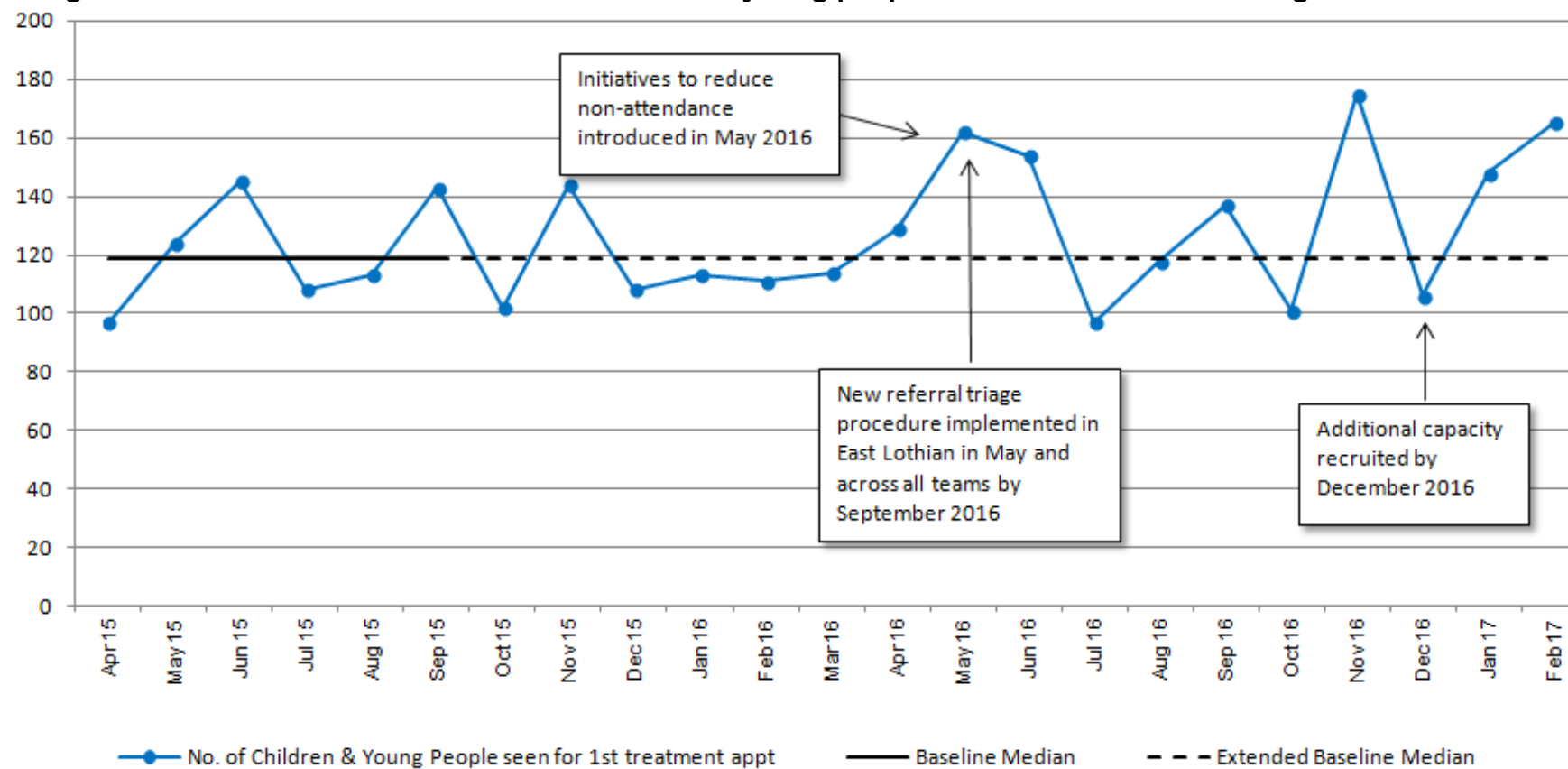


Figure 4: Generic Teams - Number of children and young people seen for 1st treatment waiting over 18 weeks when seen – Lower Count is Better

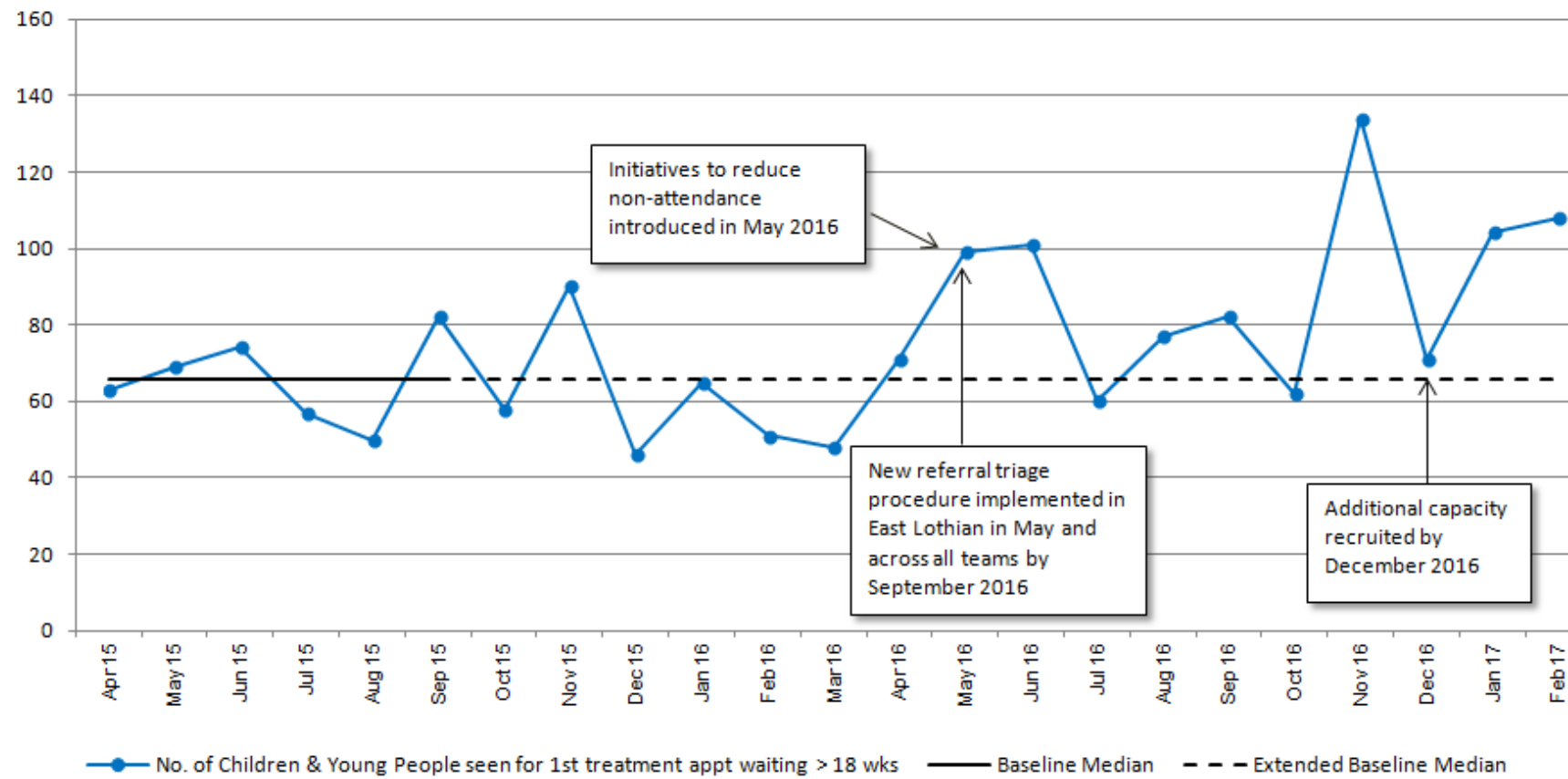


Figure 5: Generic Teams - Number of children and young people waiting over 18 weeks – Lower Count is Better

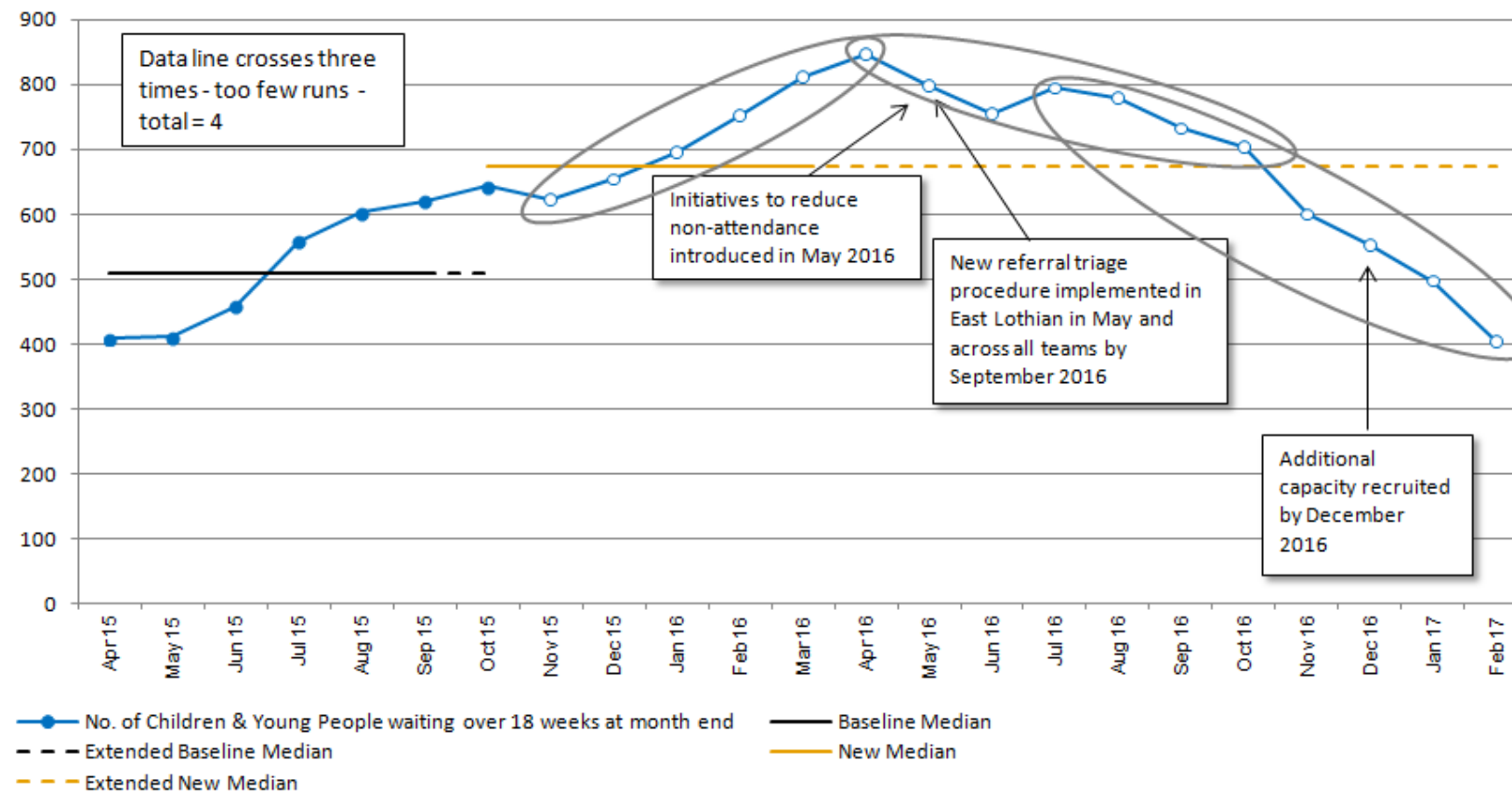


Figure 6: Generic Teams - Referrals by month

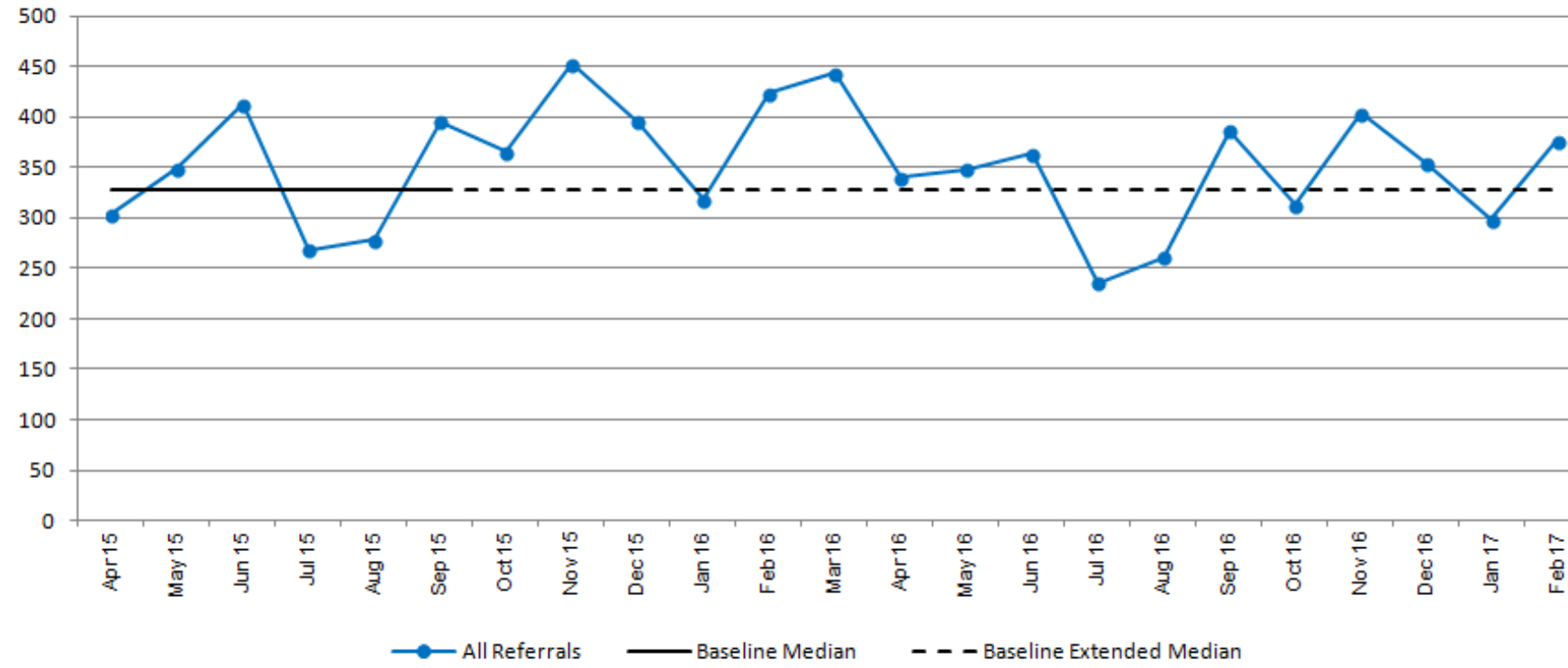
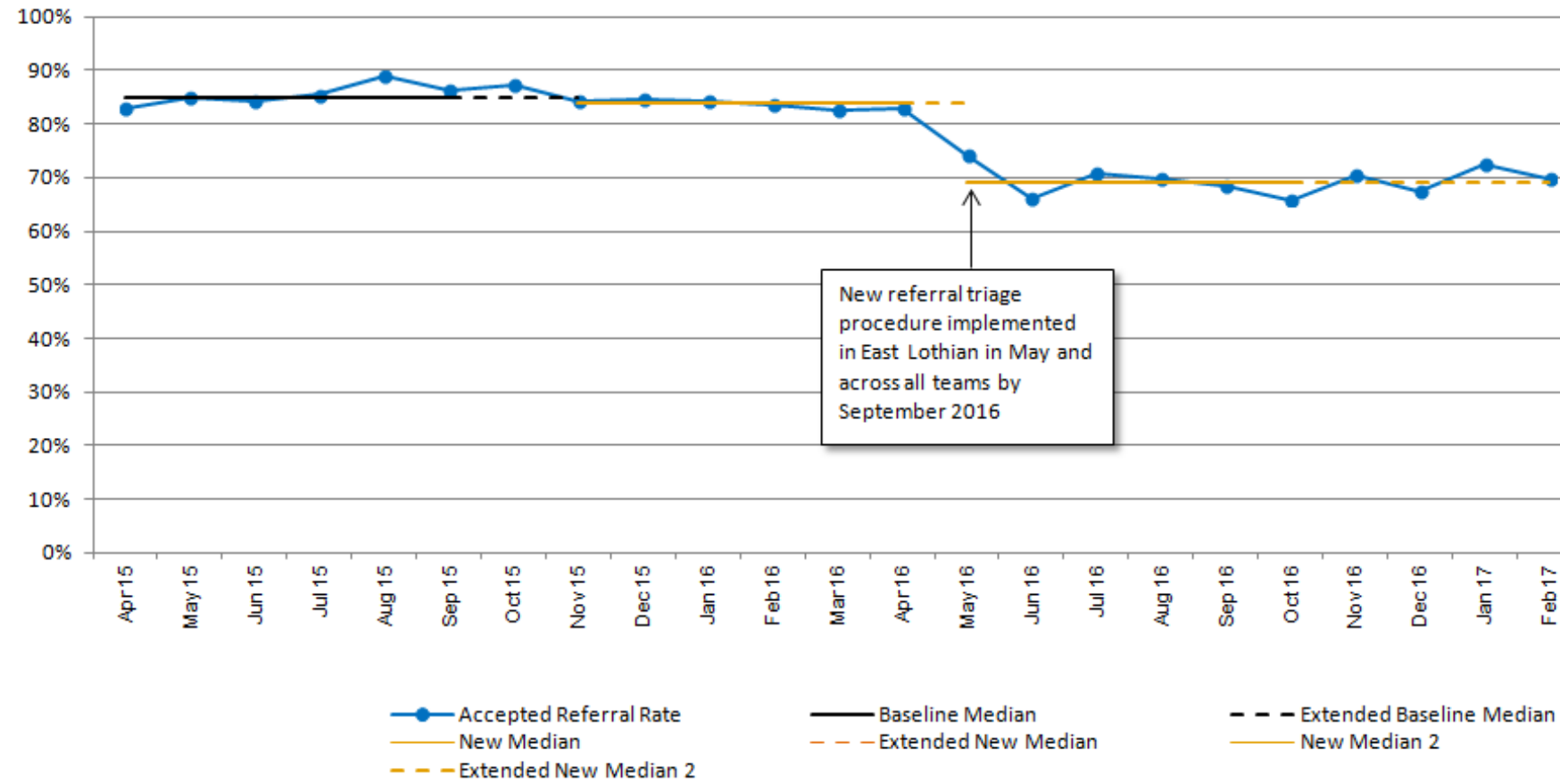


Figure 7: Generic Teams - Accepted referrals rate by month



Timescale for Improvement				
The impact of the recovery plan on those waiting over 18 weeks is anticipated to continue to impact on the achievement of the national standard until such time as the long waits are removed. Each of the 5 generic CAMHS teams operates separate waiting lists and analysis shows that each team will achieve 18 weeks at slightly different times. To date 3 out of 5 teams have met/exceeded the position expected for end of March 2017, with the remaining 2 teams very close to the modelled position.				
Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
Development of a single implementation plan for the introduction of Patient Focused Booking across CAMHS for Choice (Assessment) Appointment.	Delayed as impacted by TRAK 2016 upgrade	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments. Improved compliance with waiting times rules related to reasonable offer, unavailability and clock resets	Minimise risks associated with introduction of Text Reminders, improved capacity planning and compliance with waiting time rules	Amber
Development of an implementation plan for the introduction of Text Reminder system for CAMHS which minimises Clinical Risk	Delayed as impacted by TRAK 2016 upgrade	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments. Reduces the Clinical Risk associated with potential breaches of patient confidentiality.		Amber
Completion of updated Demand Capacity Activity Queue (DCAQ), for CAMHS whose data is recorded and reported from TRAK. Completed for all teams ongoing discussion measuring capacity.	End March 2017	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand. Confirmation that there is sufficient capacity in each of the teams to support 18 weeks on and ongoing basis.		Amber
Introduction of revised Triage "Team Method" across all teams following the East Lothian Pilot.	Complete	Improvement in management of demand to allow reduction in the number of Choice Clinics with time converted to Treatment Clinics.	All teams have been able to reduce their Choice Assessment Clinics by at least 30% as at November 2016	Green
Reduce the community development role of CMHW in CAMHS teams for 1 school year to increase direct clinical capacity to focus on long waits.	Implemented	Provide additional capacity to reduce long waits. Risks of stopping community capacity building being managed.	Additional treatment slots have been released.	Green
Further productivity gains identified and being explored with a view to supporting recurrent achievement of the 18 weeks target following removal of the "backlog".	31 March 2017	Improved use of clinical capacity and achievement of recurrent balance.		Amber
Comments				
Capacity has been released as a result of the actions in the agreed Recovery Plan being implemented. Further modelling during February and March will produce a proposed way forward to sustain 18 weeks on a recurrent basis.				
Reasons for Current Performance				
Teams have been asked to focus on patients waiting longest. It was anticipated that this will have some impact on the 18 weeks target performance in the short term.				
Mitigating Actions				
Staffing recruited using the Mental Health Innovation funding (£278,000) and Building Capacity Funding (£210,000 from July 16/17 increasing to £334,000 in subsequent years), will prioritise those children and young people who have waited the longest. All additional nursing staff are in post.				
Some changes to current work practices and the implementation of proven quality improvement test of change has identified additional capacity in existing teams to target longest waits.				

Cancer - 31-day

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard: 31-day target from decision to treat until first treatment for all cancers, no matter how patients were referred. For breast cancer, this replaces the previous 31-day diagnosis to treatment target.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Jul - Sep 16	95% (min)	90.6%	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

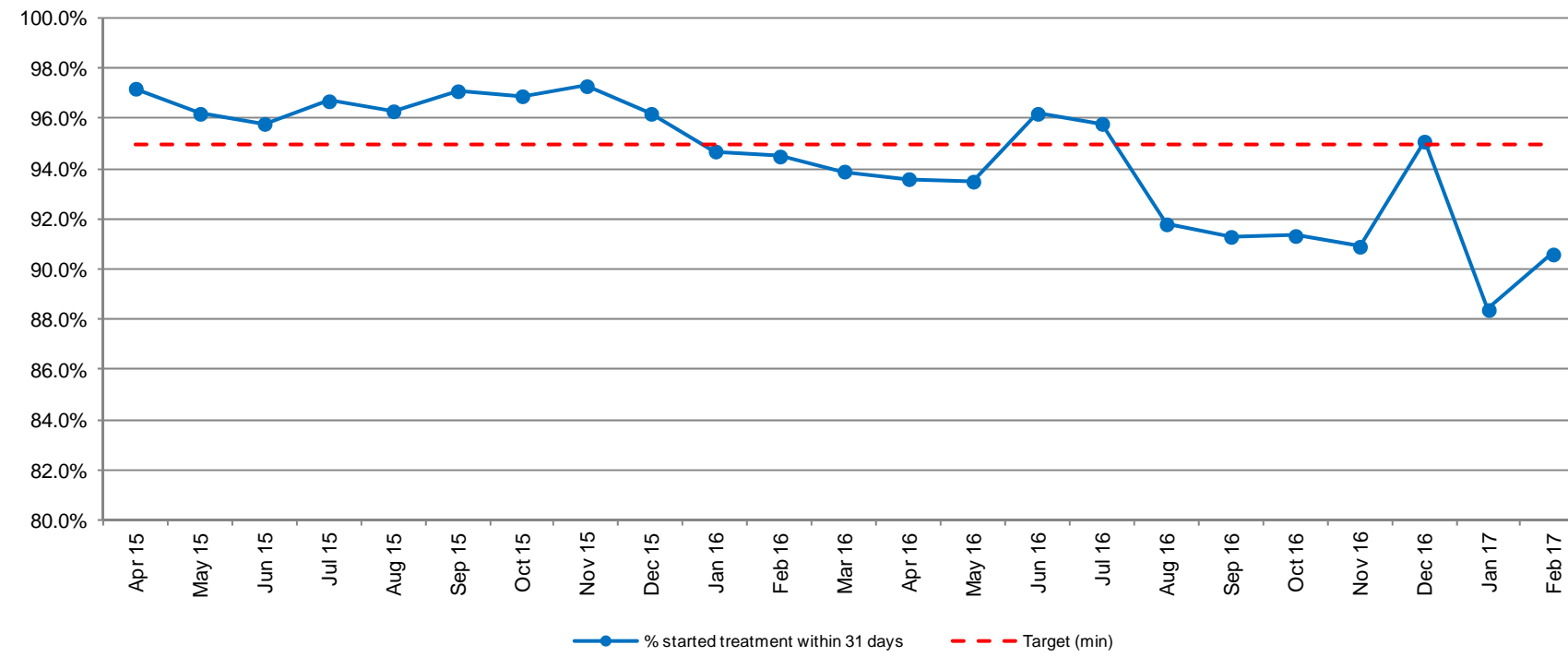
- Performance in January 2017 was 88.4% - a reduction of 6.7% from December. However improvement in the current reported January performance is anticipated after further data review completed of some reported breaches in Urology and Colorectal. This will be reported in the formal quarterly ISD submission.
- The number of eligible patients who met the 31 day pathway was 236 out of a total number of 267. Following further review it is anticipated this number will increase by 10. Due to dates for formal submission of data and need for further verification the reported figure remains conservative.
- Performance continues to be challenged within Urology at 56%.
- 7 tumour sites achieved 100%, 4 tumour sites fell below the standard.

Recent Performance – Percentages achieved towards standard

Table 1: 31-Day Performance – Higher % is Better

Cancer Type	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
All Cancer types	97.2%	96.2%	95.8%	96.7%	96.3%	97.1%	96.9%	97.3%	96.2%	94.7%	94.5%	93.9%	93.6%	93.5%	96.2%	95.8%	91.8%	91.3%	91.3%	90.9%	95.1%	88.4%	90.6%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.8%	100.0%
Cervical (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%
Cervical (screened only)	100.0%	n/a	100.0%	100.0%	n/a	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	0.0%	n/a	0.0%	100.0%	n/a
Colorectal (screened excluded)	95.2%	88.9%	100.0%	96.2%	90.6%	100.0%	100.0%	96.3%	97.1%	90.3%	96.9%	100.0%	89.3%	100.0%	100.0%	100.0%	89.5%	90.3%	88.0%	88.9%	96.3%	100.0%	88.5%
Colorectal (screened only)	100.0%	100.0%	75.0%	100.0%	50.0%	88.9%	81.8%	100.0%	66.7%	83.3%	83.3%	100.0%	100.0%	80.0%	100.0%	100.0%	66.7%	100.0%	80.0%	72.7%	85.7%	60.0%	100.0%
Head & Neck	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	85.7%	100.0%
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	100.0%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Melanoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurological - Brain and Central Nervous System (CNS)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	87.5%	83.3%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	60.0%	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper Gastro-Intestinal (GI)	95.2%	100.0%	95.2%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	86.7%	100.0%	93.3%	100.0%	100.0%	100.0%
Urological	89.5%	85.5%	84.6%	85.5%	92.9%	90.3%	90.4%	87.2%	85.4%	82.0%	77.8%	73.0%	68.8%	67.4%	82.2%	73.0%	62.5%	59.5%	69.6%	55.0%	73.8%	56.0%	57.9%

Figure 1: 31-Day Performance – Higher % is Better



Timescale for Improvement

A recovery trajectory has not been agreed with SGHD. Health Boards are expected to deliver the 31 day target.

Actions

See 62 day cancer proforma. From March 2017 the 31 day and 62 actions are described in a single cancer report on the 62 day return rather than repeating.

Cancer – 62-day

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:

- 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).

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Improving	Better	Jul – Sep 2016	95% (min)	88.7%	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

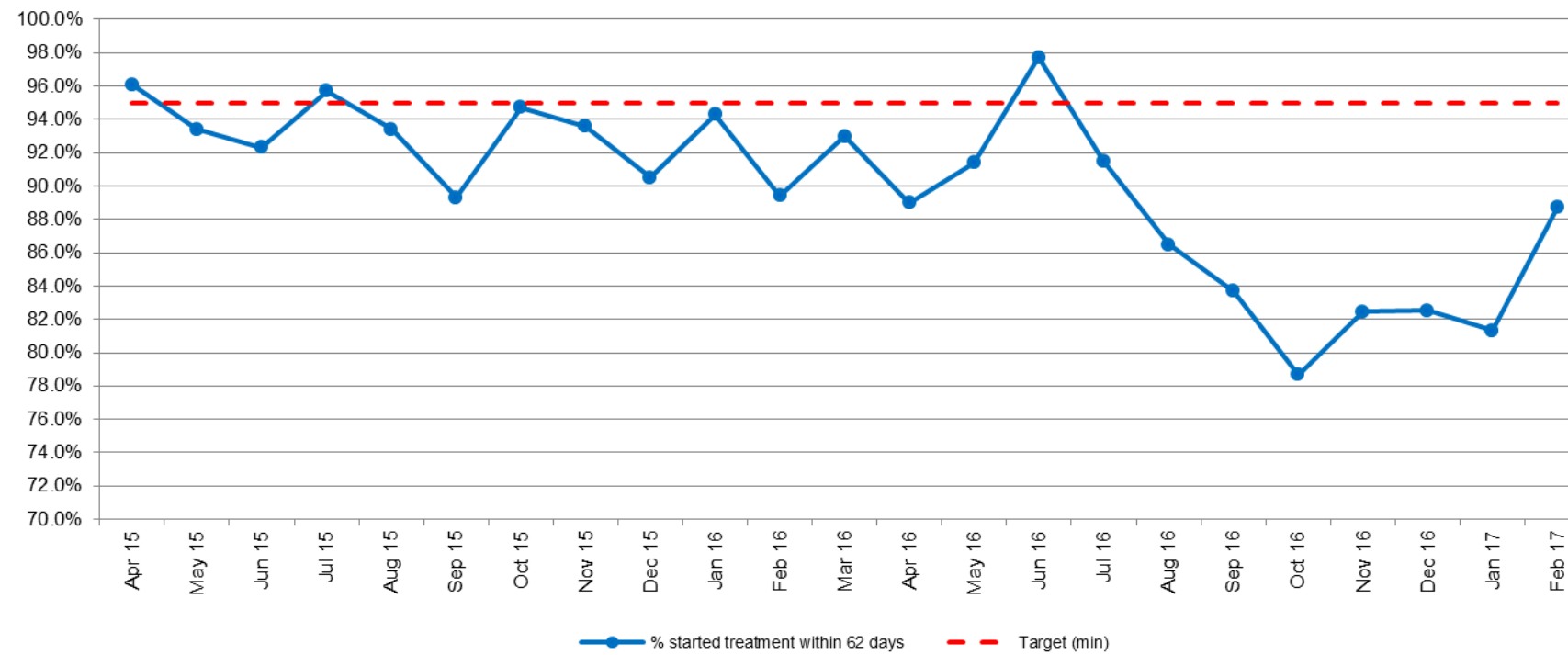
- Overall performance in January at 81.3% for 62 day pathway. However improvement in the current reported January performance is anticipated after further data review completed of some reported breaches in Urology and Colorectal. This will be reported in the formal quarterly ISD submission.
- The number of eligible patients who met the 62 pathway was 109 out of a total number of 134. Following further review it is anticipated this number will increase by 9. Due to dates for formal submission of data and need for further verification the reported figure remains conservative.
- Many tumour groups continued to see challenges on the 62 day pathway with 4 tumour sites achieving 100%.
- Capacity pressures on several pathways and performance pressures associated with the 31 day portion of the pathway have contributed to continuing difficulties with the target
- Additional scrutiny started in February in Colorectal and Urology anticipated to show initial impact in April and May.

Recent Performance – Percentages achieved towards standard

Table 1: 62-Day Performance – Higher % is Better

Cancer Type	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb-17	
All Cancer types	96.1%	93.4%	92.3%	95.7%	93.4%	89.3%	94.7%	93.6%	90.5%	94.3%	89.4%	93.0%	89.0%	91.4%	97.7%	91.5%	86.5%	83.7%	78.7%	82.5%	82.5%	81.3%	88.7%	
Breast (screened excluded)	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	97.0%	
Cervical (screened excluded)	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	100.0%	
Cervical (screened only)	100.0%	n/a	100.0%	100.0%	n/a	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a	0.0%	n/a	0.0%	n/a	0.0%	0.0%	n/a	
Colorectal (screened excluded)	91.7%	100.0%	84.2%	93.8%	85.7%	90.9%	94.4%	86.7%	84.2%	88.2%	80.0%	91.3%	77.8%	80.0%	100.0%	60.0%	53.3%	77.3%	69.2%	68.8%	62.5%	78.6%	77.8%	
Colorectal (screened only)	100.0%	100.0%	71.4%	100.0%	50.0%	75.0%	81.8%	80.0%	33.3%	83.3%	66.7%	80.0%	40.0%	60.0%	75.0%	80.0%	50.0%	66.7%	80.0%	63.6%	85.7%	50.0%	100.0%	
Head & Neck	100.0%	66.7%	87.5%	66.7%	100.0%	75.0%	100.0%	87.5%	100.0%	50.0%	0.0%	100.0%	80.0%	75.0%	50.0%	75.0%	66.7%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	
Lung	93.3%	93.3%	100.0%	100.0%	100.0%	78.9%	100.0%	100.0%	89.5%	100.0%	94.7%	100.0%	100.0%	95.5%	100.0%	100.0%	94.7%	94.7%	72.7%	100.0%	100.0%	94.7%	100.0%	
Lymphoma	100.0%	100.0%	71.4%	100.0%	80.0%	85.7%	75.0%	100.0%	100.0%	100.0%	100.0%	60.0%	n/a	80.0%	100.0%	80.0%	83.3%	66.7%	71.4%	50.0%	80.0%	42.9%	75.0%	
Melanoma	100.0%	100.0%	83.3%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Neurological – Brain and Central Nervous System (CNS)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Ovarian	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	33.3%	100.0%	
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Upper Gastro-Intestinal (GI)	100.0%	83.3%	83.3%	92.9%	100.0%	86.7%	88.9%	81.8%	83.3%	100.0%	90.9%	100.0%	85.7%	100.0%	100.0%	100.0%	90.0%	87.5%	50.0%	75.0%	50.0%	83.3%	83.3%	
Urological	85.2%	78.6%	92.3%	73.7%	85.2%	77.8%	88.6%	82.4%	78.3%	88.9%	77.8%	80.6%	76.9%	76.9%	96.2%	78.3%	58.8%	53.8%	52.9%	40.7%	60.0%	54.2%	63.2%	

Figure 1: 62-Day Performance – Higher % is Better



Timescale for Improvement

An improvement trajectory has not been agreed with Scottish Government however additional weekly monitoring of performance is being introduced which will continue until there are two successive quarters of performance above 95%.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Introduction of daily review meeting with Urology and Colorectal trackers with management support.	January 2017	Reduce risk of preventable delays in patient pathway and earlier escalation of potential delays or capacity constraints which may cause a breach against target	Improvement in compliance	On going
Identification of 'bottle necks' in pathway to target potential improvement and redesign work	January 2017	By identifying where actual problem exists will allow management team to direct support review practice to improve service and pathway	Improved compliance and access for patients	On going
Review of brachytherapy pathway to confirm if existing pathway can be shortened	April 2017	Reduce delays for patients on the radiotherapy element of the pathway	Improved compliance and access for urology patients	On going
Development of agreed letter to GP's to communicate when Consultants advise the downgrading of "urgent suspicion of cancer referral" category	May 2017	Clinical services able to maintain more protected cancer capacity for patients whose clinical presentation indicates the need rapid access slots with appropriate communication back to GP's and patients. Action also reduces the number of patients required to be tracked and scrutinised by cancer trackers.	Still under development	On going.
Increase in access to urology first Outpatient appointment	December 2016	Increase of 6 new urology slots per week will allow quicker first assessment.	Improvement in compliance	New templates now in place: COMPLETE: ACTION NOW CLOSED

Additional private sector capacity being introduced for urology/colorectal/GI	January 2017	Reducing delays to OP and to procedures for patients	Improvement in compliance	Activity being directed to private sector COMPLETE: ACTION NOW CLOSED
Introduction of 0.5wte Cancer waiting times service role to provide increase in scrutiny, support and training for trackers	February 2017	Improved training and competence for trackers to maximise patient pathway and increase reliability in data provision.	Improvement in compliance	Commence in February COMPLETE: ACTION NOW CLOSED
Implementation of Robotic Prostatectomy	Implementation on site by July 2016. Training for NHS Lothian and NHS Fife Surgeons to be completed by Spring 2017.	Investment in regional service with national and charitable funding to improve clinical outcomes and support the sustainability of the urology prostatectomy service.	Implementing not yet complete.	Robot was delivered July 16 to date over 50 procedures have been performed. No net increase, but reduced length of stay. We continue the implementation programme for robot to increase capacity for prostatectomy surgery and address existing delay. COMPLETE: ACTION NOW CLOSED.

Comments

Reasons for Current Performance

Continuing capacity pressures within Urology remain the most significant contributing factor to the performance decline in terms of volume with 11 patients out of 24 not achieving the standard in January. Delays for surgery represent an ongoing issue with potential for deterioration with the departure of a surgeon (Kevin O'Connor) at the end of February. Plans are in place to recruit.

The problems within the urological pathway have been well documented nationally and are referenced in the new national cancer strategy which references a forthcoming national review on urology services and planned Government investment in robotic prostatectomy within NHS Lothian as one of 3 centres in Scotland. An additional urologist took up an appointment in August 2016. One further Consultant retiral in November as added to a compromised service. An interview held 16 December saw a replacement appointment made from overseas. However the candidate has subsequently withdrawn their application for personal reasons and the post will now have to be re-advertised. Locums are supporting the service however a capacity gap exists.

Colorectal performance continues to be affected by capacity pressures within the service – most specifically relating to endoscopy and colonoscopy capacity on the non screened pathway. Pressures in these areas are linked to rising numbers of OP referrals on the service which have put pressure on the overall available capacity within the pathway for these tumour groups. Ceasing of private sector capacity earlier in 2016, now restarted, has added to capacity pressures on these services which is mirrored in TTG and OP performance challenges.

Mitigating Actions

There is an increased scrutiny of weekly CWT reporting process by Colorectal/Urology Service Manager to ensure early escalation of delays and appropriate action for urology, colorectal and GI patients. Within Urology newly recruited cancer trackers continue to receive training and support. The underlying poor performance in is primarily linked to capacity gaps with the service having a Consultant vacancy. Locum support is being sought by the service.

Within Colorectal, majority of breaches of patients occur from patients not from screening programme and there is a delay for initial outpatient appointment. The number of new and review appointments for patients being tracked, to ensure timely management of result outcomes is maintained

Ongoing work with Endoscopy management team to improve access for Urgent Suspicion of Cancer scope referrals to ensure 14 day maximum wait. Particular focus on combi (upper and lower GI) patients and bowel screeners.

Additional activity around robust review of the theatre matrix (with clinical input) to ensure timely scheduling of surgery to deliver maximum 31 day wait from Decision To Treat is also in place to ensure no preventable delays for patients on the cancer pathway for the theatre element of the patient pathway.

Additional senior management scrutiny of cancer performance and structure is also being undertaken. Specialty review meetings have taken place in January with the WGH site Director and individual tumour sites for Head and Neck, Colorectal, Urology and Upper GI to clarify governance arrangements and identify pathway issues associated with the current performance. This review forms part of ongoing additional management scrutiny for cancer services. Additional review meetings are being scheduled for other tumour sites on a rolling basis.

Diagnostics – Gastroenterology/ Urology Diagnostics

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:

A **six week maximum** waiting time for eight key diagnostic tests (four for Gastroenterology/ Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs - please see separate proformas for Radiology and for Vascular Labs data)), from 31st March 2009.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated Since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Dec 16 (Mthly)	0 (max)	<p style="text-align: center;">2,231</p> <p>N.b. This figure is represented in Table 2. (It is made up of the Totals in Table 1, for the relevant reporting date only, on each of the three Diagnostics proformas, summed– as together these cover the eight Standard tests.)</p>	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

- Analysis of demand and capacity has identified a gap in capacity for patients referred for endoscopy procedures;
- Patients referred via the Bowel Cancer Screening Programme or as Urgent Suspicion of Cancer are being prioritised. This cohort of patients are generally receiving an appointment within 14 days from referral but this is impacting on the ability to see routine patients within 6 weeks;
- Service continuing to balance new and repeat capacity across all Endoscopy procedures to provide patient equity.

Key Diagnostic Tests - Gastroenterology/ Urology Diagnostics

The four diagnostic tests in Gastroenterology/Urology Diagnostics are Colonoscopy, Upper Endoscopy, Flexible Sigmoidoscopy (Lower Endoscopy - excluding Colonoscopy) and Flexible Cystoscopy.

Recent Performance: Numbers against Standard

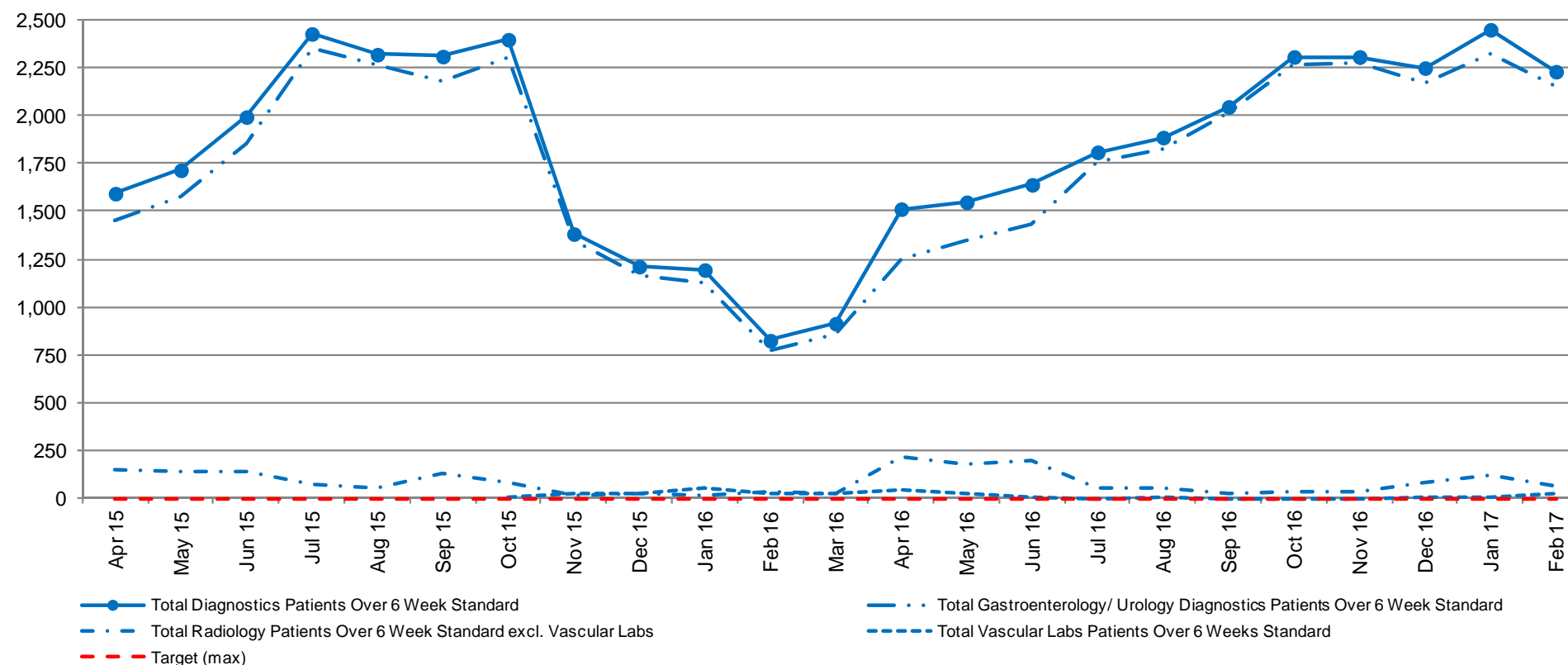
Table 1: Gastroenterology/ Urology Diagnostic Tests ONLY - Numbers over 6 Week Standard – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Upper Endoscopy	654	761	841	978	846	778	850	592	497	504	389	433	552	567	620	730	710	792	922	873	786	807	758
Colonoscopy	285	303	421	654	674	680	639	406	457	418	210	229	448	507	568	682	716	742	767	780	746	728	660
Flexible Sigmoidoscopy (Lower Endoscopy)	262	284	294	310	278	235	246	171	162	173	142	162	209	198	192	244	347	391	395	375	308	345	299
Flexible Cystoscopy	247	224	296	410	470	487	571	179	46	28	27	37	43	73	56	99	55	95	186	247	326	442	429
Total Gastroenterology/ Urology Diagnostics Patients Over 6 Week Standard	1,448	1,572	1,852	2,352	2,268	2,180	2,306	1,348	1,162	1,123	768	861	1,252	1,345	1,436	1,755	1,828	2,020	2,270	2,275	2,166	2,322	2,146

Table 2: All 8 Diagnostic Tests - Numbers (Total) Over 6 Week Standard – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total Diagnostics Patients Over 6 Week Standard	1,594	1,716	1,994	2,428	2,320	2,310	2,398	1,383	1,213	1,195	826	915	1,513	1,549	1,640	1,810	1,887	2,047	2,308	2,308	2,250	2,450	2,231

Figure 1: All 8 Diagnostic Tests - Numbers over 6 Week Standard – Lower Count is Better



Timescale for Improvement

DCAQ work has been refreshed to support the development of a trajectory from April 2017 to end of March 2018.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Continue to support evening lists via NHS	January onwards	Dependent on staff availability however aim is for 28 appointments per month (one evening per week)	28 additional slots per month	Continue to offer evening sessions across all sites in 2017/18.
Maximise use of Regional Endoscopy unit (REU) at QMH for routine repeat patients. PFB introduced for this unit.	Commenced May 2016	Increase use of REU ensuring identifiable capacity for planned repeats Patient focus booking is good for patients and reduces short notice CNAs and DNAs	Example of one weeks activity at REU under the new system Booked Capacity 90.1% DNA Rate (Points) 2.7% DNA Rate (patients) 3.6% Actual Utilisation 87.7% which is a much improved position	PFB implemented and being measured and monitored on a weekly basis.

Introduce nurse validation and telephone screening model for repeat endoscopies.	1 st June 2016	45% reduction in total numbers validated then telephone screened was achieved within NHS Lanarkshire, same model we are implementing. This was largely driven by patient choice. These patients may historically have been DNAs and therefore ensures capacity is maximised.	Safe managed reduction in planned repeat list by clinical validation and telephone pre-assessment screening. Patients most in need of early scope identified, reduction in DNA more efficient use of capacity. Since start of new process there has been a 37% reduction of patients contacted and a further 8.5% have had follow-up dates deferred based on current clinical guidelines.	Weekly monitoring ongoing. Recent reporting shows a 42% removal rate.
Faecal Calprotectin tests in Primary Care to reduce demand on the GI and Endoscopy service.	July 2016	Significant reduction in referral to Gastroenterology Outpatients and ultimately reduction in Endoscopy procedures (20-30% conversion rate)	To be seen in demand analysis	Roll-out commencing 27 th February 2017. Impact to be measured by reduction in incoming referrals.
Implement Nurse-Led Faecal Calprotectin clinics for backlog of Gastroenterology patients	January 2017	Significant reduction in current waiting list for Gastroenterology Outpatients - when negative test results received patient can be managed in primary care. Ultimately a reduction in Endoscopy procedures.	To be seen as project commences	Clinical triage complete and clinics commenced 22 nd February 2017. Patients will be removed from waiting list where FCP result is negative-impact expected in March/April 2017.
Band 2 contacting pts in the evening to confirm attendance at procedure	May 2016 onwards	Reduction in DNAs More efficient use of capacity	Already significant improvement seen in Roodlands historically very high DNAs now weekly report of 95- 100% attendance. Problem remains where small numbers of patients confirm attendance on phone week prior to scope and then still fail to attend GP letter being agreed to inform GPs.	Ongoing as DNA reduction has been noted.
Review of Nurse Endoscopist workloads and recruitment of further Nurse Endoscopist	Dec 2016	Work ongoing to maximise capacity of existing Nurse Endoscopists.	Aim to increase fixed lists for Nurse Endoscopists while retaining flexibility for backfill	Ongoing work by Service Team to ensure Nurse Endoscopists are fully utilised.
Introduction of Patient Focused Booking for all Endoscopy procedures	May 2017	Patient Focus Booking has been shown to reduce short notice CNAs and DNAs	Reduction in DNA rate which can currently vary from site to site (average 10%)	Currently being planned by Booking and Service Team and due to commence in May 2017.
External capacity secured for 900 Endoscopy procedures	Nov 2016 – March 2017	Reduction in number of routine patients waiting over 12 weeks for an Endoscopy procedure	Anticipated reduction by 900 patients	Streaming complete with patients being seen up to end of March 2017.
Housekeeping of longest waiters that have been identified as suitable for external provider is being carried out by EPO before patient details are sent to external providers in order to fill available capacity. Prior to putting this action in place 25% of patients transferred to Spire Healthcare were returned.	February 2017	Cleanse the waiting list of all patients who no longer require appointment or have multiple entries.		This action has just commenced and will be monitored weekly.
Weekly meeting with waiting list office to maximise capacity and highlight booking issues earlier	May 2016	Increase utilisation/reduced DNAs improved communication closer working between service and booking team	Early escalation of issues, close working with booking team. Changes as a result of meeting – introduction of telephoning reminder relay evening service, reduction in last minute booking creation of consultant list to manage urgents, training and familiarisation by senior endoscopy nurses to the booking team resulting in greater knowledge of service and fewer errors	Weekly meetings now routinely taking place. ACTION NOW CLOSED
Introduce a pt letter that advises direct access pts that they have been added to waiting list for procedure	On Hold	Reduce DNA rate improved patient experience with better communication	-	This action no longer required due to the implementation of Patient Focused Booking for all sites. ACTION NOW CLOSED

Comments - Gastroenterology/Urology Diagnostics

The withdrawal from private sector since 1st April 2016 to October 2016 resulted in a deteriorating position for Endoscopy where demand outstrips core provision. Additional pressure on capacity from high volume of Urgent Suspicion of Cancer patients taking priority.
Additional capacity identified for 900 Endoscopy procedures between November 2016 – March 2017 which has resulted in a substantial reduction of patients waiting over 12 weeks.

Reasons for Current Performance

Demand continues to outstrip capacity and referral rates continue to rise. Reduced volunteers (both nursing and operators) for Waiting list initiatives on both evenings and weekends.

Mitigating Actions

Continue to maximise utilisation of internal core resource. Review of referrals continues to ensure patients on waiting lists remain clinically appropriate. Additional work is ongoing to review overall endoscopy room utilisation to maximise utilisation of core funded capacity. To compensate for the DNA rate, a number of lists are being overbooked to support full use of the available capacity. Telephone initiatives, use of nurse validation and introduction of Patient Focus Booking with return patients being streamed to REU. Ongoing work by Service Team to continuously monitor Nurse Endoscopist job plans to increase fixed sessions and look at flexibility.

Diagnostics - Radiology

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:
A **six week maximum** waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs from 31st March 2009. Please see separate proformas for Gastroenterology/Urology Diagnostics and for Vascular Labs data).

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Dec 16 (Mthly)	0 (max)	<p style="text-align: center;">2,231</p> <p>N.b. This figure is represented in Table 2. (It is made up of the Totals in Table 1, for the relevant reporting date only, on each of the three Diagnostics proformas, summed– as together these cover the eight Standard tests.)</p>	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

We are continuing to take actions to reduce waiting times for key radiology tests.

Key Diagnostic Tests - Radiology

The four diagnostic tests in Radiology are Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Barium Studies and Ultrasound.

Recent Performance: Numbers against Standard

Table 1: Radiology Tests ONLY - Numbers over 6 Week Standard² – Lower Count is Better

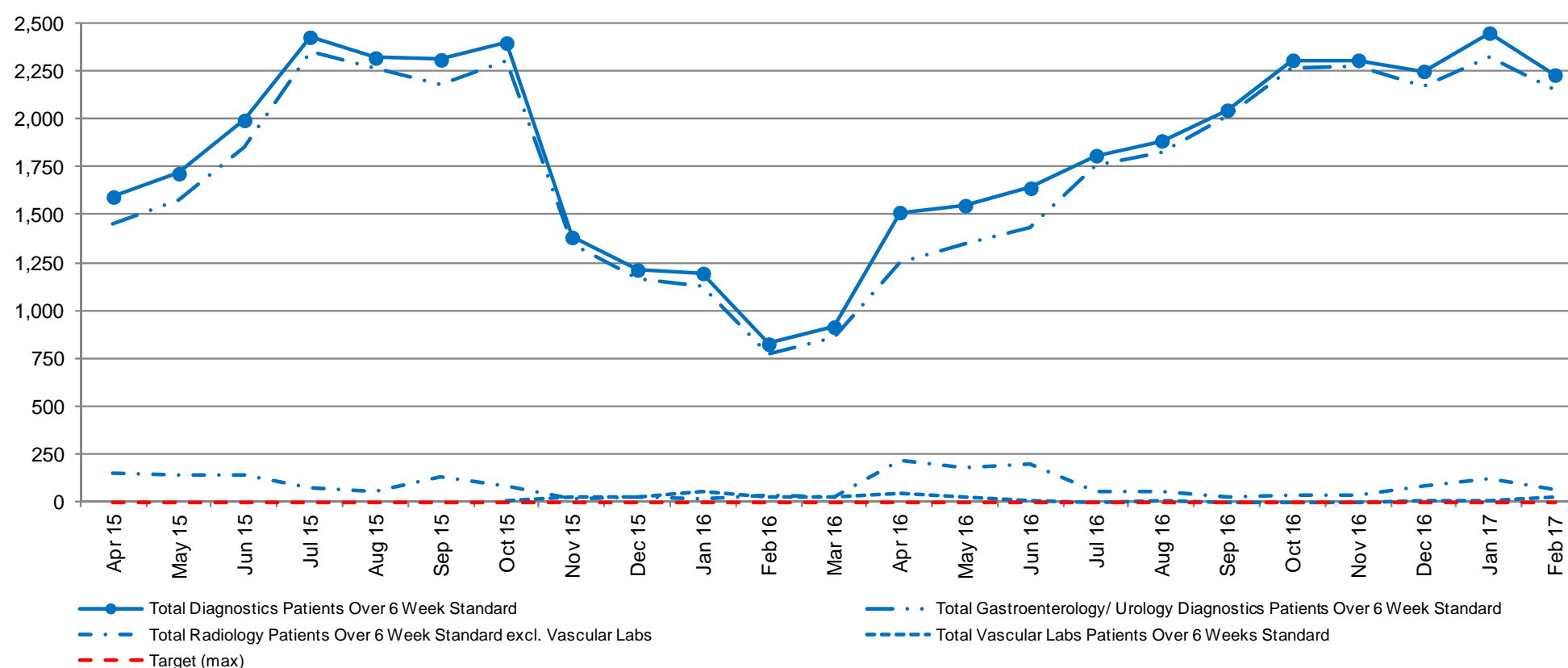
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
MRI	108	123	106	60	38	111	77	6	11	12	17	16	204	172	176	45	43	22	28	20	68	90	26
CT	15	8	6	12	9	9	3	2	6	2	5	6	7	3	19	5	7	4	8	4	3	10	7
General Ultrasound excl. Vascular Labs	23	13	30	4	5	10	1	5	5	3	9	3	3	3	3	5	5	1	2	9	9	17	30
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Radiology Patients Over 6 Week Standard excl. Vascular Labs	146	144	142	76	52	130	81	13	22	17	31	25	214	178	198	55	55	27	38	33	80	117	63

Table 2: All 8 Diagnostic Tests - Numbers (Total) Over 6 Week Standard – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total Diagnostics Patients Over 6 Week Standard	1,594	1,716	1,994	2,428	2,320	2,310	2,398	1,383	1,213	1,195	826	915	1,513	1,549	1,640	1,810	1,887	2,047	2,308	2,308	2,250	2,450	2,231

² From Oct 15 inclusive onwards, Vascular Labs figures are not included in 'General Ultrasound' but are reported on the separate Vascular Labs proforma;

Figure 1: All 8 Diagnostics Tests - Numbers over 6 Week Standard – Lower Count is Better



Timescale for Improvement against Target/Standard - Radiology

1st December to 31st March 2017

Actions Planned and Outcome - Radiology

Action	Due By	Planned Benefit	Actual Benefit	Status
External provision of CT and MRI –10 CT and 19 MRI mobile van days	End of March 2017	700 patient examinations per month	Sustain TTG	Implemented
Patients requiring MRI L. Spine invited to attend GJNH	End of March 2017	40-50 patient examinations per month	Sustain TTG	Implemented
Patients appointed to The Edinburgh Clinic for CT Colon	End of March 2017	25 patient examinations per month	Sustain TTG	Implemented
Reduce reporting beyond 6 weeks (weekly report to consultants to highlight long waits and overall position)	End of March 2017	Improved scan to report times	Sustain TTG	Implemented

Comments - Radiology

For Current Performance

41 patient Radiology examinations tripping the 6 weeks referral to unverified report at end **Feb 17**.
 26 are MRI. Extra internal MRI sessions arranged in March to reduce and timely reporting.
 7 CT and 8 US case complexity/delay in reporting.

Diagnostics – Vascular Laboratory

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:
 A **six week maximum** waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology (one of which covers data for the Vascular Laboratory. Please see separate proformas for Gastroenterology/Urology Diagnostics and for Radiology data)), from 31st March 2009.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Report?	Narrative Updated since Last Report?	Lead Director
To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Dec 16 (Mthly)	0 (max)	<p style="text-align: center;">2,231</p> N.b. This figure is represented in Table 2 . (It is made up of the Totals in Table 1, for the relevant reporting date only, on each of the three Diagnostics proformas, summed– as together these cover the eight Standard tests.)	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

- A national shortage of Healthcare Scientists (HCS) in Vascular Science resulted in a Band 7 vacancy being unfilled since Oct 2014, resulting in a reduction in service capacity.
- The service increased productivity in May 2016 and brought in vascular scientist staff from out with NHS Lothian to support a reduction in waiting times.
- The service is supporting two Band 6 trainee clinical vascular scientists (3 year training programme – commenced Oct 2015) to develop the HCS workforce and to support the service in the longer term.
- The performance of one of the Band 6 trainees is under review and the trainee has required additional support and training since Oct 2016, which is also contributing towards the reduction in service capacity.
- One senior member of the team handed in their notice in Nov 2016 which has also had an impact on the service - the Band 7 post has been vacant since Dec 2016. Interviews were held in January 2017 and two qualified and very experienced Band 7 staff have been appointed – 0.2WTE started on 6th March and 1.0 WTE will start on 17th April 2017. There will be an increase in service capacity from May 2017.

Key Diagnostic Tests - Vascular Labs

The diagnostic test for **Vascular Labs** was previously included in General Ultrasound (until September 2015 inclusive).

Recent Performance: Numbers against Standard

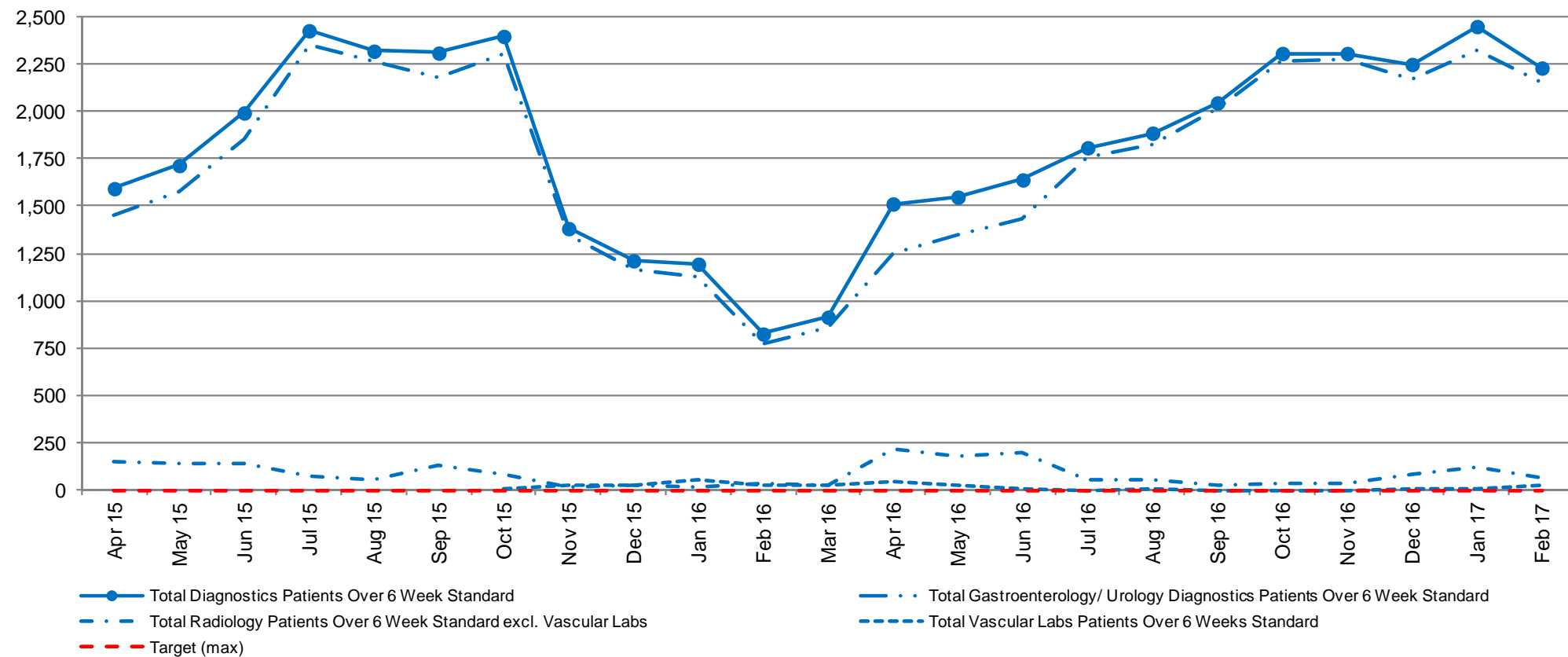
Table 1: Vascular Lab Test ONLY - Numbers over 6 Week Standard – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total Vascular Labs Patients Over 6 Weeks Standard							11	22	29	55	27	29	47	26	6	0	4	0	0	0	4	11	22

Table 2: All 8 Diagnostic Tests - Numbers (Total) Over 6 Week Standard – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total Diagnostics Patients Over 6 Week Standard	1,594	1,716	1,994	2,428	2,320	2,310	2,398	1,383	1,213	1,195	826	915	1,513	1,549	1,640	1,810	1,887	2,047	2,308	2,308	2,250	2,450	2,231

Figure 1: All 8 Diagnostics Tests - Numbers over 6 Week Standard – Lower Count is Better



Timescale for Improvement against Target/Standard - Vascular Laboratory

This continues in light of the capacity shortfall as a result of the national shortage of HCS.

Actions Planned and Outcome - Vascular Laboratory

Action	Due By	Planned Benefit	Actual Benefit	Status
Service replacing 1.2 band posts	End of May 2017	Reduction in patients waiting over 6 weeks after appointment	To be evaluated once change has come into effect	1.2WTE applicants appointed. 0.2WTE post commenced 6 th March. 1.0WTE appointment will commence 17 th April.
Increase productivity by increasing patient facing direct clinical care workload and offering overtime to staff	End of May 2017	Increase capacity in vascular laboratory	As planned	Overtime is routinely offered to qualified staff and will continue until new posts are in place. Will be reviewed after staff in place.
Review of Nurse-Led Vascular Access Service	End of February 2017	Increase capacity in Nurse-Led Vascular Access New Patient Clinics	As planned	Further discussions required with Manager of Nurse-Led Vascular Access Service. Meeting to be arranged.

Comments - Vascular Labs

Reasons for Current Performance

A national shortage of Healthcare Scientists (HCS) resulted in a Band 7 vacancy (Oct 2014) being unfilled. Post converted to a trainee clinical vascular scientist Band 6 post (filled Oct 2015). An additional NES funded supernumerary trainee clinical vascular scientist post also filled Oct 2015 to help support future workforce. In addition, Band 7 vacancy since Dec 2016 but successful appointment - start 17th April 2017. Limited number of qualified accredited clinical vascular scientists, training commitments and unexpected trainee in difficulty, requiring additional support in the Vascular Laboratory have resulted in a reduction in capacity, putting additional pressure on qualified staff and Service.

The position within the Vascular Lab will improve due to new appointment of qualified 1.2WTE staff.

There is an issue with the way in which some of the data are reported and this is being followed up with Andy Jackson's team.

Nurse-Led Vascular Access Clinics now appear as part of the Vascular Lab data (US performed during clinic) due to a recent change in how referrals are generated for these clinics.

Drug & Alcohol Waiting Times

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:

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 **90%** of clients will **wait no longer than 3 weeks** from referral received to appropriate drug or alcohol treatment that supports their recovery (90%).

Responsible Director[s]: Nurse Director

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Mar 17	Not Met	Improving	Worse	Jul – Sep 16	90% (min)	85.4%	Jul – Sep 16	ISD	No	Yes	AMcM

Summary for Committee to note or agree

All services in the area (NHS, Council & 3rd Sector)

- The Lothian wide figure is still below target by just over 6% but remains at a consistent level over the last 2 quarters.
- On a geographical basis services in Midlothian, East Lothian and West Lothian partnerships continue to exceed the target;
- Edinburgh's performance is similar to the last quarter but still below target.

NHS Lothian Substance Misuse Services Only

- Lothian NHS SMS as a whole continue on a rising trend
- NHSL SMS Services in East and Midlothian continue to meet / exceed the target;
- Performance in West Lothian has reduced in month which will show in next Quarters figures
- Plans are being implemented in Edinburgh and West Lothian to enhance productivity and capacity within the teams; The productivity plans are under pressure due to numbers of staff moving to permanent contracts in other parts of the system.

Recent Performance – Numbers Against LDP Target

Table 1: % Seen within 3 Weeks – Higher % is Better

	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16
NHS Lothian	83.5%	82.9%	79.9%	84.0%	84.1%	85.4%
Edinburgh City Alcohol & Drug Partnership (ADP)	80.7%	81.1%	75.6%	77.4%	77.7%	81.7%
Midlothian and East Lothian ADP (MELDAP)	91.9%	94.8%	94.0%	96.3%	97.2%	97.4%
East Lothian	91.5%	95.0%	90.5%	97.2%	95.6%	96.9%
Midlothian	92.4%	94.5%	98.0%	95.4%	98.5%	97.9%
West Lothian ADP	85.8%	80.0%	82.4%	93.2%	91.2%	87.3%

Timescale for Improvement

Discussions ongoing with the three ADPs and four IJBs about what the likely available funds for next year will look like.

The review of residential services is ongoing and the impact on services will be addressed as part of this review

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Substance Misuse Collaborative	End March 2017	Clarity on 17/18 funding and impact on service delivery both in community and NHS commissioning of services	Impact assessment of patient care/meeting drug treatment target	RED

The Lothian Substance Misuse Collaborative, the three ADPs and the four IJBs are working to take proposals forward to each organisation's Board to highlight what is required to meet the access target in each area and ensure sustainable services. ADPs are drawing together risk assessments on the impact on service delivery.

In addition NHS Lothian, the ADPs and the Health and Social Care Partnerships have agreed to progress the recommendations from a piece of commissioned work completed by McMillan Rome. The report and proposed next steps have been circulated to service leads. The Lothian Wide Substance Misuse Collaborative Group has set up several task groups to progress the detail of each recommendation.

Proposals and the impacts of these proposals are now going through governance processes during March and April. These proposals have been discussed at the NHS Lothian Strategic Planning Committee and the Healthcare Governance Committee as well as the CMT.

Comments**Reasons for Current Performance**

Substance Misuse Directorate (SMD) performance in the City of Edinburgh has been below 90% for some months and pulls the average for all services in NHS Lothian down (across health, social care and the voluntary sector). There have been pressures in other areas, but these have been short term and resolved.

Reasons for the pressures in the city are:-

1. Short term contracts for EADP funded posts, which constitute the majority of staff – these results in high levels of staff turnover, whose caseloads need to be absorbed by remaining staff, who are then unable to take on new cases from the waiting list. There are currently a number of vacant posts and agreement to recruit is required from EADP. The current funding stream for temporary posts.
2. Contracting budgets. whilst ADP reserves have been cushioning this reduction till now there is an ongoing shortfall until the end of the financial year
3. Bottlenecks in the patient pathway, reducing capacity for discharge to primary care, which reduces the SMD capacity to take on new cases. Several GP practices in the city are receiving direct support from HSCPs as they have excess activity for the resources available to them.
4. A fuller paper on actions to be taken will also be discussed at the NHS Lothian Board on the 5th April.

Inpatient & Day Case (IPDC) Treatment Time Guarantee (TTG)

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard: 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.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Feb 17	Not Met	Deteriorating	Better	Dec 16 (Quarterly)	0 (max)	1,497	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

Use of independent sector ceased from April 1 2016; internal capacity is unable to fully cover this previous activity which will impact on performance. Details of DCAQ work including efficiency improvements that we are undertaking are described below.

Recent Performance – Numbers beyond Standard

Figure 1: Treatment Time Guarantee Patients waiting beyond standard at month end – Lower Count is Better

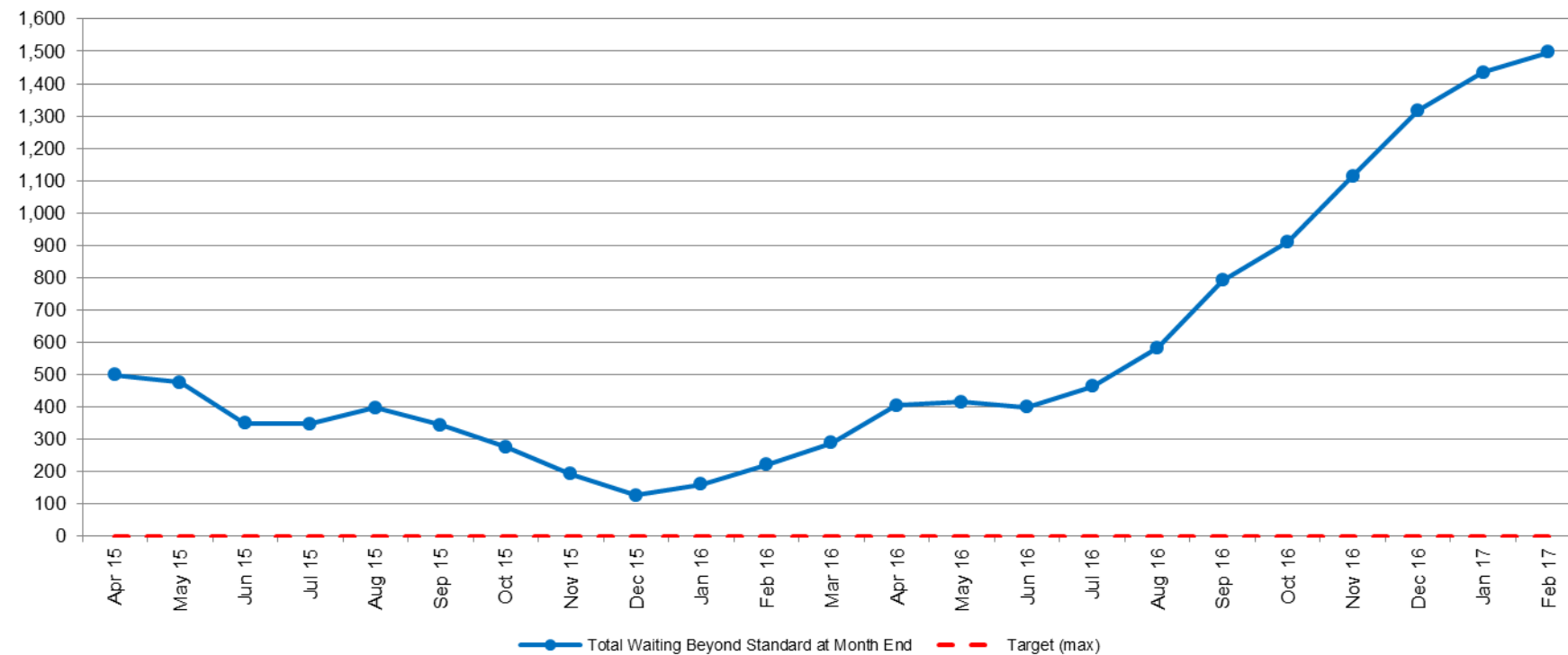


Table 1: Treatment Time Guarantee Patients waiting beyond standard at month end – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Urology	137	123	92	104	133	143	116	76	33	23	37	59	122	136	182	221	296	386	398	458	490	509	557
Orthopaedic Surgery	88	86	60	55	62	40	32	24	25	28	42	52	73	52	32	47	77	105	119	226	326	392	368
General Surgery	48	39	18	29	21	15	18	9	12	25	30	51	51	71	59	67	45	117	155	128	134	132	149
Vascular Surgery	1	0	1	2	1	0	1	2	1	13	16	21	18	5	3	4	14	10	38	87	138	138	128
Ear Nose and Throat	39	38	33	13	28	19	13	15	4	16	18	31	37	37	18	13	17	28	43	40	57	53	53
Neurosurgery	6	12	14	8	6	5	0	6	14	24	39	35	45	53	54	46	42	43	35	36	29	42	46
Gynaecology	1	4	1	1	1	1	0	0	0	2	5	2	1	1	3	4	2	2	3	11	15	39	39
Others	180	174	130	135	146	122	97	61	38	30	34	38	57	61	48	61	90	100	119	128	129	129	157
Total	500	476	349	347	398	345	277	193	127	161	221	289	404	416	399	463	583	791	910	1,114	1,318	1,434	1,497

Table 2: Treatment Time Guarantee Patients seen beyond 12 weeks

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
TTG Seen	476	463	389	314	314	368	293	276	207	163	219	297	297	404	398	318	402	373	454	500	444	559	668

Figures on Inpatient list size and unavailability are shown in the following table (Table 3). The use of unavailability and choice codes in Lothian remains low.

Table 3: List Size and Unavailability

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total List Size (TTG)	8,941	8,692	8,642	8,421	8,599	8,826	8,820	8,944	9,140	9,216	9,809	8,814	8,625	8,628	8,856	9,031	8,948	9,271	9,202	9,351	9,630	9,669	9,813
Available	7,911	7,644	7,453	7,264	7,543	7,907	8,070	7,952	8,081	8,518	8,332	7,949	7,727	7,623	7,668	7,902	7,954	8,374	8,441	8,442	8,589	8,957	9,053
Unavailable	1,030	1,048	1,189	1,157	1,056	919	750	992	1,059	698	757	865	898	1,005	1,188	1,129	994	897	761	909	1,041	712	760
Percentage Unavailable	11.5%	12.1%	13.8%	13.7%	12.3%	10.4%	8.5%	11.1%	11.6%	7.6%	7.7%	9.8%	10.4%	11.6%	13.4%	12.5%	11.1%	9.7%	8.3%	9.7%	10.8%	7.4%	7.7%
Non-TTG	1,180	1,244	1,246	1,187	1,048	1,023	1,013	1,012	1,069	1,110	1,090	1,063	976	1,073	1,091	1,064	1,096	1,147	1,167	1,220	1,174	1,261	1,234

Timescale for Improvement

Following recent DCAQ work a trajectory is being developed for TTG until end of March 2018.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
<p>Detailed review of Acute Services' available capacity and demand undertaken to inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue exercise has examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties.</p> <p>Work has now moved from data collection and analysis to performance improvement monitoring.</p> <p>Actual activity against core capacity now implemented.</p>	<p>Initial output completed end Jan 2016.</p> <p>Quarterly meetings established with each service. First series of meetings held April 2016, second series of meetings held end July 2016. Next series of meetings scheduled November 2016.</p> <p>A further series of meetings scheduled for February 2017</p>	<p>Improved performance against agreed efficiency targets, example improved Day Case rate.</p> <p>This is to ensure that this remains a key area of focus for Service Management Teams</p>	<p>Once implemented fully this will enable teams to identify improvement opportunities where capacity can be maximised.</p>	<p>Quarterly meetings established with services to monitor performance.</p> <p>Latest set of meetings took place in Feb 17 with next round planned for early June.</p> <p>Benchmarking group has now had its first meeting and a mapping exercise of tools currently in use and indicators monitored to take place</p> <p>Further plans to review theatre list uptake and introduction of a process for reallocating poorly utilised lists, First meeting to discuss plans with surgical teams and get engagement on 20th March with General surgery.</p>

Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams to improve theatre efficiency.	Full implementation by December 2016	Overall improved theatre efficiency Reducing cancellations Redesigning pre-op assessment	The programme is on track to be implemented fully by December 2016 No delivered benefits can be claimed at this point as the work-streams are now being established.	Benefits realisation paper with detailed KPIs for the programme to approved at TIP Board (20/01) and paper to discussed at February F&R with moderate assurance achieved in terms of the approach we are taking. Details timelines and efficiency opportunities are highlighted in the paper with initial gains as soon as July 2017. Focus this month on reduction of cancellation rates within Orthopaedics as part of the HSDU work stream which commenced at RIE.
Theatre matrix meetings established on all sites. Facilitates optimum use of sessions through 'pick up' of cancelled lists due to leave and optimise use of hours within sessions. Service review of all booked theatre lists one week in advance to ensure optimum booking and theatre efficiency.	Fully implemented by October 2016	Maximise theatre utilisation Delivery of a sustainable workforce	Increased theatre utilisation / increase in hours used / reduction in DNAs & CNAs	Established Weekly Theatre Matrix meeting routine practice in all specialties. Weekly waiting times meeting with E Health Waiting list office – established Programme of work signed off at the Programme Board, Good progress of individual workstreams.
Establish extent to which specialties plan routine elective patients requiring to be preoperatively assessed are appointed no later than week 4 of their journey – ensure consistent approach is taken.	Next two Specialities for implementation by End April 2017	Confidence that all patients on the waiting list are fit for surgery. Ensuring larger pool of patients prepped and ready to fill vacant theatre slots at short notice.	All patients on the IPWL are fit and ready, for surgery. Provides a pool of patients that we can contact for backfill / short notice cancellation. Detect early signs of pre / post of care.	Implemented in H&N by agreed deadline. A roll out programme of specialties is being established throughout 2017. Colorectal and Urology have now started this process with support from the TIP project team.
Development of trajectories and detailed actions maximising internal capacity; New trajectories build up from, DCAQ work. Process endorsed by SG early May. Trajectories now developed until End March 2017.	End July 2016.	Optimise internal capacity and maintain focus on delivery of TTG	Once implemented fully this will enable teams to identify improvement opportunities where capacity can be maximised.	Trajectories for 2017/8 are currently being finalised and will be included in our LDP.

Comments

Reasons for Current Performance

Demand for services is greater than core capacity

Cessation of independent sector 1st April 2016. Agreement to use Independent Sector for the specialties under pressure and with the longest waiting time and to improve the position up to end of March 2017 from November 2016

As services have been clearing backlog of patients, if patients are cancelled either by patient or by hospital, they remain on waiting list as already >than 12 weeks, as unavailability cannot be applied.

Performance target is for 12 weeks, therefore if late cancellation due to hospital reason i.e. bed pressures, urgent cases etc there is limited ability to re book within 12 week TTG date.

Lack of willingness to undertake waiting list initiatives in some specialties or within theatre teams.

Sickness absence/ vacancies in some specialties reducing ability to use all scheduled sessions.

The specialties driving the deterioration are Urology (reduced access to weekend capacity, consultant vacancy due to retiral and difficulties covering all IP lists at SJH and Roodland) and Orthopaedics (Increase in demand being explored, high volume of elective cancellations due to bed pressures, and some cancellations due to theatre instrumentation issues)

Outpatients

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard: From 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. (The target is 95% with a stretch target of 100%).

Responsible Director[s]: Executive Director: Chief Officer

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Feb 17	Not Met	Improving	Worse	Dec 16 (At month end)	95% (min)	68.4% (17,967)	Feb 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

Use of independent sector ceased from April 1 2016; internal capacity was unable to fully cover this previous activity which has had an impact on performance. Details of DCAQ work including efficiency improvements that we are undertaking are described below. Use of independent Sector recommenced in November 2016 and is in place until March 2017.

Recent Performance – Numbers beyond Standard

Table 1a: Trend in Outpatients over 12 weeks – Total - % – Higher % is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
% of patients waiting for a new outpatient appointment waiting 12 weeks or less (Table 1b Total/Table 2 Total List Size)	92.6%	91.2%	91.7%	88.5%	86.7%	85.4%	85.3%	86.1%	85.1%	83.4%	83.5%	85.5%	84.0%	82.2%	81.5%	79.6%	75.8%	72.8%	70.6%	69.2%	67.6%	67.2%	68.4%

Figure 1: Trend in Outpatients over 12 weeks – Total - % (Table 1a) – Higher % is Better

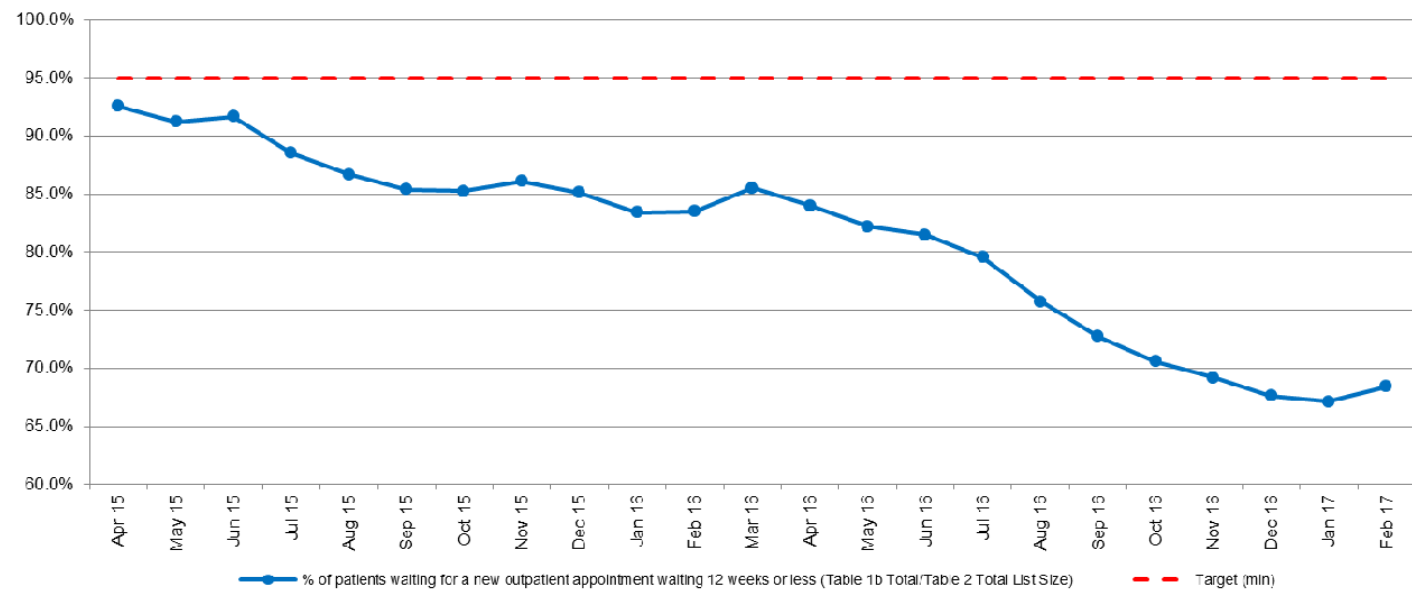


Figure 2: Trend in Outpatients over 12 weeks – Total - Numbers (Table 1b) – Lower Count is Better

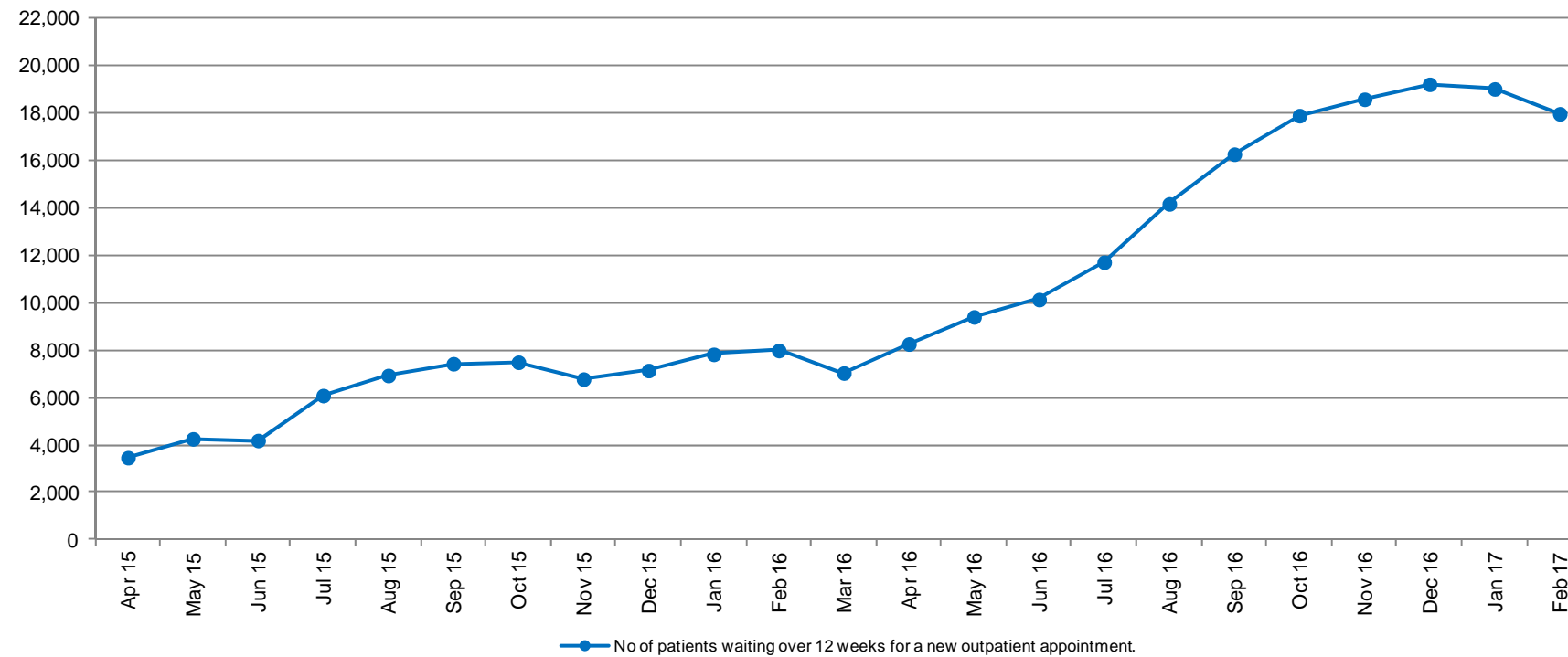


Table 1b: Trend in Outpatients over 12 weeks – Key Specialties – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
GASTROENTEROLOGY	477	671	902	1,208	1,334	1,360	1,375	1,292	1,439	1,445	1,547	1,617	1,845	2,087	2,327	2,596	3,112	3,686	3,999	4,360	4,296	4,159	3,875
TRAUMA AND ORTHOPAEDIC SURGERY	515	665	558	912	1,291	1,623	1,847	1,982	2,165	2,366	2,166	1,916	2,201	2,255	2,321	2,660	2,927	2,977	3,078	3,176	3,213	3,172	3,071
GENERAL SURGERY (EXCL VASCULAR)	454	583	632	854	1,036	1,141	1,197	1,110	1,120	1,387	1,535	1,375	1,684	2,064	2,042	2,116	2,196	2,438	2,671	2,773	2,757	2,830	2,891
DERMATOLOGY	13	19	14	19	49	68	44	29	41	217	222	157	80	44	32	213	1,130	1,839	2,425	2,443	2,439	2,249	1,854
EAR, NOSE & THROAT (ENT)	431	504	541	872	1,093	1,040	681	478	373	394	390	345	492	596	827	921	1,072	1,155	1,239	1,490	1,869	2,113	1,831
VASCULAR SURGERY	21	23	21	28	93	182	281	293	308	341	326	296	333	339	362	447	578	667	795	964	1,103	1,194	1,254
OPHTHALMOLOGY	336	378	326	475	395	412	335	212	157	192	188	121	189	224	216	342	350	356	346	354	534	752	782
UROLOGY	398	438	321	606	648	542	525	390	377	407	404	353	386	391	351	326	471	669	744	551	462	604	657
GYNAECOLOGY	256	266	216	283	379	446	583	481	524	322	308	178	180	254	193	200	350	512	565	461	559	398	262
NEUROLOGY	124	125	72	100	107	82	59	49	51	56	62	48	79	184	240	294	263	304	290	303	293	228	219
OTHERS	442	589	589	730	508	532	564	463	587	698	838	630	791	966	1,224	1,596	1,719	1,662	1,738	1,705	1,686	1,317	1,271
TOTAL	3,467	4,261	4,192	6,087	6,933	7,428	7,491	6,779	7,142	7,825	7,986	7,036	8,260	9,404	10,135	11,711	14,168	16,265	17,890	18,580	19,211	19,016	17,967

Table 2: Outpatients List Size and Unavailability

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total List Size	46,547	48,672	50,243	53,046	52,040	50,788	50,850	48,845	47,999	47,199	48,434	48,681	51,574	52,886	54,777	57,280	58,481	59,696	60,854	60,339	59,377	57,907	56,911
Available	45,843	47,951	49,004	51,930	50,867	49,746	50,011	47,890	46,516	46,319	47,485	47,874	50,912	51,652	53,490	56,083	57,414	58,721	59,783	59,268	58,154	56,692	55,608
Unavailable	704	721	1,239	1,116	1,173	1,042	839	955	1,483	880	949	807	662	1,234	1,287	1,197	1,067	975	1,071	1,071	1,223	1,215	1,303
Percentage Unavailable	1.5%	1.5%	2.5%	2.1%	2.3%	2.1%	1.6%	2.0%	3.1%	1.9%	2.0%	1.7%	1.3%	2.3%	2.3%	2.1%	1.8%	1.6%	1.8%	1.8%	2.1%	2.1%	2.3%

Timescale for Improvement

Following recent DCAQ work an out-patient trajectory has been developed until end March 2017.

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
<p>Review of Acute Services' available capacity and demand undertaken to inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue (DCAQ) exercise examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties. Move from data collection and analysis to performance monitoring and improvement trajectories.</p> <p>Cessation of independent sector capacity from April 2016, factored into DCAQ work</p> <p>Independent sector engagement for additional 'See and treat' capacity recommenced in November 2016.</p>	<p>Initial output end Jan 2016.</p> <p>Programme of further work around performance monitoring –quarterly review process in place First series of review meetings undertaken April 16. Further meetings held in September 16 and January 17. Meetings being scheduled now for June 17.</p>	<p>Improved performance against agreed efficiency targets, example reduced DNA rate.</p>	<p>Once implemented fully this will enable teams to identify improvement opportunities where capacity can be maximised.</p>	<p>Further work on activity and capacity is being taken forward under the mantle of DfP (Delivering for Patients) with quarterly reviews being scheduled for June 17.</p>
<p>In line with the National Towards Our Vision for 2020 Delivering Outpatient Integration Together Programme. Aim of the programme is manage flow through consistently and sustainably delivering a suite of changes.</p> <p>Progress following work streams;</p> <ul style="list-style-type: none"> Advice Only – Allows clinician to provide advice as an alternative to an outpatient appointment where appropriate and safe to do so. Accommodation Matrix – 'At a glance' view of physical clinic space which is used by Outpatient Service Manager and Clinical Service Managers to identify available staffed clinic space and facilitate clinic reconfiguration without additional resource, thus increasing capacity for both new and review patients. Return Patient List – Demand for return patients will be captured. Allowing return patients to be seen at clinically appropriate times. Capacity can be planned in advance; rescheduled return appointment through cancellation will decrease, protecting new patient slots. Template Harmonisation – process of reviewing clinic templates to ensure they reflect current practice and demand Review of the Refhelp service for GPs focusing on key specialties under significant pressure. GP and Specialist engagement in the review. Detail on waits per specialty to be made available to GPs so they are aware of length of wait prior to referring. Engagement with 'Leonardo' to progress 100 day project on primary and secondary care collaboration on future role of outpatients. 'The Modern Outpatient, a collaborative Approach' has been launched by SG and its implementation is being progressed through Outpatient Strategic Board. Clinical Board established to progress development of plan for 'Consultant to Consultant' referrals, establishing clear expectations for referral of patient to outpatients and review and progression of Refhelp. Develop business case for implementation of patient focussed booking. 	<p>Specific work streams have various local target dates but overall programme delivering by 2020.</p> <ul style="list-style-type: none"> Advice only – to be established across acute services OP Matrix - Established on main hospital sites Return waiting lists implemented within some areas with high return demand i.e. ENT, General Surgery, Ophthalmology, Arthroplasty and Vascular Surgery. Template Harmonisation fully completed by March 2017 in agreed specialties Template with key specialty waits to be made available to GPs by end of December 2016. GP engagement sessions ongoing Engagement sessions with Practice Manager groups ongoing 	<p>Decrease in number of new outpatient appointments (better demand management).</p> <p>Achieve upper quartile for the return: new ratio.</p> <p>Decrease DNAs.</p> <p>Improve patient and referrer awareness of waits</p> <p>Clear NHS Lothian strategy development for Outpatient services</p>	<p>Advice only clinics set up – able to Triage letters and provide GP / Patient with advice without attending the hospital.</p> <p>OP Matrix – identify clinic space & nursing during core times – reducing the need for WLI weekend / evening clinics</p> <p>Return waiting lists - able to manage return demand, – able to track pt journey to ensure no patients are missed. Reported weekly at WT meetings.</p> <p>Harmonisation – better patient / Dr experience – pt Triage outcomes are aligned to the correct appointment slot – reducing the need for further visits</p> <p>Ref Help – providing GP with essential advice before referring pt to hospital – reduce unnecessary referrals / ensuring referrals are suitable for acute site</p>	<p>Progressing each of these work streams through the outpatient operational group.</p> <p>Advice only in place in 17 specialties. Work ongoing to implement in other areas.</p> <p>Template Harmonisation In place for 7 specialties. This is running later than planned due to TRAK upgrade and staffing issues within Health Records. Further 8 specialties in progress.</p> <p>Improved platform for RefHelp with enhanced navigation and search facilities now in process of being tested. Transition plan from current to new website being developed. Work is progressing well with the new RefHelp website, Sharing sessions with GPs commenced and being received positively. There is an ongoing technical challenge which will be addressed during 2017 when the roll out of IE11 is completed. New Ref Help requires IE11 to operate. A short term work-around is in place using Mozilla Firefox for those who require it.</p> <p>PRL implementation group for Ophthalmology now progressing implementation of planned review waiting lists, initially with 5 sub specialty queues.</p> <p>New outpatient wait lengths are now available on Ref Help and will be refreshed on a monthly basis.</p>
<p>Independent sector capacity for see and treat patients has been switched on at Spire Healthcare and The Edinburgh Clinic.</p> <p>Re-engagement with Medinet for Adult and Paediatric ENT and Dermatology</p>	<p>31st March 2017</p>	<p>Reduction in length of new outpatient waits.</p>		<p>99% of contract volume referrals have been transferred to Spire. Dermatology clinics commenced on 7th January and will run until 26th March. Capacity is available for 990 patients.</p> <p>Adult ENT clinics commenced from Roodlandson 11th February and will run until 15th March.</p> <p>Paediatric ENT clinics ran on 22- 24 February. Further clinics scheduled on 22 – 24 March.</p>

Comments**Reasons for Current Performance**

Demand greater than capacity.

Overall increase in demand of 2% but significant rises seen in General Surgery, Dermatology, Ophthalmology and Gastroenterology.

Return demand in some key specialties impacting on additional capacity- i.e. additional in house clinics required to manage return demand rather than new.

Cessation of independent sector capacity; however funding has been approved until end of March to reduce the waiting times for the most pressured specialties.

DCAQ exercise to identify any mismatch in outpatient demand and capacity and take actions to address this.

Implementing actions in line with National Programme of Outpatient Redesign.

Sickness absence/vacancies in some specialties. i.e Dermatology, urology

Psychological Therapies

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard: 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.

Responsible Director[s]: Chief Officer - West Lothian IJB

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Moderate	Nov 16	Not Met	Deteriorating	Worse	Dec 16 (Mthly)	90% (min)	66.1%	Feb 17	Management Information	Yes	Yes	JF

Summary for Committee to Note or Agree

Recent Performance – Percentages against Standard

Table 1: Patients Seen for 1st Treatment – Higher % is Better

Service	Patients seen for 1st treatment [adjusted]				
	Number seen	Within 18 wks	Over 18 wks	% within 18 wks	% over 18 wks
CAMHS	7	5	2	71.4%	28.6%
General Adult Services	212	84	128	39.6%	60.4%
Learning Disabilities	18	17	1	94.4%	5.6%
Older Adult Services	18	12	6	66.7%	33.3%
Psychotherapy	12	1	11	8.3%	91.7%
Specialist Service [Adult]	45	28	17	62.2%	37.8%
Clinical Health Psychology	138	131	7	94.9%	5.1%
Neuropsychology	47	44	3	93.6%	6.4%
GSH (3rd Sector)	19	19	0	100.0%	0.0%
Overall Performance	516	341	175	66.1%	33.9%

Figure 1: Psychological Therapies: % of Patients seen within 18 wks for 1st Treatment

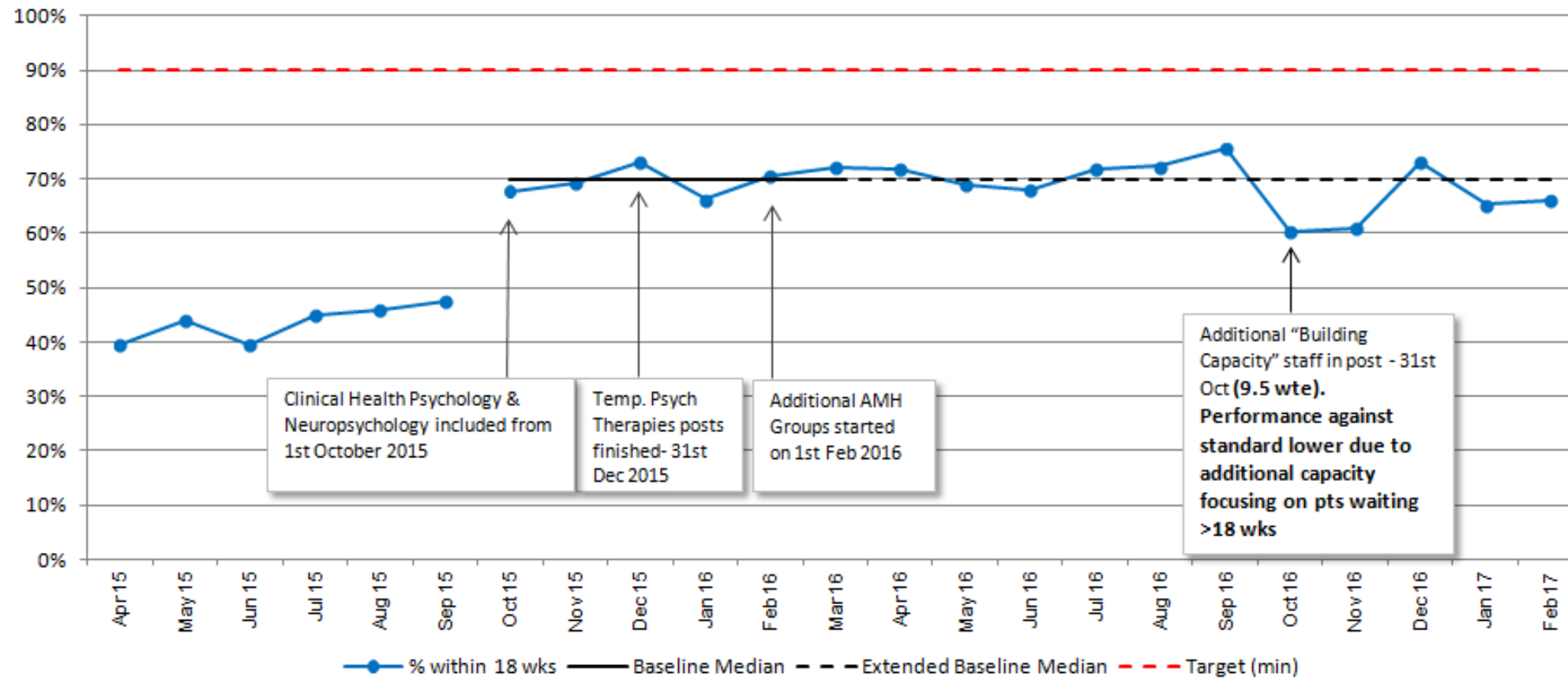


Table 2: Patients Waiting at Month End

Service	Patients waiting at month end [adjusted]				
	Number waiting	Within 18 wks	Over 18 wks	% within 18 wks	% over 18 wks
CAMHS	29	17	12	58.6%	41.4%
General Adult Services	2,589	1,734	855	67.0%	33.0%
Learning Disabilities	39	32	7	82.1%	17.9%
Older Adult Services	141	104	37	73.8%	26.2%
Psychotherapy	259	55	204	21.2%	78.8%
Specialist Services [Adult]	473	308	165	65.1%	34.9%
Clinical Health Psychology	566	540	26	95.4%	4.6%
Neuropsychology	126	120	6	95.2%	4.8%
GSH (3rd Sector)	119	113	6	95.0%	5.0%
Total waiting	4,341	3,023	1,318	69.6%	30.4%

Figure 2: Psychological Therapies: Number of Patients waiting >18 wks at Month End by Month – Lower Count is Better

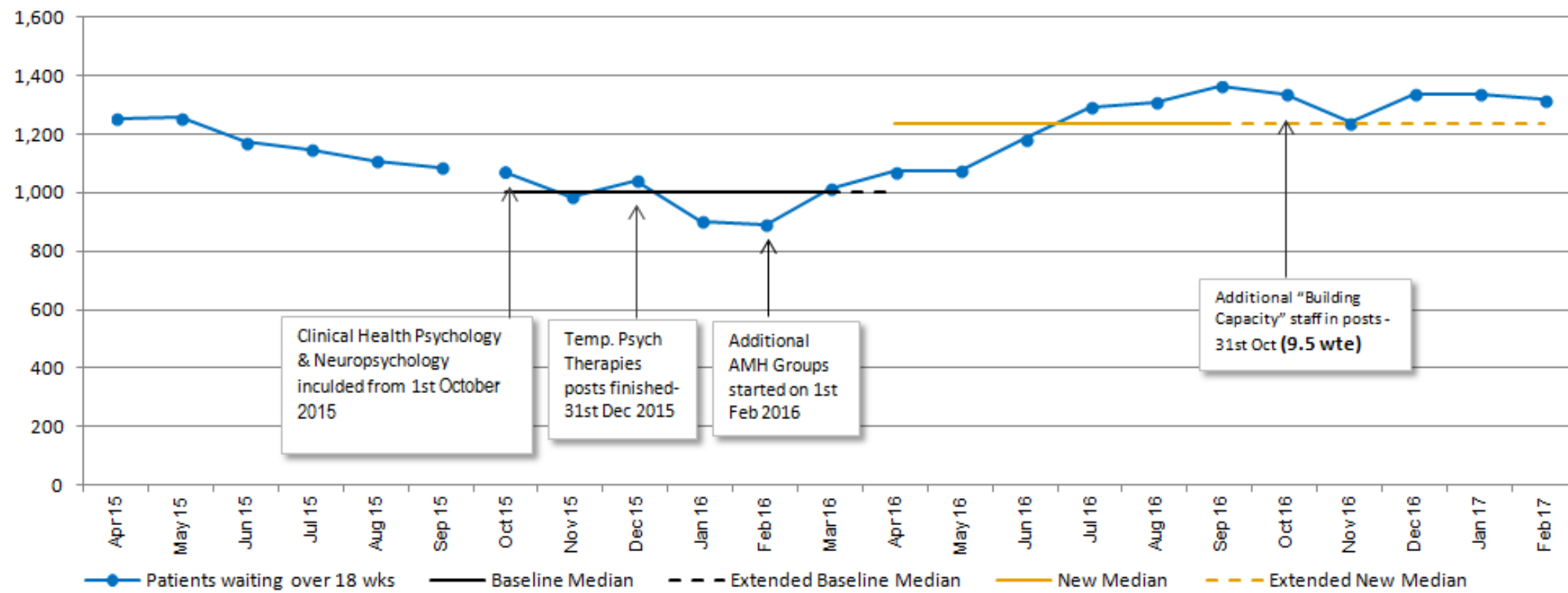


Figure 3: Referrals for Psychological Therapy (All Teams)

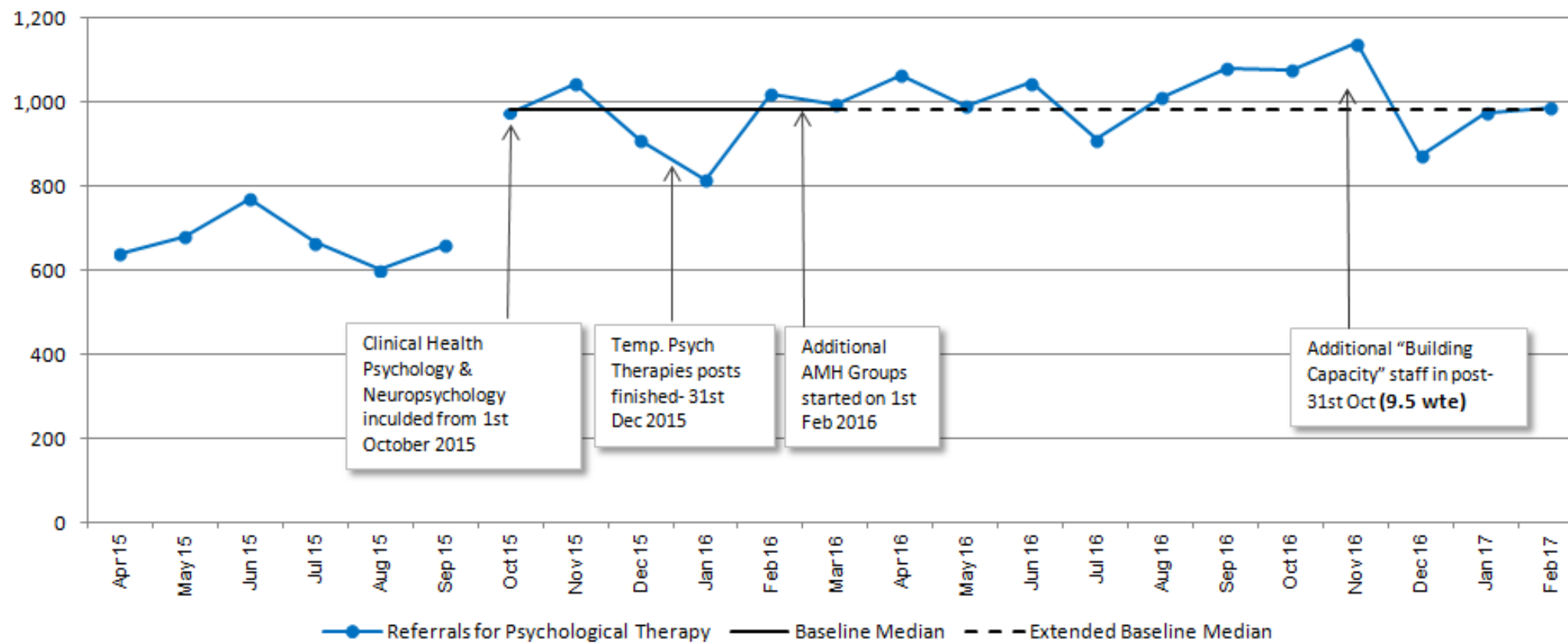


Figure 4: General Adult Services: Number of patients seen for 1st Treatment – Higher Count is Better

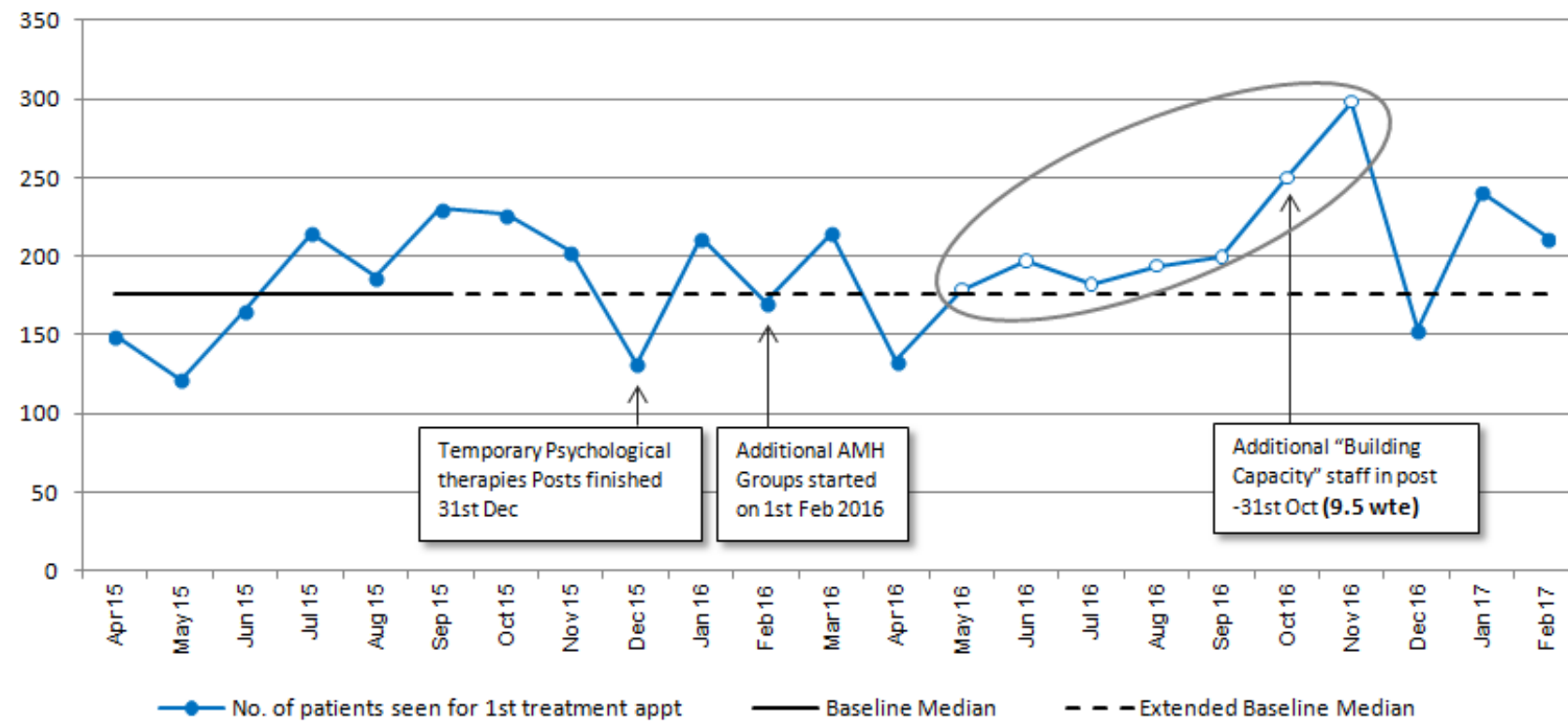


Figure 5: General Adult Services: Number of patients seen for 1st Treatment waiting >18 wks – Lower Count is Better

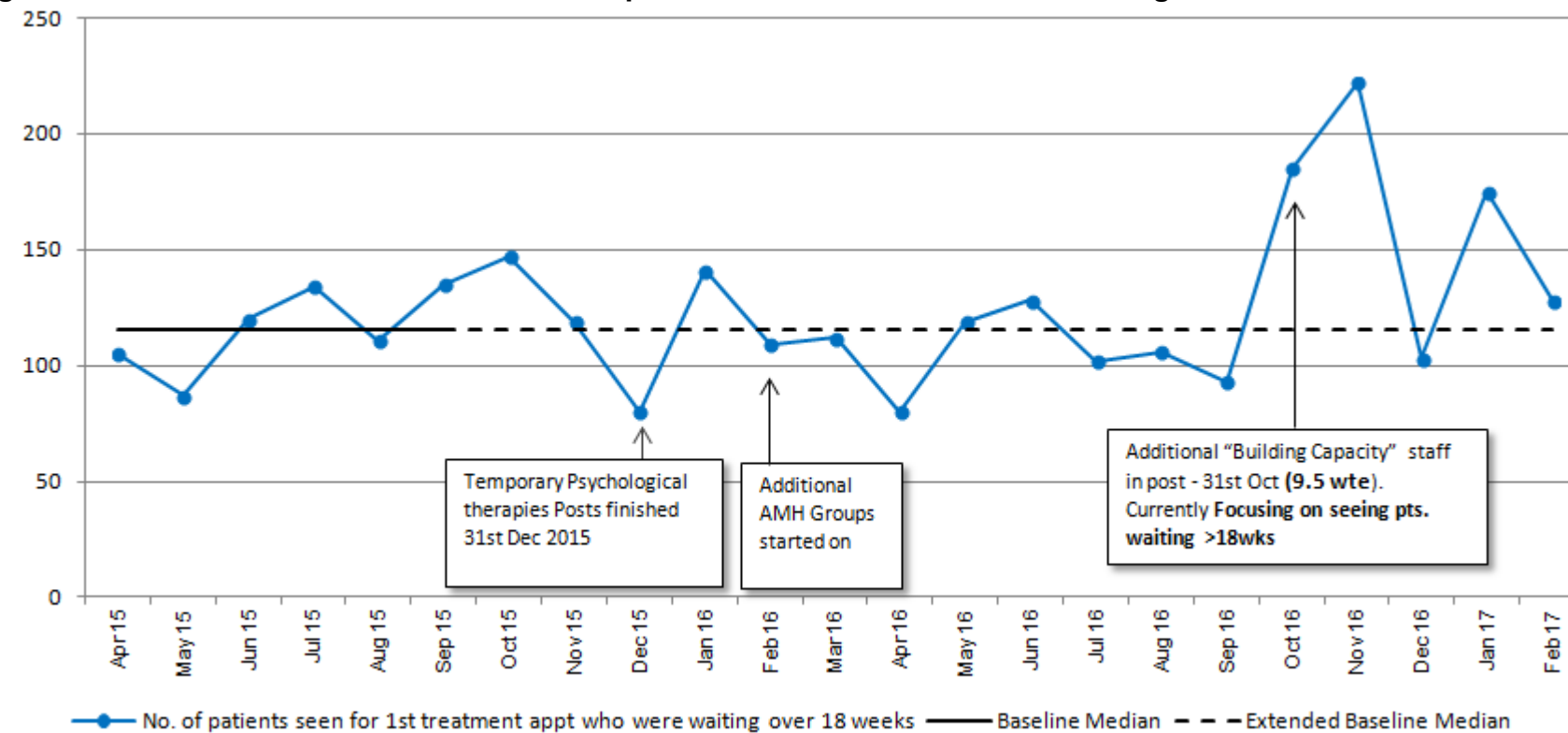


Figure 6: General Adult Services: Number of patients waiting >18 wks at Month End – Lower Count is Better

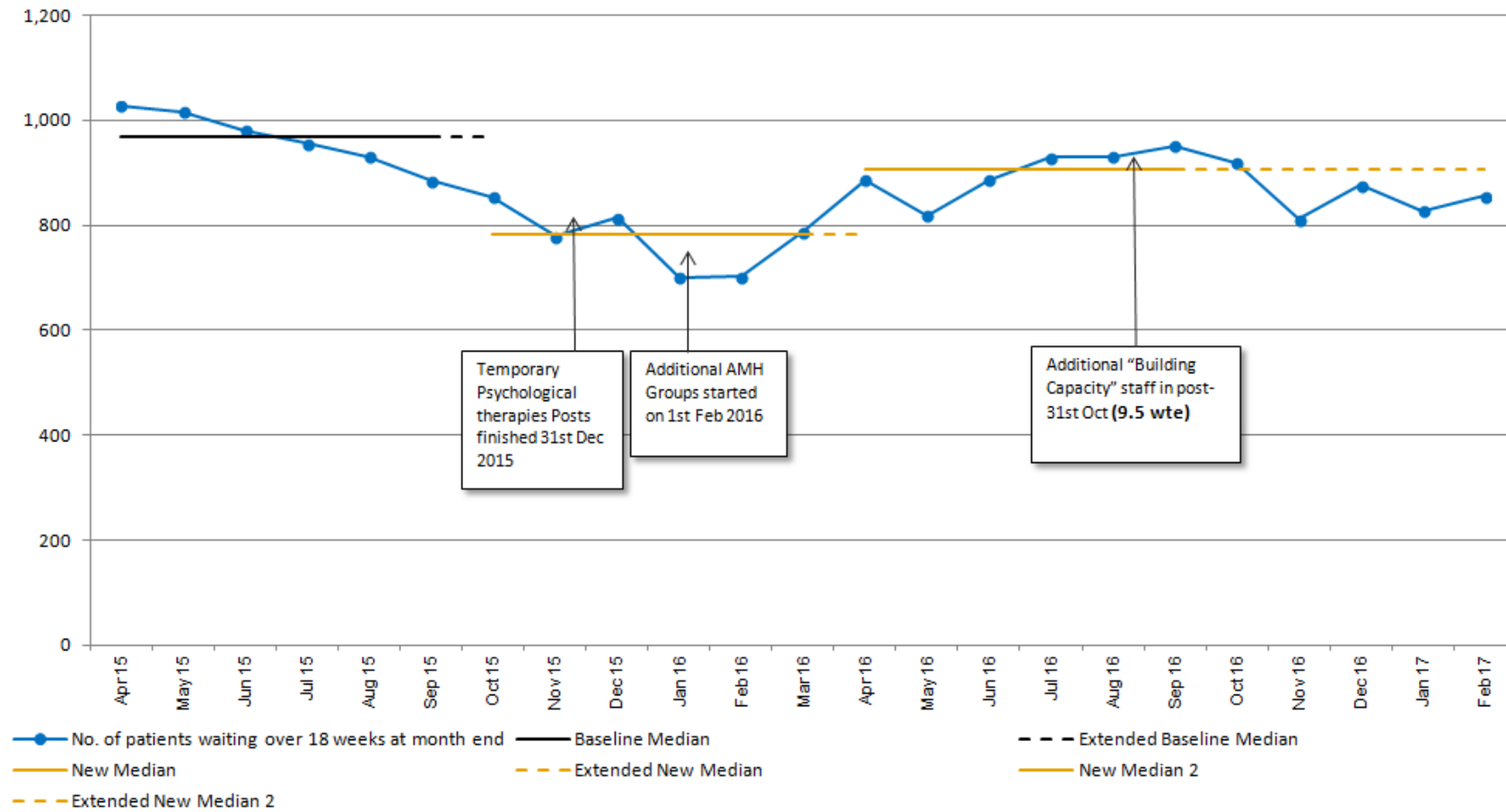
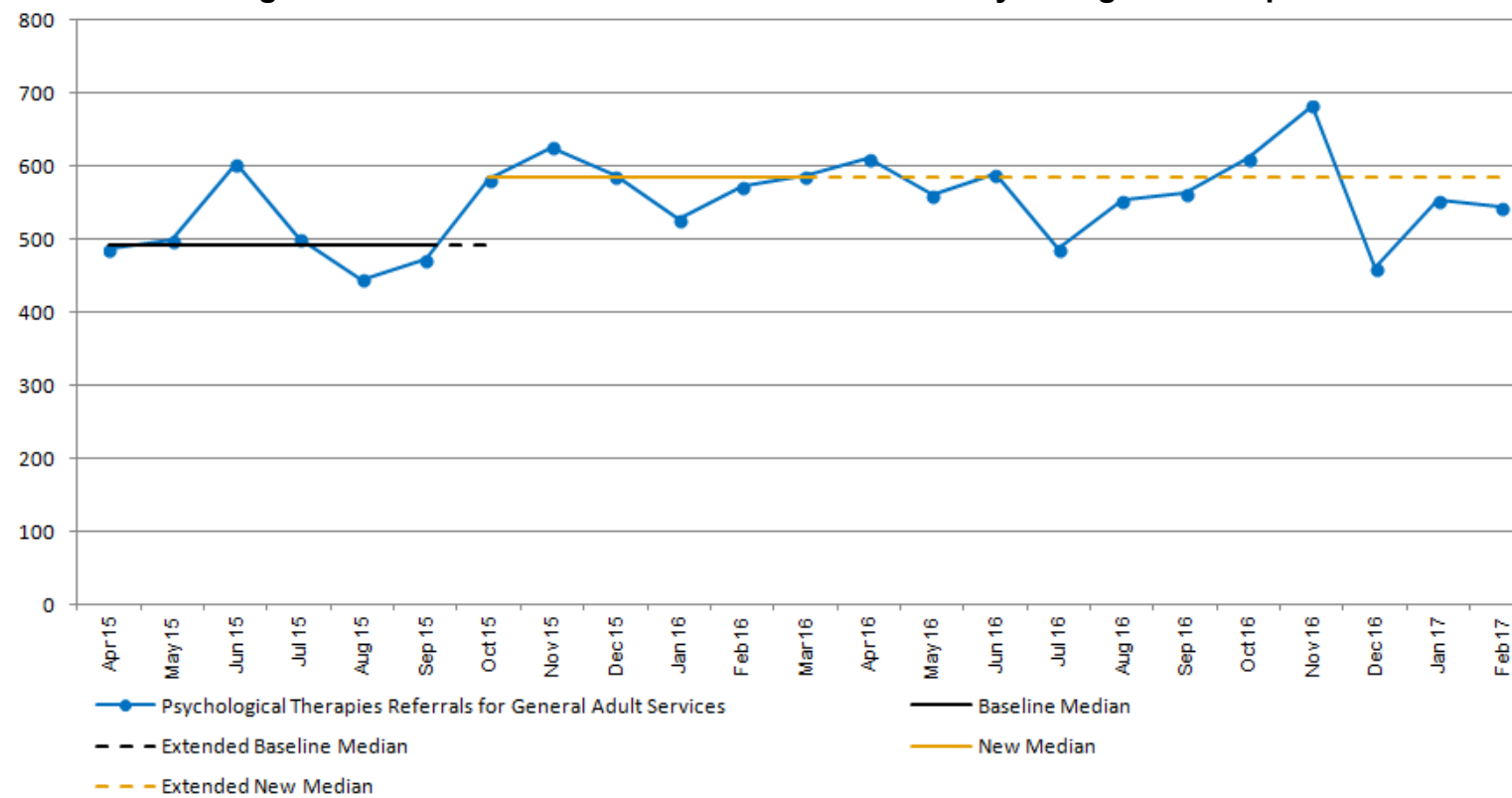


Figure 7: General Adult Services: Referrals for Psychological Therapies



Timescale for Improvement

The revised trajectory will be set by the end of July – this was delayed due to agreement being reached on the allocation of the “Building Capacity funding.”

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
Updated Service Improvement plans for each service / team delivering psychological therapies.	Ongoing and reported and monitored via A12 Project Board.	Standardised reporting and monitoring and ability to escalate issues to Senior Management through the Project Board.	As per planned benefit.	Green
A single prioritised amendments / additions work-plan for TRAK with named analytical, data and system support staff from clinical services, e-health and planning.	Completed and being monitored via A12 Project Board.	Transparency of progress; alignment of TRAK work; reporting of progress formally to the Project Board enabling escalation and resolution of issues.	As per planned benefit.	Amber
Development of a single implementation plan for the introduction of Patient Focused Booking across all service delivering psychological therapies.	Original date was May 2016. Due to configuration issues now anticipated July 2016. Pilot started.	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments. Improved compliance with waiting times rules related to reasonable offer, unavailability and clock resets.	Centralised service implemented at REH and booking for SW OPD. Agreed process for utilizing TRAK PFB with Edinburgh PCMH & Edinburgh Psychology Services Clinic Templates submitted to eHealth for PCMHs & Psychology Staff training booked for end Nov/ Beginning Dec 2016.	Amber
Development of a single implementation plan for the introduction of Text Reminder system across all service delivering psychological therapies.	Expected implementation: June 2016. Delayed – anticipated delivery September 2016	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments.	There continues to be a delay to the start of the pilot phase. The previous date was 31st August 2016 . The delay is due to issues with the TRAK 2016 upgrade which has delayed all scheduled work. The services participating in the 1 st test phase will be SE Edinburgh Psychology Service, West Lothian Psychological Therapies service, SMD Psychological Therapies Service.	Amber
Agreement of norms per WTE for direct clinical contact (appointments) based on banding and role across teams delivering psychological Therapies. Improved reporting of expected versus actual activity.	Completed	Increased number of total appointments available for psychological therapies. Increase in new patient treatment appointments available each month	Detailed under 'Summary for Committee to Note'.	Green
Amendment of the Meridian work allocation tool within Psychological Therapies in Edinburgh only for job planning with nurses and AHP delivering formal Psychological Therapies within REAS.	1 st March 2016	Continue to maximise clinical capacity through forward planning of workload and ensuring appointments slots utilised.	Tool has been amended	Green
Completion of updated DCAQ for all general adult services.	Requires to be run again for each service.	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand and activity.		Green
Completion of remaining DCAQ for all services / teams whose data is recorded and reported from TRAK.	Completed	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand and activity.	Agreed capacity for each team in March 2016. Delivery against capacity monitored on weekly basis	Amber
Introduction of Lothian-wide Group Programme funded by Mental Innovation funding.	1 February 2016	Document and agree expected activity and monitor actual over monthly periods.	Group programme implemented, reducing numbers being treated on individual basis. Training established for leads to maintain group programme after funding stopped.	Green
Comments				
Reasons for Current Performance				
Incomplete data A small number of specialists in patient services (Forensic services, Psychiatric Rehabilitation) delivering psychological therapies are still unable to report data due TRAK configuration, service configuration or extracts not being available from TRAK.				

To mitigate - prioritised work-plan for TRAK and service / team improvement plans.

Reduced capacity: Adult Mental Health General Services ONLY

Revised DCAQ continues to highlight capacity issues for adult mental health services. DCAQ has consistently demonstrated a capacity gap in *General Adult Psychology Services* and as at Feb 16 that gap was 13.1 WTE. An additional 12 WTE are required to clear the queue of patients waiting. "Building Capacity" allocation has been agreed at 10.5 WTE Clinical staff for Adult mental Health General Services to be recruited on a permanent basis. 9.5 WTE Clinical Staff have been recruited to as of October 2016.

The DCAQ QUEST tool was used to arrive at these figures. The services have been working closely with colleagues in HIS regarding use of the DCAQ tool. We agreed to highlight the following:

1. The tool has been designed to model different scenarios; exploring the impact of various service changes on DCAQ. For example: what might happen if sickness rate reduced by 10%? Data is displayed in bar charts that summarise a period of time
2. The tool uses averages to produce ball park figures for demand and capacity therefore the better the quality of the data inputted, the better the ball park figure will be. The outputs require use of judgement by the service to inform service improvement/ planning.
3. At the current time MHAIST feel the tool remains valid for the purposes intended in the above

1.0 WTE Band 8a remains to be recruited to.

0.8 WTE band 7 has been recruited to CFS service from these funds.

Increased demand

Increase in demand due to the increasing efficacy and awareness of the positive contribution of psychological therapies to improving patients' outcomes.

To mitigate –

Updated DCAQ for all services / teams. Reviewing the range of psychological therapies available and ensuring delivery of those with the most robust evidence bases are prioritised and matched to those who will most benefit.

Building Capacity funding will be target at those who have waited longest in adult mental health services.

18 Weeks Referral to Treatment

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard:

90% of planned/elective patients to commence treatment within 18 weeks of referral.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Feb 17	Not Met	Deteriorating	Worse	Dec 16	90% (min)	79.3%	Feb 17	Management Information	Yes	No	JC

Summary for Committee to note or agree

Use of independent sector ceased from April 1 2016, however funding has been agreed till March 17 to target and support those specialities with the longest waiting times with ; internal capacity remains unable to fully cover this previous activity which will impact on overall RTT performance. Details of DCAQ work including efficiency improvements that we are undertaking are described in OP and IP/DC proformas.

Recent Performance – Percentages towards Standard

Figure 1: % of Patient Journeys within 18 Weeks – Higher % is Better

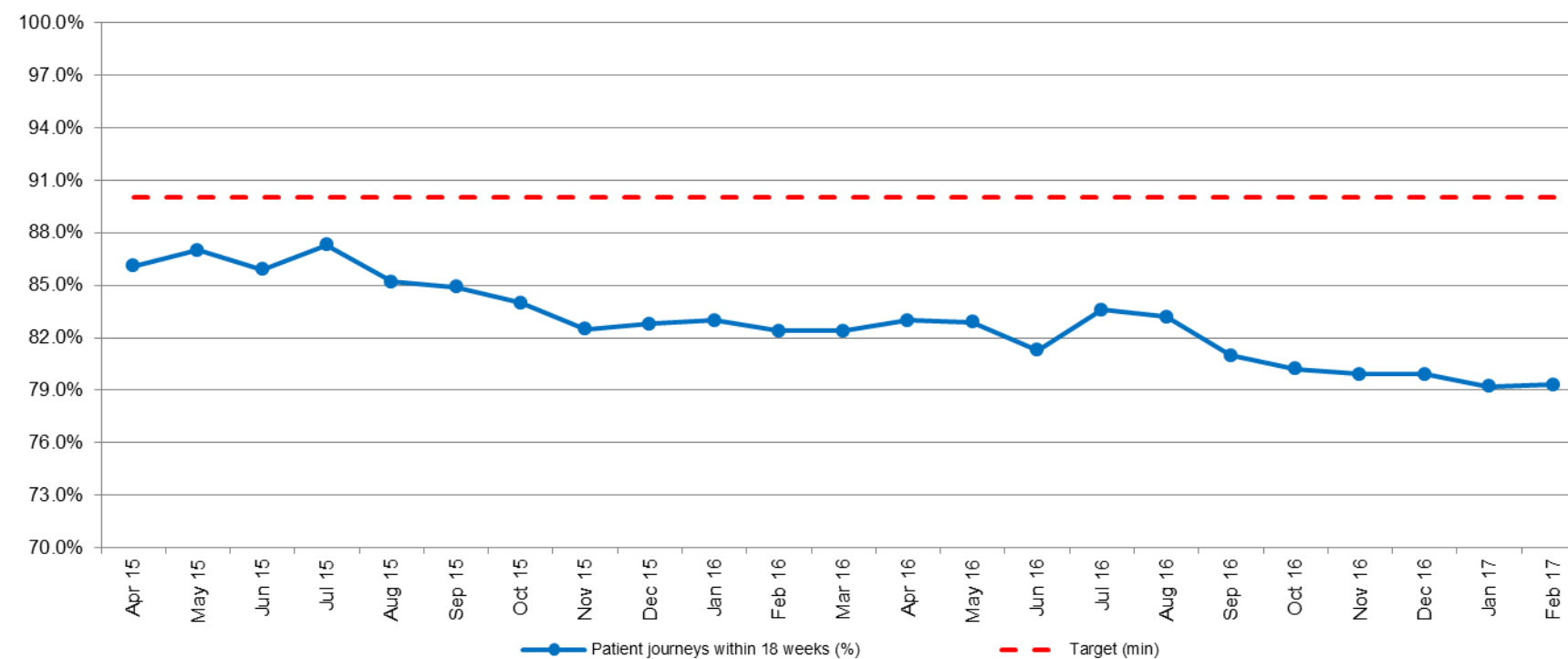


Table 1: Trend in 18 Week Performance and Measurement – Higher % is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Patient journeys within 18 weeks (%)	86.1%	87.0%	85.9%	87.3%	85.2%	84.9%	84.0%	82.5%	82.8%	83.0%	82.4%	82.4%	83.0%	82.9%	81.3%	83.6%	83.2%	81.0%	80.2%	79.9%	79.9%	79.2%	79.3%
Number of patient journeys within 18 weeks	12,446	12,417	13,795	13,297	12,631	13,820	13,642	13,000	13,133	11,931	12,396	12,791	13,157	13,067	13,303	11,213	13,080	11,498	11,307	12,485	10,409	11,030	10,578
Number of patient journeys over 18 weeks	2,001	1,849	2,265	1,941	2,201	2,449	2,604	2,749	2,720	2,443	2,647	2,736	2,688	2,703	3,061	2,197	2,632	2,691	2,785	3,146	2,614	2,888	2,763
Patient journeys that could be fully measured (%)	85.1%	85.7%	86.0%	84.8%	84.9%	86.7%	87.4%	86.3%	86.1%	86.8%	87.0%	87.1%	87.0%	87.0%	89.3%	87.3%	87.6%	87.0%	87.3%	87.2%	87.1%	87.0%	86.8%

Timescale for Improvement

None provided.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Pursue significant programmes of work to improve efficiency and reduce patient waits for IP and OP access: Theatre Improvement Programme; Demand and Capacity Programme, and Outpatient Redesign Programme.	DCAQ Phase1 - end of January 2016. Phase to monitoring of performance against key indicators started April 2016. Second round of performance meetings undertaken end July 16., scrutiny of progress against performance indicators , and monitoring of actual activity against baseline capacity Theatre programme- December 2016. Outpatient programme – 2020.	Improved performance against agreed efficiency targets, example improved Day Case rate. Improved demand management.	Refer to IPDC TTG and OP proformas.	Progressing individual work-streams. Refer to IPDC TTG and OP proformas.
Ensuring clinic outcome data is completed - Develop a monthly report that details by speciality and clinician clinic outcome completeness, supporting targeting improvement actions	First report December 2016	Clocks stop appropriately in line with clinical pathway.	-	Monthly monitoring of completeness data and impact of improvement actions

Comments

Reasons for Current Performance

Challenges within specific specialties as highlighted on the Outpatient and TTG proformas.

Stroke Bundle**Healthcare Quality Domain:** TimelyFor reporting at **April 2017** meetings**Target/Standard:** This is a **New Standard**, implemented from 1st April 2016:**80% of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle.****Additional information**

The key elements of the stroke care bundle are:-

1. Admission **to the stroke unit on the day of admission, or the day following presentation** at hospital;
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**;
3. CT/ MRI imaging **within 24 hours** of admission; 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.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services**NHS Lothian Performance:-**

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Moderate	Nov 16	Not Met	Improving	Not Applicable	Not Applicable	80% (min)	73.9%	Jan 17	Scottish Stroke Care Audit (SSCA) database	Yes	Yes	JC

Summary for Committee to note or agree

Stroke care is part of the Clinical Quality Programme during 2016, and stroke services have been identified as a priority to be supported by NHS Lothian's Quality Management Strategy. Projects developed from the Leadership Course are ongoing and support from NHS Lothian Quality Improvement leaders is continuing. SSQIB (Stroke Services Quality Improvement Board) meetings are focusing on quality improvement and actions resulting from the improvement work being undertaken across the stroke units. The data analytics team are providing support and working on linking stroke audit and Trak data. These run charts will then form the basis for discussion on interventions to improve performance and agree tests of change. Local Quality Improvement groups are now established at RIE, SJH & WGH, and meet regularly to look at all aspects of stroke services and local improvement opportunities. Outputs from these meetings are circulated widely to communicate any updates to services.

The majority of bundle fails are for admission to the stroke unit or swallow screen. There was a 30% increase in patients with initial diagnosis of stroke from November to December and this has meant performance against stroke unit admission remains challenging, and the bundle target is unmet. Access to a stroke unit bed is improving month on month across Lothian and although December's performance dipped to 69.3%, there were increasing numbers of patients accessing the stroke units overall: 54 in October, 63 in November and 70 in December. An hourly report is sent to the outreach team at RIE to alert them to any stroke patients arriving at the front door, and this has substantially improved prompt treatment for them. There were six patients failing the access standard (to the stroke unit) because they needed appropriate critical care beds in neuro HDU at WGH.

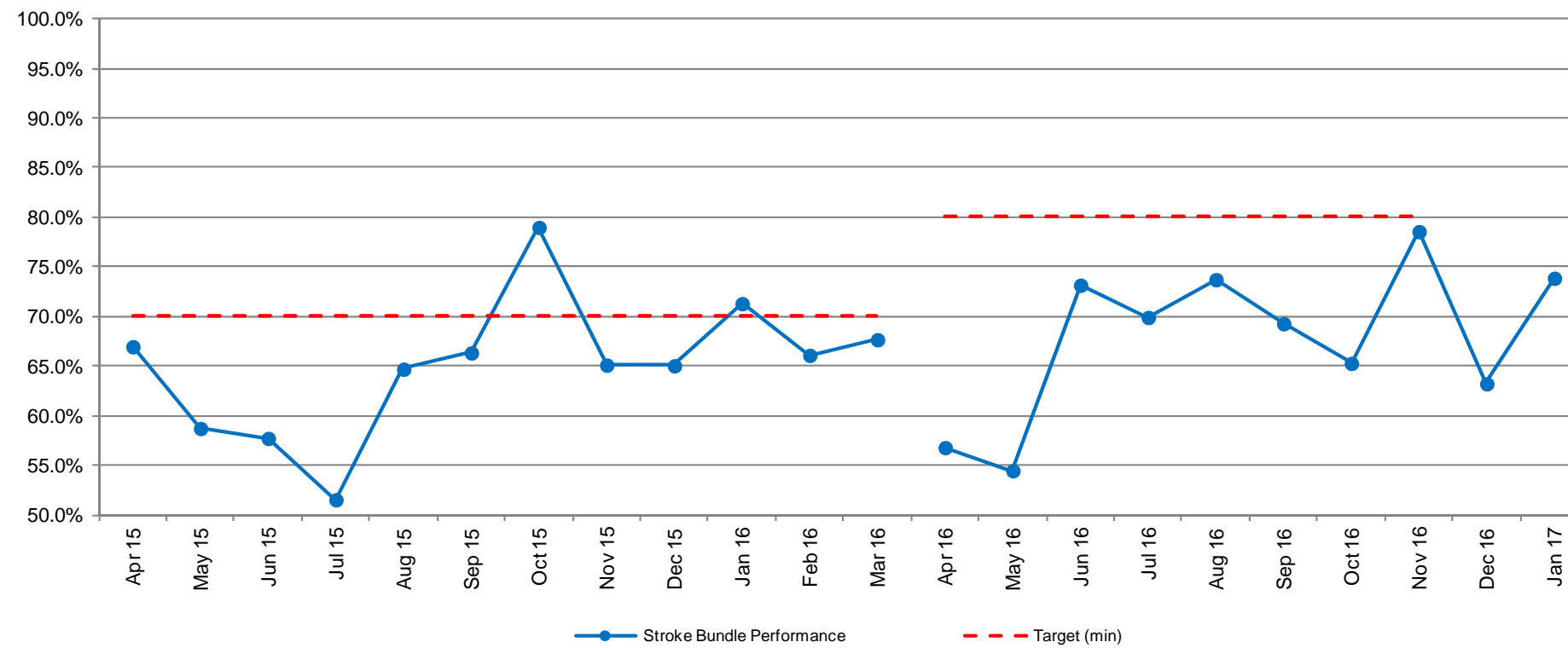
The swallow screen standard is now within four hours of admission and performance against this rigorous standard still provides challenges, particularly with in-hospital strokes with unknown onset time. Stroke teams on all sites are engaging with front door teams to discuss options to support this standard and quality improvement work across all sites is ongoing. Nine of the 24 breaches were screened within eight hours, but there are still occasions when the screens are not accurately documented. Performance for imaging remains steady and continues to meet the updated national standard. Aspirin performance fell short of the 95% target and achieved 88.2%. Half of the patients who missed the standard received aspirin or an alternative by day two following their stroke.

Recent Performance – Numbers achieved towards standard

Table 1: Stroke Bundle Performance – Higher % is Better
(provisional data for management, and liable to change)

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Stroke Bundle Performance	67.0%	58.7%	57.7%	51.5%	64.7%	66.3%	79.0%	65.1%	65.0%	71.3%	66.1%	67.7%	56.8%	54.5%	73.2%	69.9%	73.7%	69.3%	65.3%	78.6%	63.2%	73.9%
1. Access to stroke unit by day after admission	74.7%	66.3%	66.3%	48.5%	68.8%	71.1%	83.0%	75.8%	67.1%	77.3%	65.0%	71.3%	72.3%	64.1%	83.3%	78.6%	83.6%	84.3%	72.0%	87.5%	69.3%	78.2%
2. Swallow screen within 4 hours of admission	81.7%	83.3%	82.5%	80.4%	86.3%	90.4%	89.1%	82.9%	83.5%	86.9%	84.7%	87.9%	77.7%	74.6%	85.8%	83.6%	84.1%	80.2%	83.5%	83.5%	83.1%	89.1%
3. Imaging undertaken within 24 hours	95.4%	95.2%	95.9%	97.9%	94.1%	96.2%	97.5%	98.5%	95.2%	97.7%	97.6%	94.5%	96.2%	97.6%	93.5%	95.1%	98.3%	97.6%	95.0%	98.0%	98.5%	94.6%
4. Aspirin by the day following admission	92.8%	90.9%	95.1%	87.7%	94.9%	92.1%	95.5%	93.8%	90.0%	93.3%	92.3%	81.7%	90.5%	93.4%	93.8%	92.1%	96.3%	90.5%	87.8%	92.2%	88.2%	94.4%

Figure 1: Stroke Bundle Performance – Higher % is Better
(provisional data for management, and liable to change)³



³ The performance line is broken on the chart as data to March 16 incl. is not comparable to data from April 16 onwards, due to change in Swallow Screen standard (from 90% on day of admission, to 100% within 4 hours of admission).

Timescale for Improvement

A trajectory (local target), has been agreed with SGHD and set out below (Local target agreed at 70% for 2015/16. National target of 80% to be enforced from April 2016):-

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Trajectory (local target)	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
<p>AHP rehabilitation triage to identify 'fast track' patients for increased intensity of treatment and earlier sign-posting to community rehabilitation services pan Lothian.</p> <p>Development of a patient categorisation system to determine best pathways for them. Current test of change is looking at those who need intensive stroke-specific rehabilitation in the stroke unit.</p>	June 2017	Decrease LOS, more patients going home quicker – LOS for patients, who met the "fast track" criteria, is reduced by three days. Increased intensity of rehabilitation for targeted patients to prepare for earlier discharge.	Mean LOS pre-test was 22.83 days, and post-test, 20.26 days. Of 112 patients referred into the Edinburgh Intermediate care Service with stroke up to January 2017, 34 were "fast track" with a median referral to ICS time to hospital discharge of 1.5 days. Thus a reduced LOS for patients on fast track referral to community services.	<p>Continue to fast track suitable pts to community rehab. Currently looking at those who need intensive stroke-specific rehab in the stroke unit and whether the resources are there to achieve this.</p> <p>Working with Lothian Analytical Services to improve automatic data generation.</p>
Redesign of the stroke unit at WGH, from two MOE/Stroke wards to a single stroke ward.	April 2017	Increase clarity to patient flow across NHS Lothian, while meeting required capacity. Better develop nursing staff stroke specific skills.		Options appraisal completed with preferred option identified. In process of consulting staff, and for Partnership and Workforce Planning at end of March.
Outreach service at WGH is delivered within ward nurse staffing establishment by senior band 5s and above.	Completed	Increased capacity to identify and take care of more patients at an earlier stage.	To be determined. Audit of calls from ARU to Outreach underway.	Confirmation awaited from WGH team regarding improved capacity. COMPLETED: ACTION CLOSED JANUARY 2017.
<p>Determine best approach to identify stroke patients early on admission and alert stroke liaison nurse to them.</p> <p>Business Object (BO) report being developed by TRAK team to alert stroke unit (via blackberry) when patient with stroke symptoms is clerked in at front door (RIE).</p>	Operational from mid November 2016. Has become part of normal work practice at RIE.	Early identification of stroke patients	This has provided patients with improved outcomes from early diagnosis.	Automated TRAK report sent hourly to stroke liaison nurse - to identify when a patient with stroke symptoms attends front door at RIE. Those identified with stroke on admission are being seen promptly. COMPLETED, ACTION CLOSED FEBRUARY 2017.
Refocus on the role of the stroke bundle nurse at St John's, training of staff in swallow screening and completion of written documentation.	End of December 2016	Prompt identification of stroke patients and appropriate pathway in place.	Anticipated that this will provide patients with improved outcomes from early diagnosis.	Daily named nurse in ED and AMU now established. COMPLETED, ACTION CLOSED FEBRUARY 2017.

Comments

Reasons for Current Performance

High demand on stroke unit beds across all sites and 30% increase in patients being admitted with stroke diagnosis in December. The new automated TRAK report at RIE is alerting outreach team to patients who arrive with stroke symptoms so they can be treated promptly. However there are still some delays in identifying patients at front door as 'stroke' which puts additional pressures to swallow screen within four hours.

Surveillance Endoscopy

Healthcare Quality Domain: Timely

For reporting at **April 2017** meetings

Target/Standard: No patient should wait past their planned review date for a surveillance endoscopy.

Responsible Director[s]: Chief Officer – NHS Lothian University Hospitals & Support Services

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0 (max)	4,523	Feb 2017	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

- Undertaking Surveillance Scopes in a timely fashion has continued to prove challenging;
- Independent sector capacity from October to March 2017 has been utilised for new patients only;
- Booking of the Regional Endoscopy Unit (REU) has transferred to External Provider Office;
- As well as reviewing options to increase capacity, the service introduced a Nurse Led 'Pre-Assessment' process in May 2016, aimed at reducing demand.

Recent Performance – Numbers Against Standard

Figure 1: Surveillance and Review Patients Overdue Appointment – Lower Count is Better

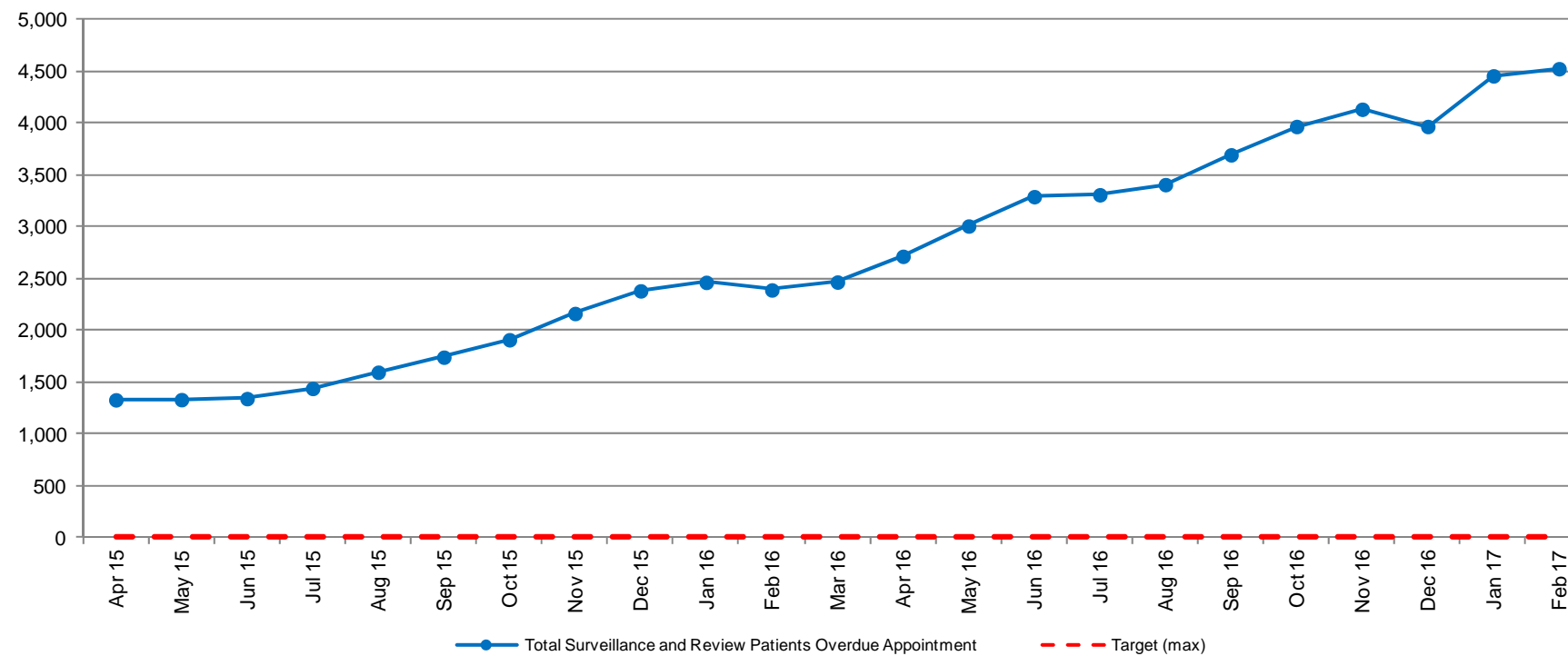


Table 1: Surveillance and Review Patients Overdue Appointment – Lower Count is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Colonoscopy	614	621	611	627	686	741	869	1,017	1,142	1,265	1,347	1,456	1,596	1,790	2,030	2,068	2,072	2,207	2,342	2,185	2,507	2,693	2,750
Upper Endoscopy	320	326	307	340	369	404	436	497	546	597	605	602	637	666	730	734	748	789	826	824	776	854	830
Flexible Sigmoidoscopy	109	119	126	135	155	165	153	168	182	187	186	197	206	220	236	227	222	239	248	251	236	264	250
Flexible Cystoscopy	196	164	200	235	290	327	342	355	374	273	120	73	114	145	82	53	161	248	319	365	295	415	448
Other	93	104	100	105	98	106	111	127	138	142	133	139	162	186	212	226	203	210	231	507	152	228	245
Total	1,332	1,334	1,344	1,442	1,598	1,743	1,911	2,164	2,382	2,464	2,391	2,467	2,715	3,007	3,290	3,308	3,406	3,693	3,966	4,132	3,966	4,454	4,523

Timescale for Improvement

Timelines for various actions outlined below.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Completion of DCAQ for Endoscopy to confirm overall gap in list capacity	Quarterly monitoring process throughout 2016/17 and 2017/18	Accurate measure of available capacity vs demand for both surveillance and new diagnostics	-	Meetings recommenced in February 2017.
Transfer of booking of surveillance scopes by PFB at Regional Endoscopy Unit to EPO, providing a dedicated resource and maximising use of REU for routine surveillance patients.	May 2016	Increase use of REU ensuring identifiable capacity for planned repeats Patient Focused Booking is better for patients and reduces short notice CNAs and DNAs	Example of one weeks activity at REU under the new system Booked Capacity 90.1% DNA Rate (Points) 2.7% DNA Rate (patients) 3.6% Actual Utilisation 87.7% which is a much improved position	Transfer occurred in May. PFB implemented and being measured and monitored with a weekly report being produced.
Work continuing on additional flexi cystoscopy activity. Addition of Botox patients to Flexi Cysto waiting list has impacted position as has retiral of a Consultant and increase in number of combined Flexi Cysto and Botox cases being undertaken.	Continuous evaluation of new and backlog demand against now reduced capacity. Focus on reducing longest waits	Reducing backlog and longest waits.		Continuing to evaluate with waiting list staff on a weekly and monthly basis to identify any capacity challenges.
Nurse Led Validation system in place for all Repeat Endoscopies	1 st June 2016	45% reduction in total numbers validated then telephone screened was achieved within NHS Lanarkshire, same model we are implementing. This was largely driven by patient choice. These patients may historically have been DNAs and therefore ensuring capacity is maximised	Safe managed reduction in planned repeat list by clinical validation and telephone pre-assessment screening. Patients most in need of early scope identified, reduction in DNA more efficient use of capacity. Since start of new process 42% reduction of patients contacted and a further 8.5% have had follow-up dates deferred based on current clinical guidelines.	Weekly monitoring ongoing.
Capacity ringfenced for Urgent Surveillance patients.	January – March 2017	Core capacity identified for this patient group who are seen as a clinical priority by Clinicians.	Reduction in waiting times for this patient cohort.	Continued review during January – March 2017 has resulted in a continuance of ringfenced capacity in April.

Comments

Reasons for Current Performance

Underlying capacity gap for endoscopy with additional demand pressures evident. Endoscopy units also balancing provision of urgent in-patient scoping to support in-patient flow and reduced length of stay.
Consultant vacancy in Urology service resulting in shortfalls in flexible cystoscopy sessions.
Previous poor utilisation of REU with high DNAs now improved by PFB process

Mitigating actions

New Consultant Urologist appointments commenced in May 2016 providing additional flexible cystoscopy capacity.
Continued focus on booking process for surveillance patients appointed to the Regional Endoscopy Unit to maximise uptake of capacity and reduce DNAs and cancellations.
Impact of model for 'pre-assessment' service for all surveillance patients requiring a procedure continues to be monitored.

Delayed Discharges – East Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

For reporting at **April 2017** meetings

Target/Standard: To minimise delayed discharges over 3 days, with none over 14 days, pending national clarity.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Improving	Worse	Jan 17	0 (max)	230 (>3 days, excl. Code 9s ⁴ & 100s ⁵)	Feb 17	Trak	Yes	Yes	DS
East Lothian IJB Performance							24 (10.4% of NHS Lothian Performance)					

Summary for Committee to note or agree

- East Lothian's performance had been steadily improving from a peak of 43 in 2014, reducing to between 15 to 25 at each monthly census until spring 2016. From then until August 2016 the number increased, in part due to new reporting rules, but mainly due to suspension of admissions to a large local care home and capacity problems with care at home providers. This figure peaked at 61 in August. Since then numbers have steadily reduced with the expected seasonal surge in December and January 2017. The care home in East Lothian, which had been closed to new admittances since early 2016, is now at full capacity.
- East Lothian routinely had around 1,000 hours of unmet care at home demand each week due to capacity problems with providers. This had risen to 1,800 hours per week in September 2016, but has reduced slightly to 1,700 hours at the end of the 1st week in February 2017. The same week saw 24 Home care packages -1 new from hospital, 9 restarts from hospital and 14 new packages in the community. Currently 22,100 hours of home care are provided weekly. The HSCP is in the process of re-tendering the contracts and awards have been made and providers advised. The new contracts will be phased in from April 2017. . The contracts include terms designed to improve the responsiveness of providers to delayed discharges.
- The implementation by the East Lothian Health and Social Care Partnership of the Living Wage – contributes to having a stabilising effect on the workforce within home care sector providers, supports better staff retention.
- The increased use of Hospital at Home- which avoids hospital admissions and all the associated dangers of some individuals then becoming a delayed discharge. The hospital team has been increased by 20%, and prevents hospital admission many of which would become a delay 4-6 weeks after admission.
- Led by the Head of Older People and Access/Chief Nurse weekly session are held with relevant partnership staff, to finding solutions for all patients/clients with a delayed discharge, be they in hospital, waiting in step down units, interim placement, as well as our complex and reprovisioning delays (the code 9's and 100's) - the session is focused on actions and outcomes.
- Further improving the effectiveness and responsiveness of the Emergency Care Service, ELSIE (East Lothian Service for Integrated care for the Elderly).
- Increased experience with in the 'discharge hub' at Roodlands Hospital, that enables NHS Lothian and Adult Wellbeing to manage discharges, and monitor care home vacancies both with and increasingly out with the county.

⁴ Code 9s are used for 'complex' cases - they are codes used when a partnership is unable, for reasons beyond their control, to secure a patient's safe, timely and appropriate discharge from hospital.

⁵ Code 100 is used for commissioning/re-provisioning.

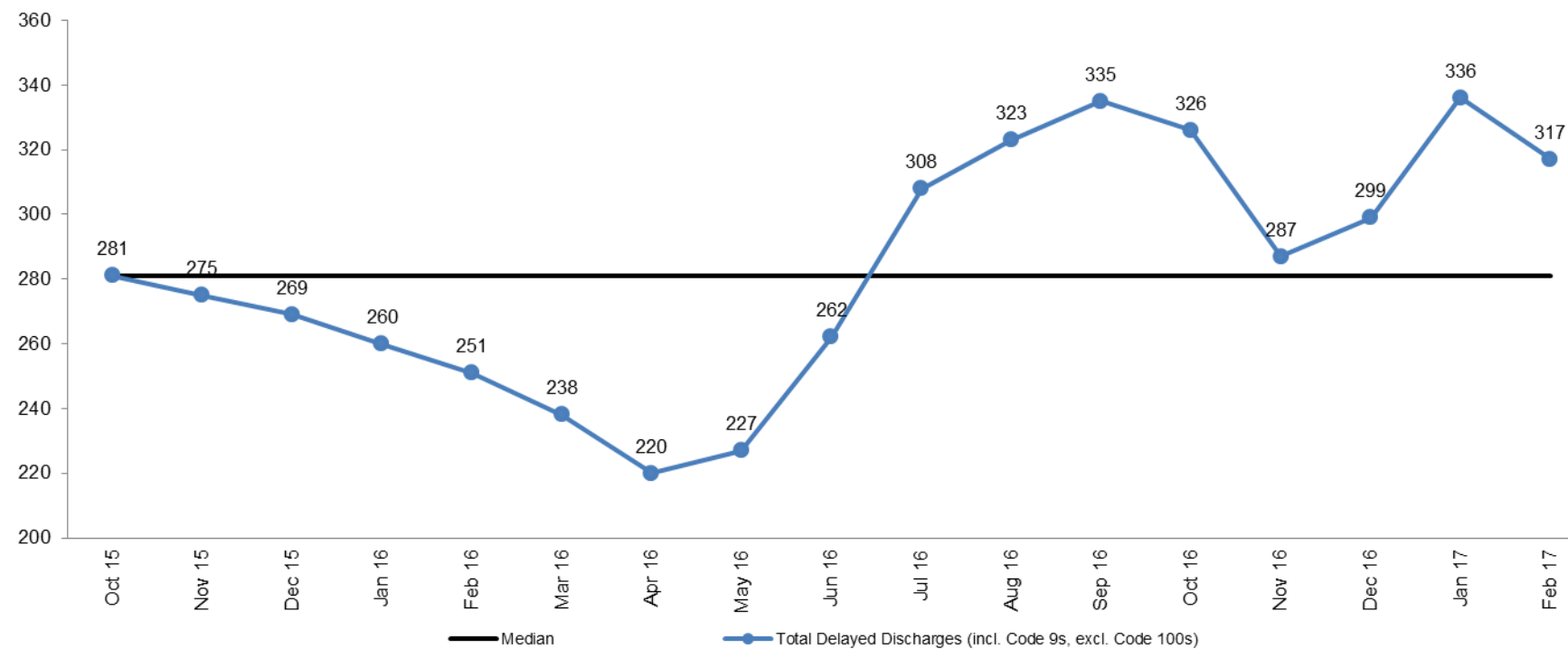
- East Lothian has no complex 9 code delayed discharge clients (February 17).
- The ELH&SCP step down capacity has increased from 20 to 27 beds across two units.
- East Lothian validated number for standard delayed discharges at February 2017 census was 25 against a trajectory target of 26 (16 of the 25 were over two weeks). East Lothian continues to be below trajectory.

Recent Performance – Delayed Discharges

Table 1: Census Return Data - Total Delayed Discharges (incl. delayed discharges <=3 days, >3days, and Code 9s; excl. Code 100s) – Lower Count is Better⁶

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
City of Edinburgh										198	192	201	225	198	203	228	222
East Lothian										40	61	60	41	26	47	41	25
Midlothian										24	27	34	21	22	22	16	18
West Lothian										40	38	38	36	41	26	51	49
Total Delayed Discharges (incl. Code 9s, excl. Code 100s)	281	275	269	260	251	238	220	227	262	308	323	335	326	287	299	336	317

Figure 1: Census Return Data - Total Delayed Discharges (incl. Code 9s, excl. Code 100s) – Lower Count is Better



⁶ New national definitions from July 2016 prevent a breakdown of delayed discharges by IJB, delay reason or length of delay being provided for prior to this point, on a comparable basis.

Figure 2: Census Return Data - Delayed Discharges >3 Days (excl. Code 9s & 100s) – Pre & Post-Definition Change– Lower Count is Better

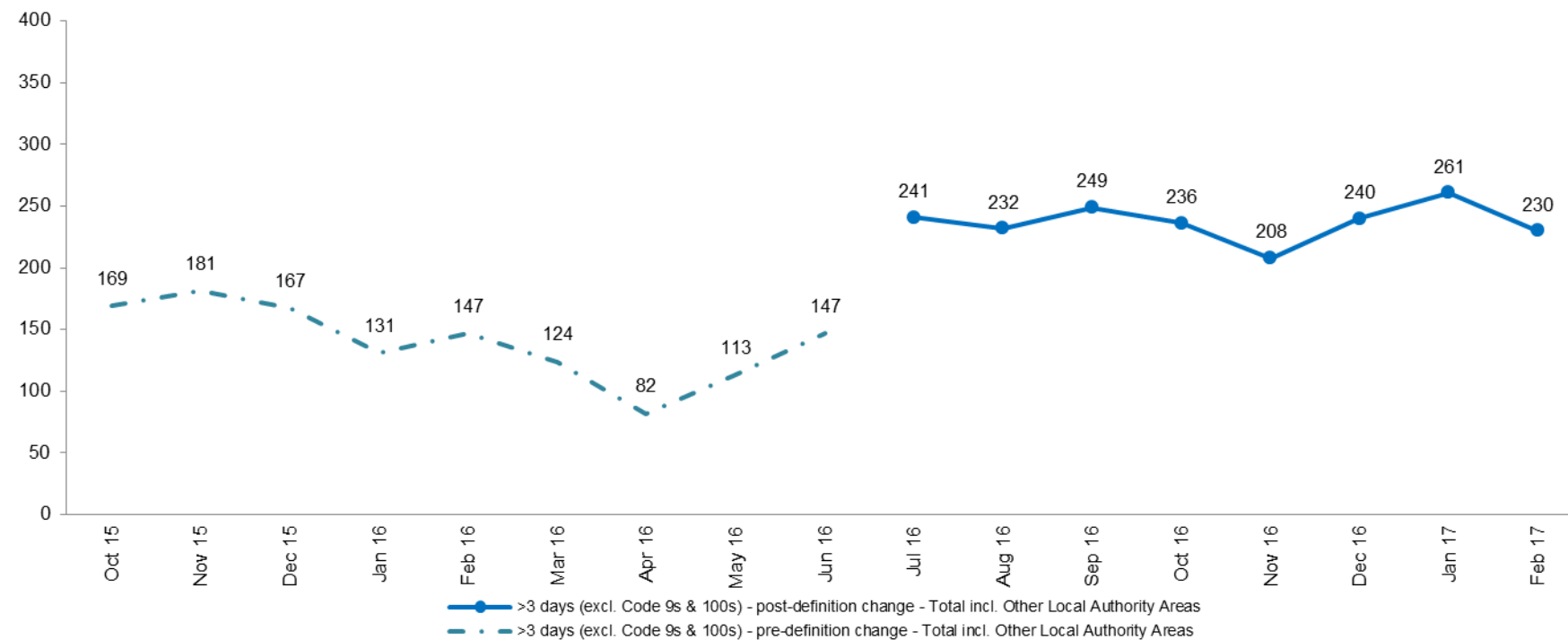


Table 2: Census Return Data - Delayed Discharges – New Methodology – Lower Count is Better

	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
<=3 days (excl. Code 9s and 100s)								
City of Edinburgh	20	26	23	32	28	15	28	38
East Lothian	2	11	14	9	4	11	12	1
Midlothian	2	8	4	5	7	1	4	2
West Lothian	4	10	6	8	10	6	11	18
Total incl. Other Local Authority Areas	29	55	47	55	49	33	55	61
>3 days (excl. Code 9s and 100s)								
City of Edinburgh	153	144	155	168	148	170	188	171
East Lothian	35	47	44	31	21	35	28	24
Midlothian	15	13	25	12	13	17	9	10
West Lothian	33	23	23	23	26	17	36	24
Total incl. Other Local Authority Areas	241	232	249	236	208	240	261	230
Code 9s								
City of Edinburgh	25	22	23	25	22	18	12	13
East Lothian	3	3	2	1	1	1	1	0
Midlothian	7	6	5	4	2	4	3	6
West Lothian	3	5	9	5	5	3	4	7
Total incl. Other Local Authority Areas	38	36	39	35	30	26	20	26
Code 100s								
City of Edinburgh	23	23	27	23	25	27	26	21
East Lothian	3	5	4	2	2	1	2	2
Midlothian	4	3	3	5	5	4	3	3
West Lothian	4	6	6	5	5	6	6	6
Total incl. Other Local Authority Areas	34	37	40	35	37	38	37	32

Timescale for Improvement – East Lothian IJB

A trajectory had been proposed by East Lothian that covers all delayed discharges—those that are part of the monthly census and those that are excluded from the census, and is set out below: - whilst a trajectory has not been required to be agreed with SGHD, the numbers below are a suggested trajectory for East Lothian. However since July 2016 was significantly off trajectory it has been agreed that a revised trajectory is required. This is in the table below. It should be noted that East Lothian has been ahead of trajectory. At February 2017, there were 27 delays in total at the census –made up of 25 standard and 2 re-provisioning, with zero complex delays, against a target of 31

Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17	April 17
56	50	44	47	31	25	20

Actions Planned and Outcome – East Lothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
East Lothian has funded additional capacity in Hospital to Home using delayed discharge fund.	Completed	Reductions in delayed discharge.	April 2015 total was 15	
East Lothian planning for implementation of living wage in home care	October 2016	Increase attractiveness of career in care and improve retention of staff.	Total numbers of delays have fallen to 42 on EDISON on 28/10/16	Implemented
East Lothian planning to invest c £1m of social care fund in purchasing additional capacity in care at home following introduction of living wage. Innovative procurement methods will be used to secure blocks of activity for people delayed in hospital.	October 2016	Increase capacity of care at home	To be determined	Achieved, purchasing budgets increased as planned.
Investment in ELSIE through Integrated Care Fund to provide 24/7 cover to prevent hospital admission.	tbc	Avoid admission and support rapid discharge	To be determined	Being planned
Retendering of current care at home framework	April 2017	Improve capacity of providers in tandem with Living Wage implementation.	To be determined	Contracts awarded and implementation begins in April 2017
Introduction of second additional team in hospital to home service	October 2016	More care hours – 4 more complex packages	4 packages	Implemented
Introduction of third additional team in hospital to home service	November 2016	More care hours – 4 more complex packages	4 packages	Implemented
Support care home to reopen	September/October 2017	Reduction in numbers waiting for care home by at least 11 (current number of vacancies)	N/A	care home fully now open –but still under restrictions following most recent CI inspection
Consider bringing unused NHS or Council capacity into use.	tbc	Up to 10 residential care home places (but only 1 waiting at present – so not value for money)	N/A	Keep under consideration

Comments – East Lothian IJB

Reasons for Current Performance

The key issue is capacity of care at home providers to meet demand. The actions above are mostly aimed at addressing this factor. The care home market is vulnerable in East Lothian, however, temporary cessation of admissions to one large care home has been reversed and patients/ clients who have this as one of their choices are being admitted on a phased basis. This will reduce the number of people waiting for care homes.

Delayed Discharges – Edinburgh Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

For reporting at **April 2017** meetings

Target/Standard: To minimise delayed discharges over 3 days, with none over 14 days, pending national clarity.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Improving	Worse	Jan 17	0 (max)	230 (>3 days, excl. Code 9s ⁷ & 100s ⁸)	Feb 17	Trak	Yes	Yes	RMG
Edinburgh IJB Performance							171 (74.3% of NHS Lothian Performance)					

Summary for Committee to note or agree

- Targets for the reduction of delayed discharge for the Edinburgh Partnership have been agreed up to December 2017 with the objective of achieving a level of 50 by the end of this period. These targets are currently under review and will be reviewed at the Flow Programme Board on 27 March.
- A comprehensive programme of actions to address delayed discharge for Edinburgh residents is being overseen by the Patient Flow Programme Board, which meets on a monthly basis. The Board has specific work streams to support improvements in discharge and admission avoidance and in September a **whole system** self-assessment was undertaken to determine performance against best practice. This was intended to enable the Flow Board to review targets and oversee the improvement plan to be developed through the self-assessment process.
- The self-assessment event led to the identification of four further priority actions in the following main categories: performance dashboard, ICT strategy, procedures and practice issues for locality working and procedures and practice issues for hospital stays.

Recent Performance – Delayed Discharges

Table 1: Census Return Data - Total Delayed Discharges (incl. delayed discharges <=3 days, >3days, and Code 9s; excl. Code 100s) – Lower Count is Better⁹

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
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⁹ New national definitions from July 2016 prevent a breakdown of delayed discharges by IJB, delay reason or length of delay being provided for prior to this point, on a comparable basis.

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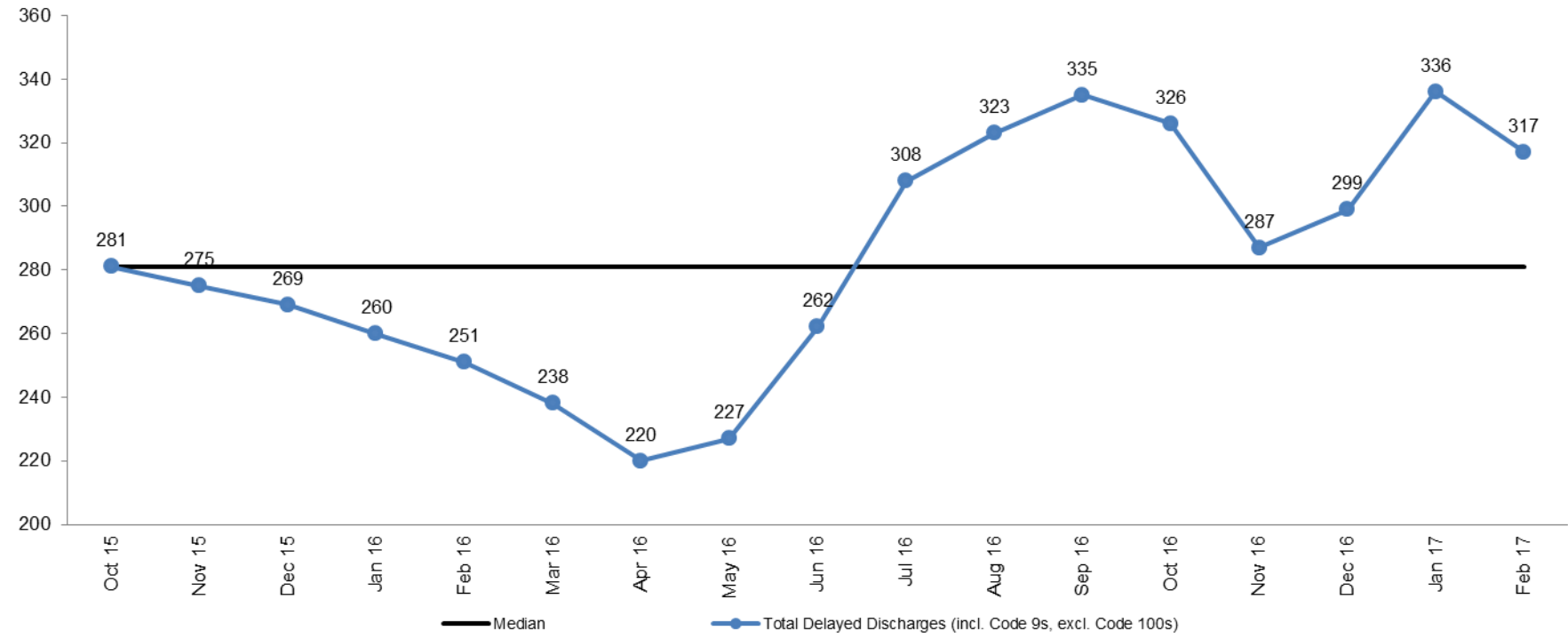


Figure 2: Census Return Data - Delayed Discharges >3 Days (excl. Code 9s & 100s) – Pre & Post-Definition Change – Lower Count is Better

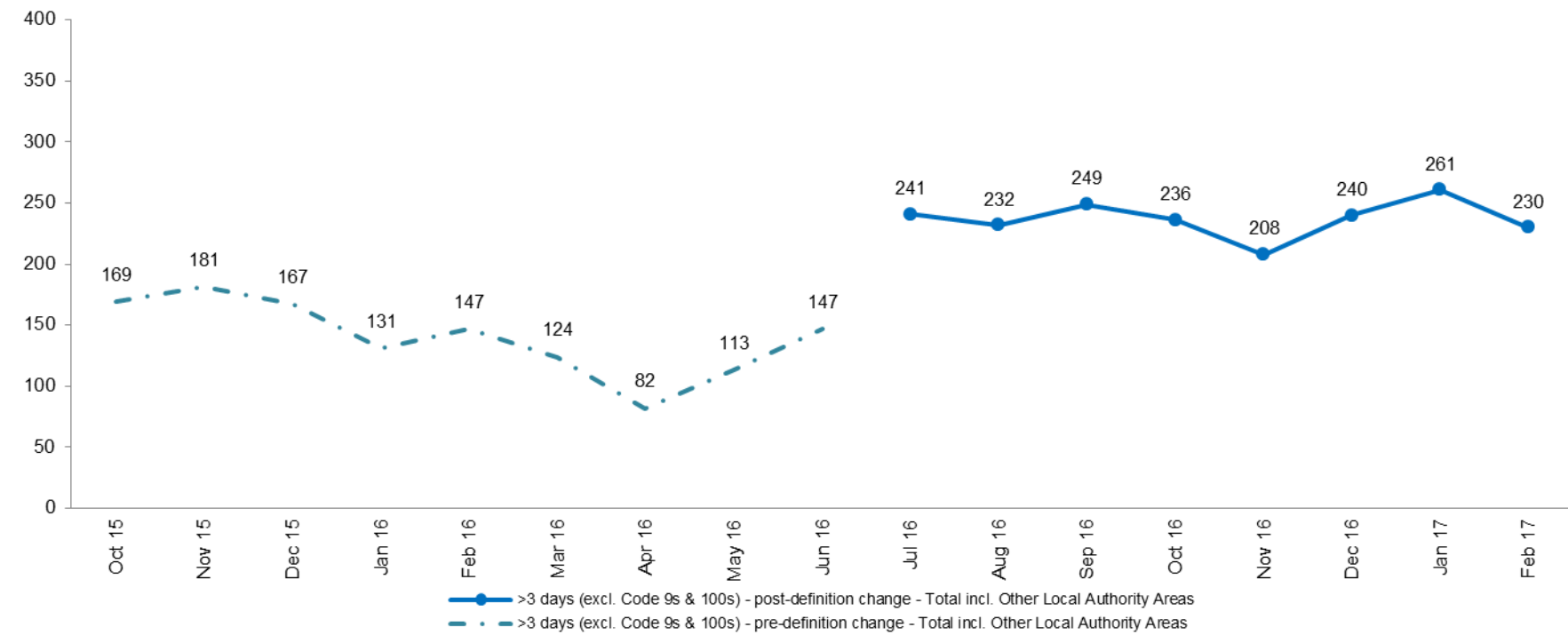


Table 2: Census Return Data - Delayed Discharges – New Methodology – Lower Count is Better

	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
<=3 days (excl. Code 9s and 100s)								
City of Edinburgh	20	26	23	32	28	15	28	38
East Lothian	2	11	14	9	4	11	12	1
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West Lothian	4	6	6	5	5	6	6	6
Total incl. Other Local Authority Areas	34	37	40	35	37	38	37	32

Timescale for Improvement – Edinburgh IJB

A trajectory for the period to May 2016 was agreed with SGHD for the Edinburgh partnership, and set out below:-

Reportable Delays excluding x codes					>2 weeks (derived from all reportable delays excluding x codes)					>4 weeks (derived from all reportable delays excluding x codes)					All targets
Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	From June 16
118	100	80	55	50	64	46	26	1	0	36	33	15	0	0	TBD

Actions Planned and Outcome – Edinburgh IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Continued work on the work streams initiated following the key stakeholder event in March 2016: admission avoidance; rehabilitation and recovery; supporting discharge	Ongoing	Reductions in delayed discharge Reduced delays across the pathway Reduction in hospital admissions		Work is underway and progress is being closely monitored by the Patient Flow Programme Board. This includes: <ul style="list-style-type: none"> The discharge element is focusing on complex supported discharges to ensure that the pathway for people with complex needs is as streamlined as possible and that social and health care support are available at the stage when hospital care is complete. Admission avoidance – work streams relate to the falls pathway and to anticipatory care plans (ACPs) with collaboration underway with primary and secondary care, and with care homes.

Rehabilitation and recovery – phase 2: realignment of reablement provision to ensure effective use of the resource. This is part of the demand management work stream, being led by EY.	June 2016	With more effective targeting of the reablement service to people who are likely to benefit, it is anticipated that there will be a greater reduction in the level of support needed.	Average package reduction: 57% (target was 45%)	Work is proceeding on phase 2: <ul style="list-style-type: none"> There has been a pause with the arrangements to develop the bridging service, pending the outcome of the initiative to introduce a Hospital to Home Service.
Increase capacity and responsiveness of care at home through the new contracts.	November 2016	New contactors must take work within a week. In house service being restructured to support this and to enhance reablement		The next steps for the Rapid Improvement Team include: <ul style="list-style-type: none"> working with partner providers and stakeholders to design and implement a time limited whole system approach to increasing the capacity available to discharge people from hospital; continue further work with partners to: <ul style="list-style-type: none"> devise and implement a recruitment and retention strategy; and streamline the referral and service matching process, including the potential introduction of an online process. identify differences between volumetric assumptions in providers business cases and the actual situation on the ground, and determine whether these can be addressed within the contracted commercial terms; examination of the Innovation contracts and how they link to the Care at Home contract; and hold a third workshop with locality teams and partner providers.
Actions resulting from the whole system self assessment: performance dashboard, ICT strategy, procedures and practice issues for locality working and procedures and practice issues for hospital stays.	Ongoing	Improved flow and prevention of unnecessary hospital admission.		Work is ongoing to develop a performance overview of the whole system. Two operational managers (one locality manager and one hospital based manager) are part of the project team and are identifying the performance information they need to enable them to develop an understanding of the whole system, and to initiate in-depth analysis of areas of concern. Work to prepare for the full implementation of the MATTs and Hubs is underway. The aim is to implementation to begin early in the new year. Preparations include determining ICT requirements and this is being overseen by the ICT Steering Group.
Mental health – the aim is to reduce delayed discharges for adults with incapacity who are going through the guardianship process and to accommodate reduced bed capacity for mental health patients	30 Jan 2017	Reduced delayed discharges for a) people with mental health problems and b) adults with incapacity		Current work includes: <ul style="list-style-type: none"> Ongoing work to address Guardianship-related delays: the number of people who are delayed for this reason has reduced from 26 to 9. Progress of REH Phase 1 is scrutinised by the Flow Board. All three work streams now have a RAG status of green: provision for adults under age 65, for people aged 65+ and the development of the community infrastructure needed to offset the reduction of 7 acute beds.
Weekly delayed discharge management meetings	Ongoing	Reduction in delays and greater shared awareness of system-wide challenges and pressures		Weekly meetings have been introduced, chaired by the newly appointed Chief Strategy and Performance Officer and attended by a range of people including the four Locality Managers and the four Hub Managers, where delayed discharge levels and associated activity are being closely scrutinised, and any gaps in capacity or problems arising from current processes will be identified and addressed.

Comments – Edinburgh IJB

The number of reportable delays in Edinburgh increased in January from 185 to 216 (excluding complex cases i.e. code 9s).

The main reason for delay continues to be waiting for domiciliary care, but there are also a significant number of people waiting for a care home place. Recruitment of people to posts in the care sector remains a challenge within Edinburgh.

A self assessment of the current approach in Edinburgh to tackling delays in transfer of care has been undertaken, utilising the best practice guidance contained within the Joint Improvement Team “Self Assessment Tool for Partnerships” (updated 2015) and The National Institute for Health and Care Excellence guidelines (Dec 2015) for “Transition between inpatient hospital settings and community or care home settings for adults with social care needs”. The results of the self-assessment are forming the basis of further improvement actions as outlined above.

Reasons for Current Performance

Waiting for care arrangements continues to be the most common reason for delay (97 people) followed by people waiting for care home place (77). Recruiting staff to posts in the care sector remains a challenge in Edinburgh.

Delayed Discharges – Midlothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

For reporting at **April 2017** meetings

Target/Standard: To minimise delayed discharges over 3 days, with none over 14 days, pending national clarity.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Improving	Worse	Jan 17	0 (max)	230 (>3 days, excl. Code 9s ¹⁰ & 100s ¹¹)	Feb 17	Trak	Yes	Yes	EM
Midlothian IJB Performance							10 (4.3% of NHS Lothian Performance)					

Summary for Committee to note or agree

- The performance within Midlothian remains off-target but is an improvement on previous performance, with 9 patients delayed, which is a reduction on the 17 patients reported in December. There has also been an overall reduction in all delays within Midlothian.
- The continues to be challenges in providing care at home, with a provider indicating that the contract for care at home services in the west of Midlothian will end on 31 March 2017.
- The ongoing work to support early discharge from acute settings to the Midlothian Community Hospital has continued to result in a significant reduction in the number of patients delayed in the RIE, WGH and Liberton Hospitals.

Recent Performance – Delayed Discharges

Table 1: Census Return Data - Total Delayed Discharges (incl. delayed discharges <=3 days, >3days, and Code 9s; excl. Code 100s) – Lower Count is Better¹²

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
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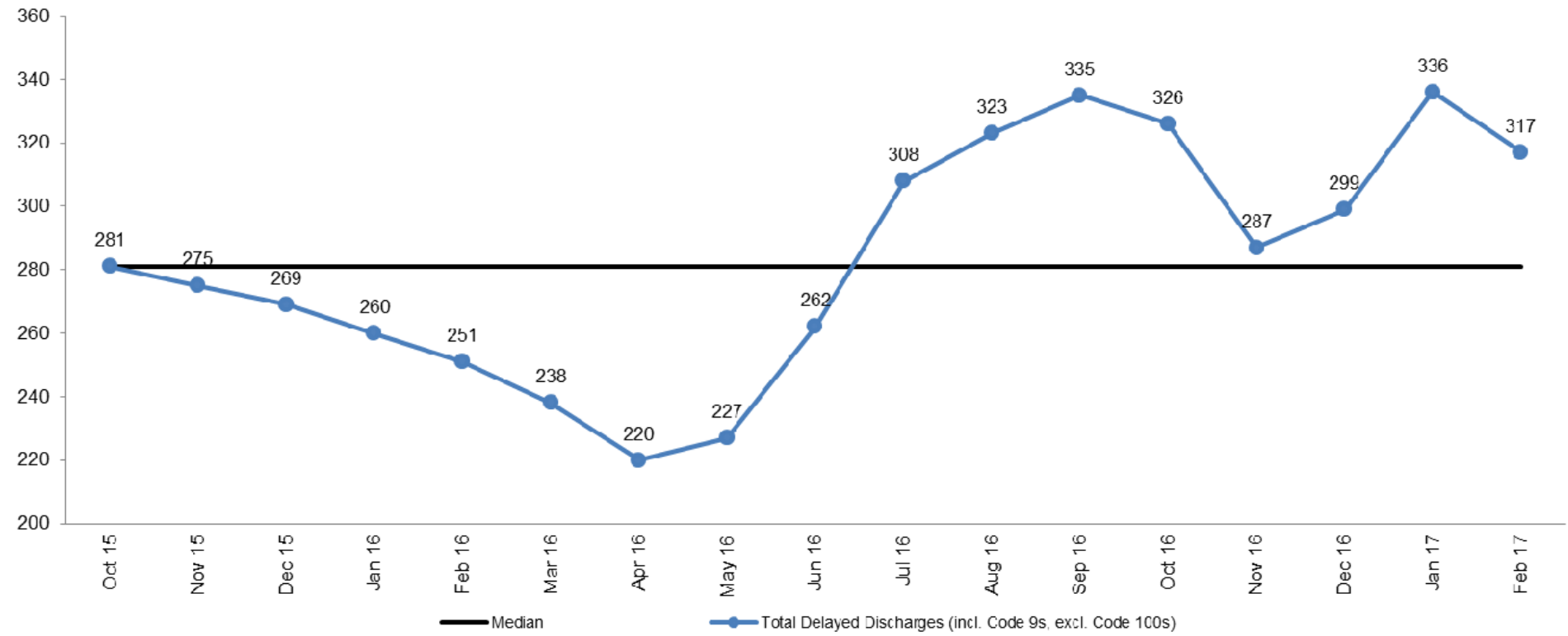


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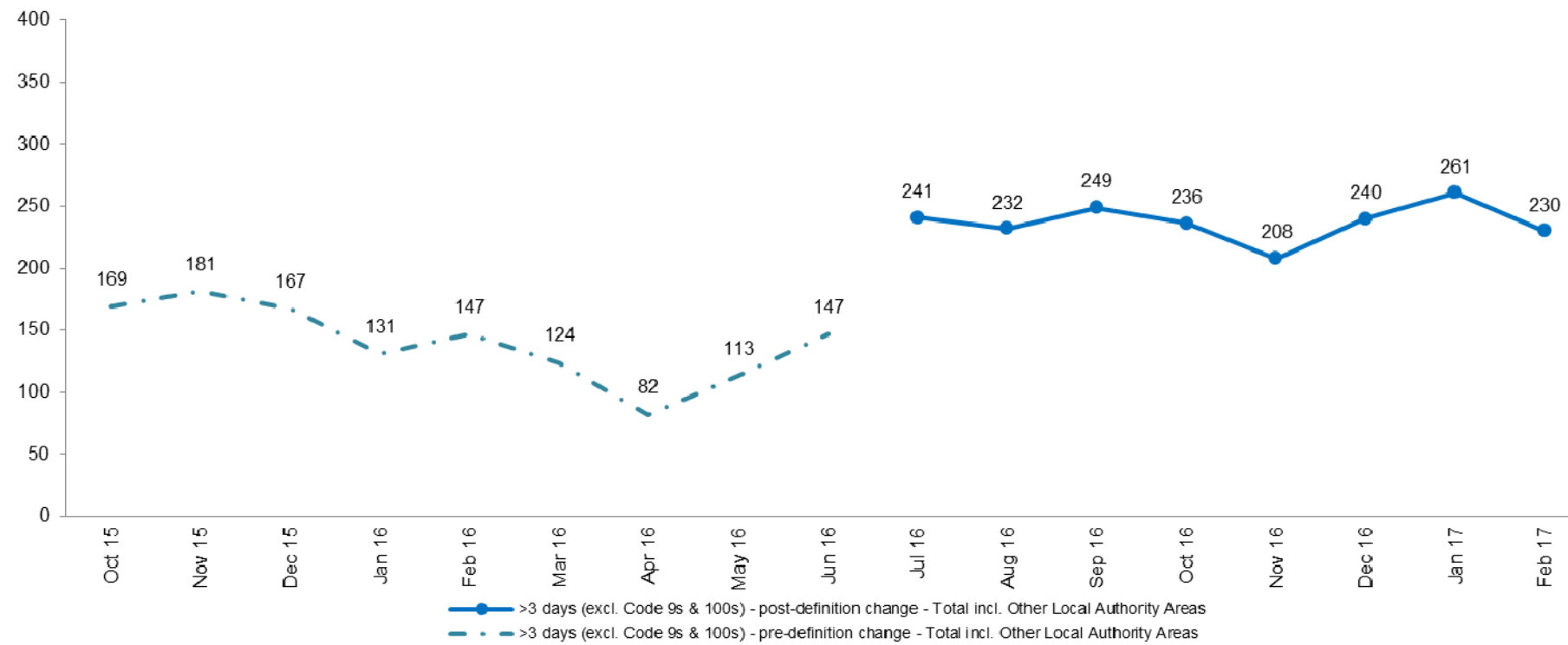


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West Lothian	4	6	6	5	5	6	6	6
Total incl. Other Local Authority Areas	34	37	40	35	37	38	37	32

Timescale for Improvement – Midlothian IJB

A trajectory has been agreed with SGHD and set out below (or please provide alternative information, if a trajectory has not been agreed):- The target for Midlothian has now been revised to reflect the ongoing pressures within care at home services and challenges in achieving discharge within agreed timescales. The current performance in Midlothian is in line with the revised trajectory.

May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	April 2017	May 2017
0	10	10	10	10	10	10	10	10	10	10	10	10

Actions Planned and Outcome – Midlothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Action Plan developed and being implemented to address under-performance by Care at Home provider	31 July 2016	Increase in care packages	No benefit delivered with existing provider	The actions have not yielded any benefits as the Provider is not able to take on further packages of care. The Provider has now handed back the service contract.
Increased capacity within Hospital Inreach Team to support improved discharge across acute and community sites	31 Aug 2016	Reduced length of stay and delays	Additional support for team to increase discharges	Member of staff has now been appointed and is supporting patient discharges
Appointment of 10 additional Care Support Workers within the Complex Care Team to increase capacity	30 Sept 2016	Additional 10 packages of care for complex discharges	To be monitored through Reablement systems (CRM2000)	Interviews completed and HR checks now being completed – only 5 workers appointed so further recruitment now underway.
Development of dementia and complex care beds within Partnership run Care Home to support increased choice for LA funded service users	30 Sept 2016	Reduced length of stay and delays, particularly for dementia patients	To be determined through service management	New staffing model being implemented within the Care Home to reflect changed focus of care. Interviews currently underway for staff following service review and NHS Lothian nursing staff (2.6wte) have now been appointed and will take up post in October and

				November.
Increased medical input to MERRIT (Hospital at Home) with further 0.6 wte doctor	30 Sept 2016	Increase in the number of patients accepted in to the service	To be monitored through MERRIT reporting processes	GP with 6 sessions now in post and increased medical cover to 1.1wte doctors per week.
Agreement being reached with alternative provider to consider options for delivering care at home service	30 Sept 2016	Stability within the service and planned increase in care packages	To be monitored through weekly contract management	Agreement reached with Carr Gomm to take on the Service from 6 November and to work towards developing a new model of care through a Public Social Partnership by April 2017.
Expansion of MERRIT (Hospital at Home) Service to enable growth in beds on virtual ward by 50% (10 to 15 beds)	31 Oct 2016	Increase in admission avoidance and more supported discharge	To be monitored through MERRIT reporting processes	Advanced Practitioner Physiotherapist will take up post on 6 February
Agreement to recruit additional nursing staff within MERRIT to support the expansion noted above.	31 Dec 2016	Increase in admission avoidance and more supported discharge	To be monitored through MERRIT reporting processes	Posts now being advertised – still ongoing
Appointment of staff to review care packages to identify additional capacity within the system	31 Dec 2016	Increased capacity through review process	To be monitored through Resource Panel	Staff now in place and actively reviewing care packages – additional capacity now being identified within the system.
Implementation of a 4 week pilot to divert all possible nursing home admissions to the Flow Centre and then to MERRIT to prevent admission to hospital	31 Dec 2016	Reduce admissions from Care Homes	Being monitored through the pilot	There has been a continual reduction in admissions from Care Homes
Increased use of Midlothian Community Hospital to support patient moves to downstream beds and relieving some of the pressures on acute sites	1 Nov 2016	Reduced number of patients delayed on acute sites	Significant reduction in patients who are delayed at RIE and WGH	This remains an effective model for reducing delays on acute sites and will be continued in 2017
Review of in-house service provision to increase capacity within Reablement through more effective use of the Complex Care service	15 Jan 2017	Increased capacity within homecare	33 service users moved to complex care	An additional 206 hours has been moved to the complex care service, releasing additional capacity within Reablement
Additional management support being provided to external Care at Home provider to address concerns over service delivery	Feb 2017	Sustainable position for Care at Home provider	Early indication suggests some improvements in the service	Management input will continue over the coming weeks and months
Work underway to transfer care at home service that is now due to end on 31 March 2017 to ensure continuity of care for clients	Mar 2017	Reduce the impact of service withdrawal	Will be monitored through internal management arrangements	Work progressing to manage transition process

Comments – Midlothian IJB

Reasons for Current Performance

Whilst there have been improvements in performance in Midlothian, it remains below target and, as reported last month, is a result of the significant challenges within the care at home sector, which is both a local and national issue. There continues to be one provider under large scale investigation, which is limiting capacity for new packages of care and it has now been confirmed that another provider will not continue providing a service in Midlothian from 31 March 2017. However, we continue to work closely with all providers to ensure a safe and consistent service is being delivered. The ongoing work to maximise the use of the Community Hospital is supporting an overall reduction in patients who are delayed on acute sites.

Delayed Discharges – West Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

For reporting at **April 2017** meetings

Target/Standard: To minimise delayed discharges over 3 days, with none over 14 days, pending national clarity.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	Not Met	Improving	Worse	Jan 17	0 (max)	230 (>3 days, excl. Code 9s ¹³ & 100s ¹⁴)	Feb 17	Trak	Yes	Yes	JF
West Lothian IJB Performance							24 (10.4% of NHS Lothian Performance)					

Summary for Committee to note or agree

- Target to reduce delayed discharge level is based on scheduled investments and anticipated benefits.
- A comprehensive programme of actions to address delayed discharge is incorporated within the West Lothian Frailty Programme which is focussed on improvements across the whole system of Health and Social Care. The Frailty Programme Board continues to monitor the programme and identify priorities for further work.
- Some improvement noted in Care at Home Contract provision which is being augmented with hospital to home/ community nursing teams to facilitate discharge and provide interim care until POC established.
- January census position has 36 standard delays over 3 days.
- We are continuing to review all delayed discharge cases to track the key issues and are addressing these within our unscheduled care plans
- We have put in additional MHO resource to Discharge Hub to focus on Code 9 delays.
- MDT support to focus on consistent application of Moving On Policy.
- Weekly meetings held to progress work plan and monitor performance.

Recent Performance – Delayed Discharges

Table 1: Census Return Data - Total Delayed Discharges (incl. delayed discharges <=3 days, >3days, and Code 9s; excl. Code 100s) – Lower Count is Better¹⁵

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
City of Edinburgh										198	192	201	225	198	203	228	222
East Lothian										40	61	60	41	26	47	41	25
Midlothian										24	27	34	21	22	22	16	18
West Lothian										40	38	38	36	41	26	51	49
Total Delayed Discharges (incl. Code 9s, excl. Code 100s)	281	275	269	260	251	238	220	227	262	308	323	335	326	287	299	336	317

¹³ Code 9s are used for 'complex' cases - they are codes used when a partnership is unable, for reasons beyond their control, to secure a patient's safe, timely and appropriate discharge from hospital.

¹⁴ Code 100 is used for commissioning/re-provisioning.

¹⁵ New national definitions from July 2016 prevent a breakdown of delayed discharges by IJB, delay reason or length of delay being provided for prior to this point, on a comparable basis.

Figure 1: Census Return Data - Total Delayed Discharges (incl. Code 9s, excl. Code 100s) – Lower Count is Better

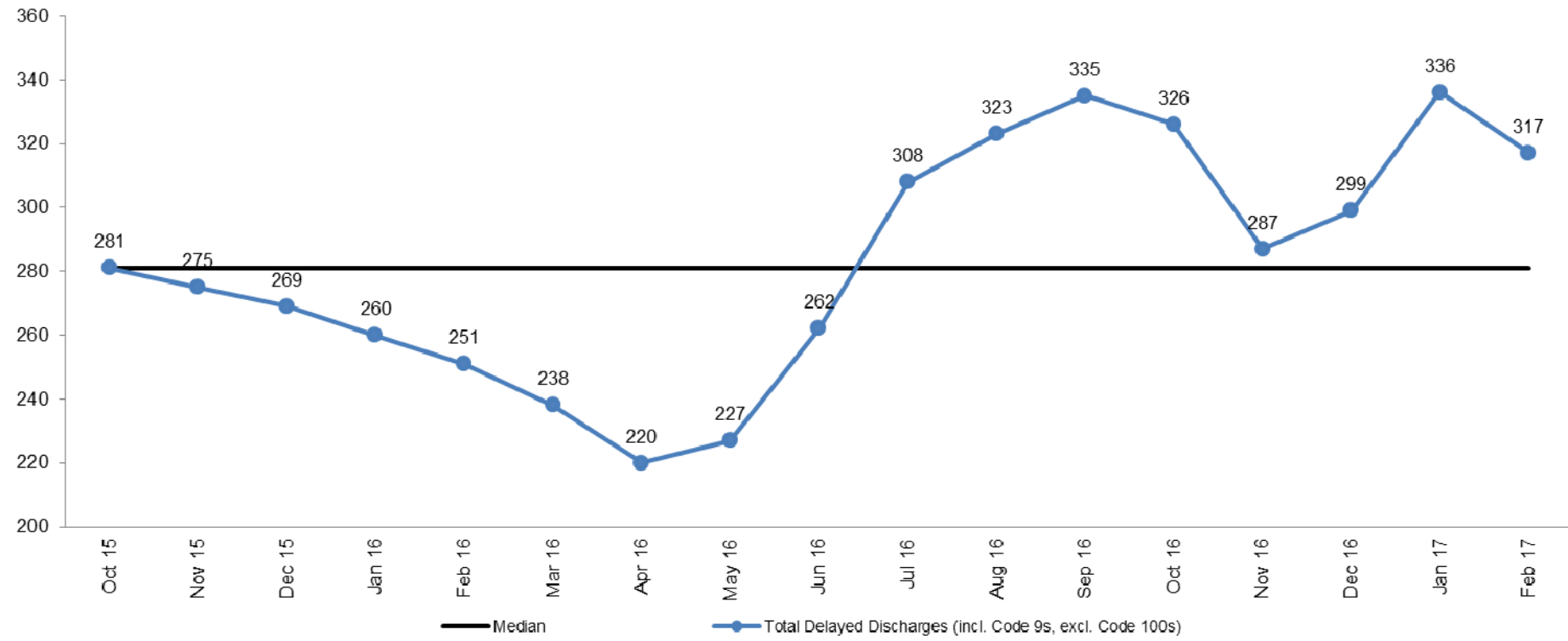


Figure 2: Census Return Data - Delayed Discharges >3 Days (excl. Code 9s & 100s) – Pre & Post-Definition Change– Lower Count is Better

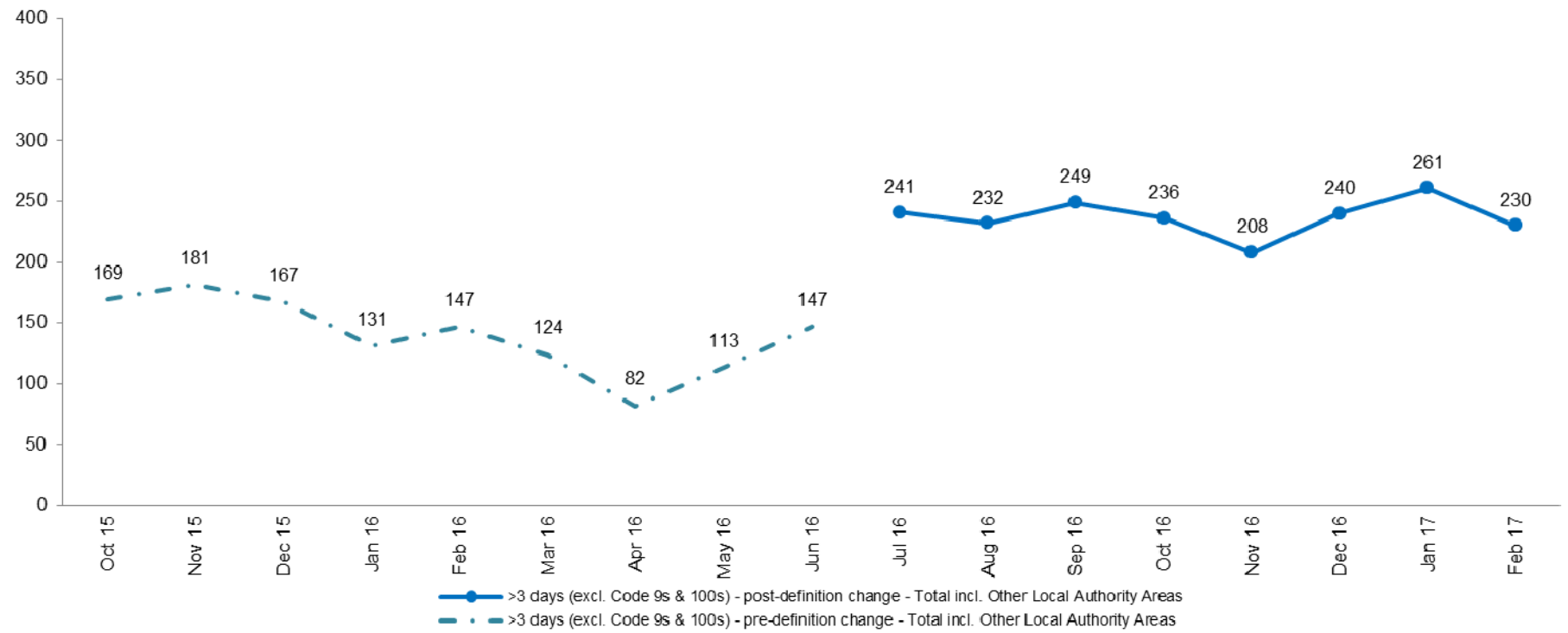


Table 2: Census Return Data - Delayed Discharges – New Methodology – Lower Count is Better

	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
<=3 days (excl. Code 9s and 100s)								
City of Edinburgh	20	26	23	32	28	15	28	38
East Lothian	2	11	14	9	4	11	12	1
Midlothian	2	8	4	5	7	1	4	2
West Lothian	4	10	6	8	10	6	11	18
Total incl. Other Local Authority Areas	29	55	47	55	49	33	55	61
>3 days (excl. Code 9s and 100s)								
City of Edinburgh	153	144	155	168	148	170	188	171
East Lothian	35	47	44	31	21	35	28	24
Midlothian	15	13	25	12	13	17	9	10
West Lothian	33	23	23	23	26	17	36	24
Total incl. Other Local Authority Areas	241	232	249	236	208	240	261	230
Code 9s								
City of Edinburgh	25	22	23	25	22	18	12	13
East Lothian	3	3	2	1	1	1	1	0
Midlothian	7	6	5	4	2	4	3	6
West Lothian	3	5	9	5	5	3	4	7
Total incl. Other Local Authority Areas	38	36	39	35	30	26	20	26
Code 100s								
City of Edinburgh	23	23	27	23	25	27	26	21
East Lothian	3	5	4	2	2	1	2	2
Midlothian	4	3	3	5	5	4	3	3
West Lothian	4	6	6	5	5	6	6	6
Total incl. Other Local Authority Areas	34	37	40	35	37	38	37	32

Timescale for Improvement – West Lothian IJB

An official trajectory for West Lothian has not been agreed with the SGHD.

Improvement plan and trajectory agreed locally and performance monitored on a weekly basis

Actions Planned and Outcome – West Lothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Established Frailty Programme with following aims <ul style="list-style-type: none"> To design a whole system model of care for frail elderly adults that meet overall IJB strategic priorities To reduce hospital admission and re-admission and minimise delayed discharge To contribute to the financial efficiencies of the IJB To identify areas of skills development to support the new model of care. 	March 2017	Reduction in emergency admission Reduction in delayed discharge.	Frailty programme work streams reviewed and priorities identified Delayed discharge clearly identified within the work stream Additional work stream on Intermediate Care commenced	Green
Embedding of new Care at Home contract: Performance management of providers to meet terms of contract	Mar 2017	Increase capacity of Care at Home provision Reduction in delayed discharge	Care at Home Contract fully implemented from April 2016 Proportion of reablement capacity blocked with clients with unmet needs reduced as independent providers are providing more packages of care leading to increased capacity in Reablement and Crisis Care teams	Amber
Further development and expansion of REACT	Dec 2016	Reduction in emergency admission	REACT providing acute care at home, good evidence of success in reducing admission and high level of patient and carer satisfaction.	Amber

		Reduction in delayed discharge	Development plan in progress within overall Frailty Programme and within unscheduled Care plan to extend provision over 7 days	
Comprehensive needs assessment is in progress which will inform the IJB Commissioning Plan for Older People	Sept 2016	Clear identification of needs for older population	Needs Assessment will inform priorities for IJB and Commissioning Plan Priorities identified within Strategic Plan	Green
Review application of Choice and Moving On Policies to ensure consistent with Lothian and Government Guidance	December 2016	Patient moved to right destination 1 st time	Awareness sessions commenced with MDT	Green
Review Interim Care Home beds and need for intermediate care provision	December 2016	Establish optimum capacity and use of downstream beds Reduce average length of stay in interim care facility Establish requirements for intermediate care	Discussion progressed with WLC and Scottish Care to establish capacity Intermediate care work stream established in Frailty programme	Amber
Provide addition MHO resource to Discharge Hub to focus on Code 9 delays	October 2016	Establish additional capacity for assessment and timeous activity to reduce delays for complex patients where possible	Ensure patients correctly coded and actions progressed to facilitate discharge process	Green

Comments – West Lothian IJB

Reasons for Current Performance

Current Capacity of Care at Home and Care Home provision continues to have impact.
We are actively working with providers to improve on time taken to arrange POC and have established team to support discharge whilst waiting on POC.
Local improvement actions implemented to focus on MDT approach and consistent application of moving on policies.
We are now looking at wrap around provision at home to support those waiting on care home to allow them to be discharged home

Staff Sickness Absence

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard: 4% Staff Hours or Less Lost to Sickness

Responsible Director[s]: Director of Human Resources and Organisational Development

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed (not yet provided to Board Committee)	To be reviewed (not yet provided to Board Committee)	Not Met	Deteriorating	Better	2015/16	4% (max)	5.45%	Jan 17	Scottish Workforce Information Standard System (SWISS) - Management Information.	Yes	No	JB

Summary for Committee to note or agree

- Performance remains slightly below standard but has decreased by 0.04% in month.

Recent Performance – % against Standard

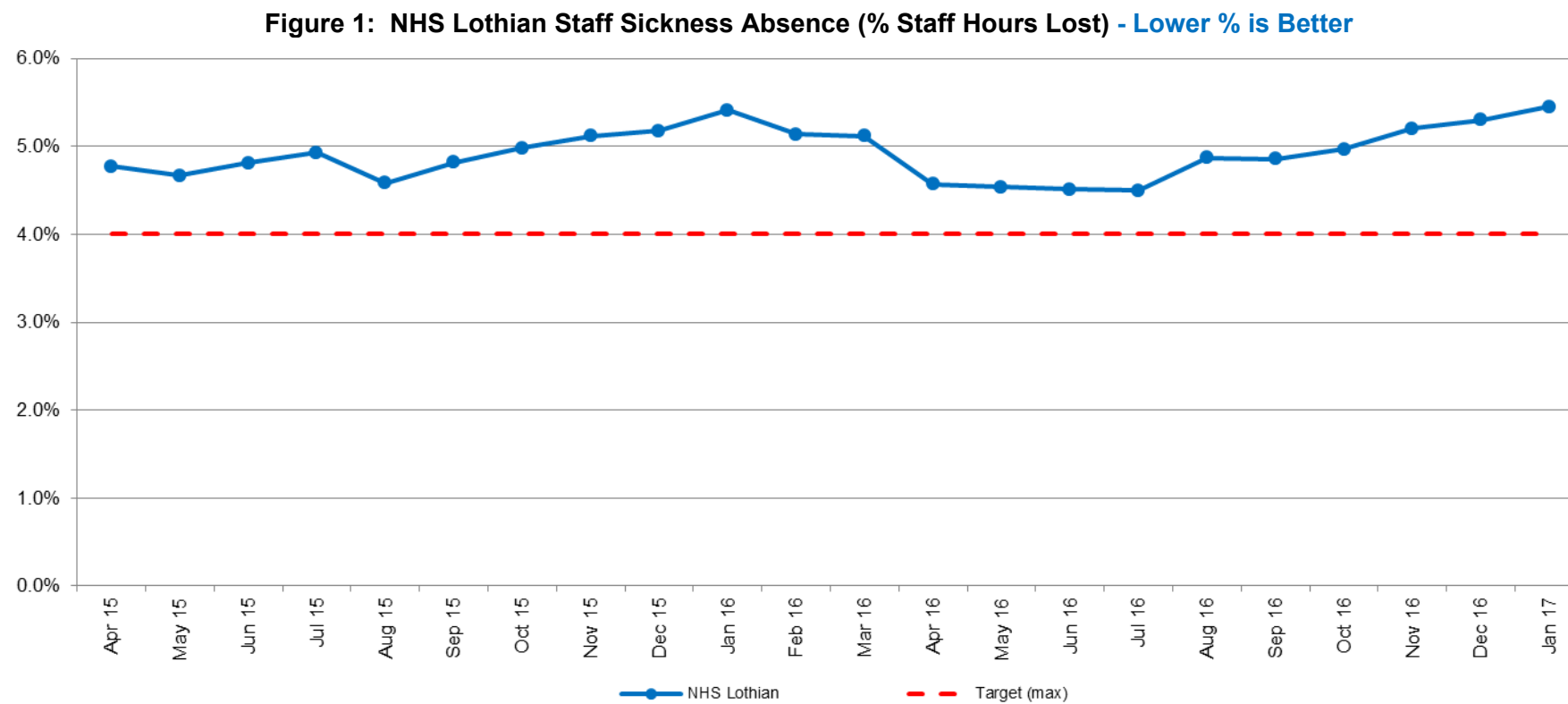


Table 1: NHS Lothian Staff Sickness Absence (% Staff Hours Lost) - Lower % is Better

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
NHS Lothian	4.77%	4.67%	4.81%	4.93%	4.58%	4.82%	4.98%	5.12%	5.18%	5.41%	5.14%	5.12%	4.57%	4.54%	4.51%	4.50%	4.87%	4.86%	4.97%	5.20%	5.30%	5.45%

Timescale for Improvement

A trajectory has not been agreed with SGHD.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Attendance Management Training Sessions continue to be held.	Ongoing			
Master Classes have also been held to assist managers in dealing with difficult conversations at work in the context of staff absence.	-			Completed
Targeted support has been put in place for absence hotspots i.e. Nursing Bands 1-5 and A&C Bands 1-4.	Ongoing			
Absence Review Panels have taken place to review how absence cases are being handled and provide further advice and guidance.	-			Completed
An Absence Dashboard available to all managers has been set up to facilitate effective performance monitoring.	-			Completed
As part of the Efficiency and Productivity Group a sickness absence project has been set up to focus on what could be put in place to assist with an improvement in absence levels. This will initially be focussed on the RIE but any successful improvements will be rolled out across NHS Lothian.	Ongoing			
An Internal Audit of Absence Management has recently taken place. The overall summary was that there are appropriate controls in place to manage sickness absence within the organisation with only a few control issues to be addressed which will now be taken forward.	January 2017			
A paper was taken to the Staff Governance Committee and the Lothian Partnership Forum in January 2017, and agreement reached that a Health and Wellbeing Strategy should be developed over the next 6 months to focus on trying to prevent absence by addressing the health and wellbeing of staff.	June 2017			

Comments

Reasons for Current Performance

We continue to be challenged in achieving the 4% standard with the added dimension of an aging workforce. The HR function will continue to provide a range of technical support and governance frameworks to support the management of sickness absence, but ultimately it is the line managers who will need to ensure that they manage absence appropriately in their areas for the required reduction in absence to the 4% level to be achieved. Outlined above are some of the actions that are being undertaken to support managers currently with this task. The sickness absence assurance levels will also be discussed and reviewed at the Staff Governance Committee in March 2017.

Smoking Cessation

Healthcare Quality Domain: Equitable

For reporting at **April 2017** meetings

Target/Standard: NHS Boards to sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas (60% in island areas).

Responsible Director[s]: Director of Public Health and Health Policy

Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated Since Last Month?	Narrative Updated Since Last Month?	Lead Director
To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Not Met	Deteriorating	Better	2015/16	1,469 quits for 2016-17; 20% i.e. 294 quits (min) – to be achieved this quarter; 50% of each quarters' target to be achieved by Pharmacy & Non-Pharmacy respectively:-	235	Jul - Sep 2016	National Smoking Cessation database	No	Yes	AKM
						a. Non-Pharmacy & Prisons – 147 (50% of overall quarter Q1 target)	171					
						b. Pharmacy – 147 (50% of overall quarter Q1 target)	64					

Summary for Committee to note or agree

- The target for Q2 2016-17 is 294 (147 for PCR Pharmacies and for 'Non-Pharmacy and Prisons' respectively).

Recent Performance – Numbers Achieved towards Standard

Table 1: Successful Quits in 40% most deprived areas for NHS Lothian for financial years 2015-16 & 2016-17 (For Quit Dates per Rolling 3 Months) - Higher is Better

Quit Dates	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16		
NHS Lothian Target (for financial year quarters) (min)	442	441	441	441	293	293	293	293	367	294	404	404
NHS Lothian Total - Overall	251	244	276	368	304	315	234	314	219	235		
50% share of NHS Lothian Target (for financial year quarters) – for PCR Pharmacies; and for Non-Pharmacy & Prisons, respectively (min)	221	221	221	221	147	147	147	147	184	147	202	202
NHS Lothian Total – Non-Pharmacy & Prisons only	224	189	195	229	210	229	155	193	156	171		
NHS Lothian Total – PCR Pharmacies only	27	55	81	139	94	86	79	121	63	64		

Figure 1: Comparison of NHS Lothian Quarterly Smoking Cessation Outcomes Against Standards* incl. 50% Target Shares (HEAT for 2014/15 & LDP for 2015/16 & 2016/17) (Source: Smoking Cessation Database for 2014/15 & ISD for 2015/16) - Higher is Better

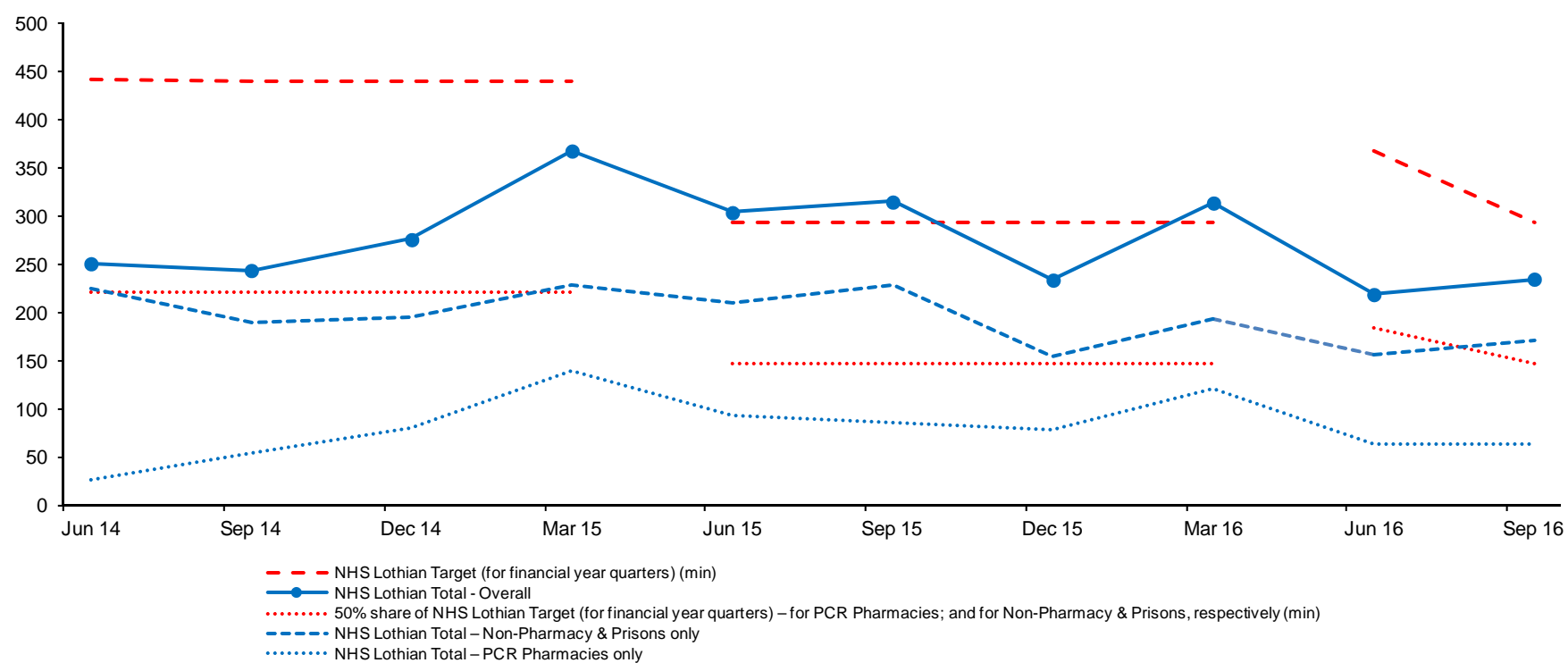
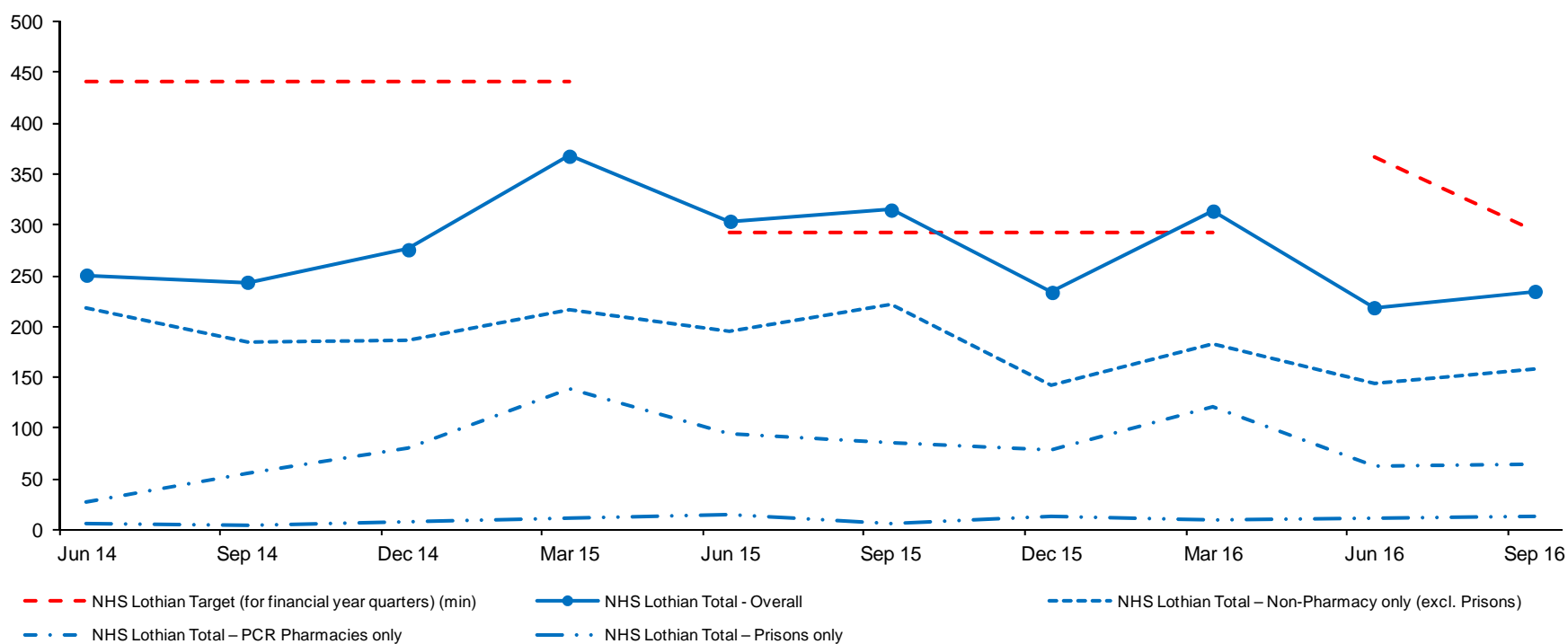


Figure 2: Comparison of NHS Lothian Quarterly Smoking Cessation Outcomes Against Standards* for Pharmacy, Non-Pharmacy & Prisons (HEAT for 2014/15 & LDP for 2015/16 & 2016/17) (Source: Smoking Cessation Database for 2014/15 & ISD for 2015/16) - Higher is Better



*Current standard is 'Successful Quits in 40% most deprived areas for NHS Lothian for financial year 2015-16 (For Quit Dates per Rolling 3 Months)'

Timescale for Improvement

A trajectory has been agreed with SGHD and set out below (or please provide alternative information, if a trajectory has not been agreed):-

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
The core NHS service is entirely funded from a Scottish Government allocation. The service remains in the process of significant redesign to meet reductions in budget including a reduction in the Scottish Government allocation. As a consequence there has been disruption to staffing levels.				

Comments**Reasons for Current Performance**

The reduction in funding was coupled by a significant increase in the target which was introduced without discussion.

Mitigating Actions

A new service manager took up post in December 2016 to take forward further improvements and will help optimise the outcomes the service can achieve against reduced funding.

New Service Manager and Consultant in Pharmaceutical Public Health established Smokefree Lothian Working Group, agreed to target low performing Pharmacies and review training and resources, including administrative support from Smokefree staff. Discussions about a future shared care model 17/18.

Complaints: 3-Day & 20-Day Acknowledgement/Response Rate

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard:

1. 3-Day Response [Acknowledgement] Rate – 100% formal acknowledgement within 3 working days;
2. 20-Day Response Rate – 80% of complaints responded to within 20 days.

Responsible Director[s]: Nurse Director

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
3-Day: Moderate	Nov 16	Not Met	Deteriorating	Worse	2015/16	100% (min)	85.0%	Jan 17	DATIX	Yes	Yes	AMcM
20-Day: Moderate	Nov16	Not Met	Improving	Worse	2015/16	80% (min)	78.0%	Jan 17		Yes	Yes	AMcM

Summary for Committee to note or agree

- There is no nationally agreed target for complaints. However we are required to submit data quarterly to Information Statistics Division and this data is published annually on their website.
- NHS Lothian has set a local stretch target of 80% for the 20 Day response rate.
- As the data is reviewed (extracted from DATIX) on a monthly basis it is anticipated that the previous months performance may be amended for accuracy as required.
- The denominator (number of complaints received) will change every month.
- Complaints account for 62% of the team's activity in January 2017. Other types of feedback include concerns, comments, enquiries and compliments.

Recent Performance – Numbers against Target/Standard

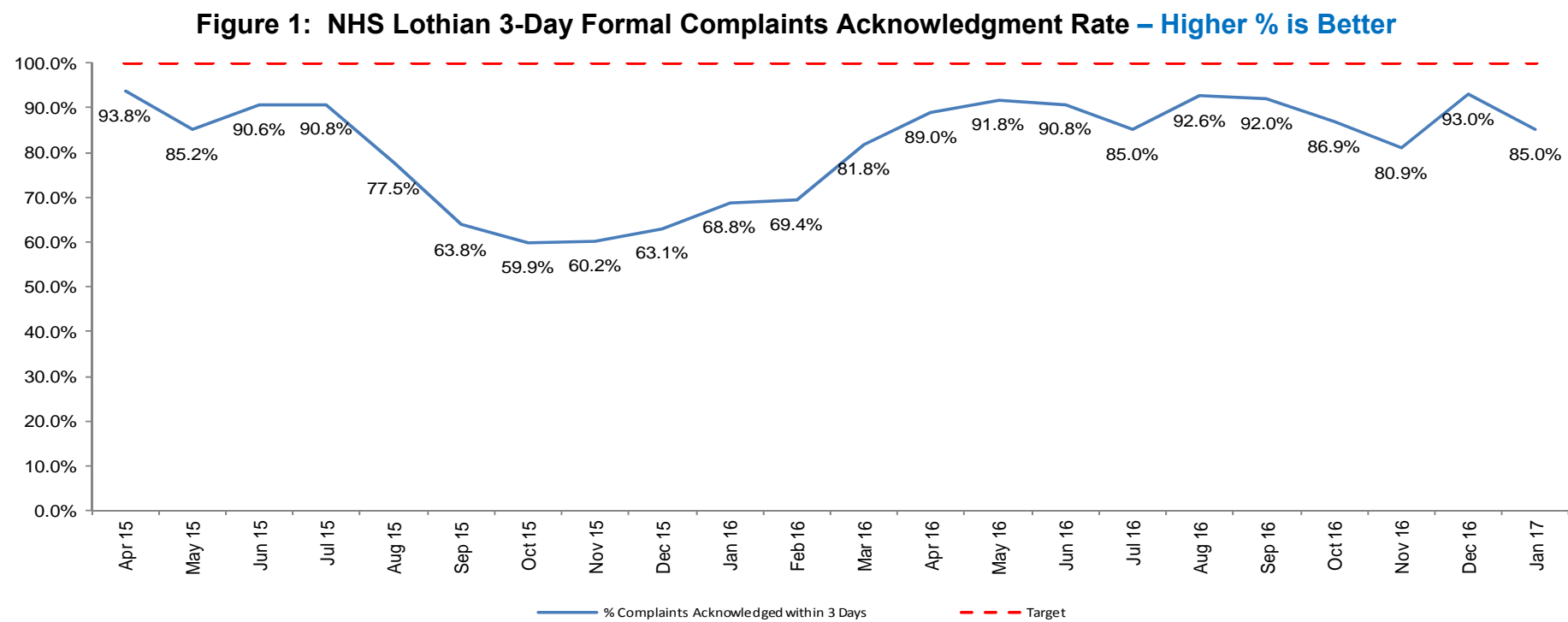
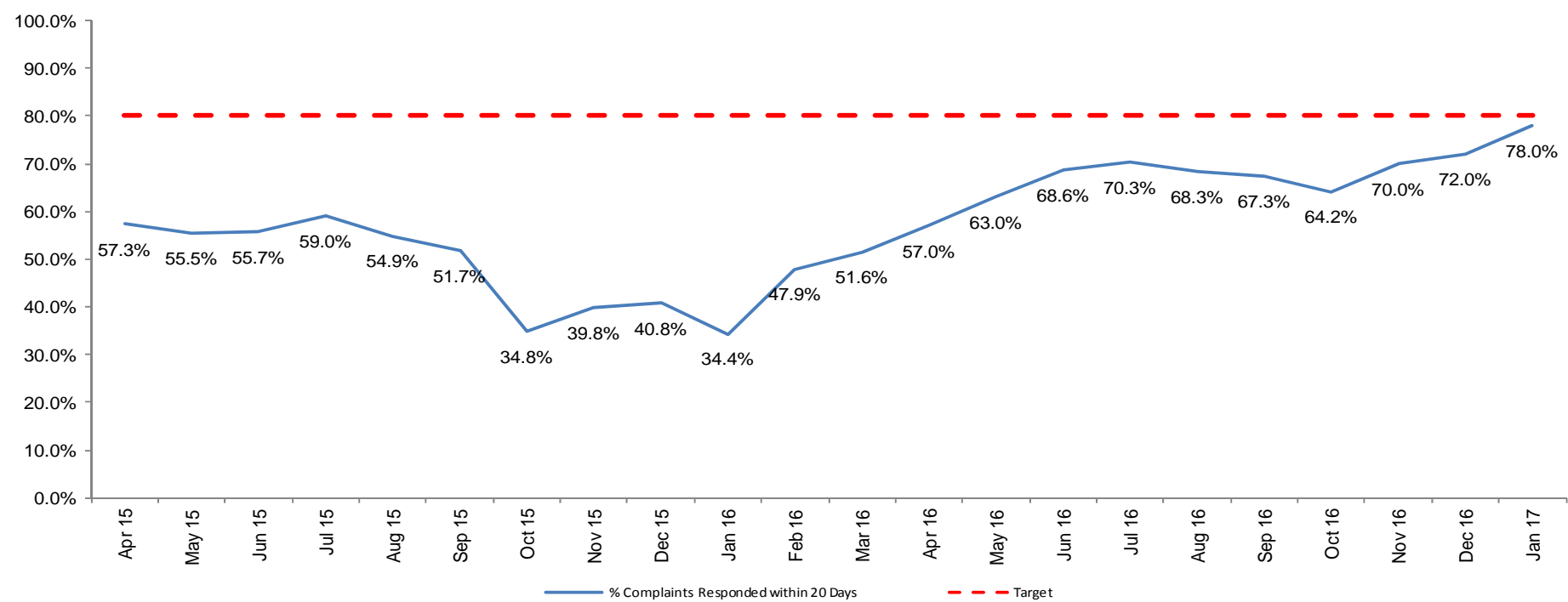


Figure 2: NHS Lothian 20-Day Complaints Response Rate – Higher % is Better



Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:-

Measure	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Reviewed targets with Executive Director. In the absence of national targets, targets have been set for 100% of complaints to be acknowledged within 3 days. 80% of complaints to be responded to within 20 working days.	Completed	Agree trajectory with LPNF- improved compliance with 20 working day response target	Improving	Amber
Appoint to vacant posts.	Completed	Improved performance to meet targets	Improving	
Non-Executive appointed as Board Champion for complaints & feedback.	Completed	Champion the process and organisational focus around improving our performance in handling but also learning from complaints and other forms of feedback. Working group established and meets monthly chaired by the non executive champion.	Organisational Focus	Green
An improvement plan has been developed for all aspects of Scottish Public Services Ombudsman activity which will be discussed and agreed by the Patient Safety Action Group in t, Healthcare Governance Committee and the Board.	April 2017	Continued improved performance, reduction of premature contacts with SPSO, shared learning/ implementation of changes across the organisation.		Amber
Appoint to vacant 2 WTE post	Completed	Improve team performance to meet targets		Amber

Comments

Reasons for Current Performance

Staff in the Patient Experience Team have been working to improve the performance with the 3-day acknowledgement measure (NHS Lothian – 85%). The data was reviewed in more detail and it was found that the prison services were having some difficulties with the 3-day acknowledgements. Of the 298 complaints received, there were 114 complaints relating to prisons, of which 38 were acknowledged outwith 3-days. Of the remaining 184 complaints, all except 1 were acknowledged within 3-days. PET has been working with HMP Addiewell staff to test a new acknowledgment process and this commenced at the end of January. Work is continuing with the SPSO re improvement work in women’s services and maternity and with the Patient Experience Team. Work is also continuing with the new policy and procedure to meet the new legislation on complaints handling from 7th April 2017. The draft policy is currently out for consultation on the consultation zone and we are reviewing the capacity within the team and in light of the new legislative demands options re complaint handling.

Detect Cancer Early (DCE)

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard: 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%.

Responsible Director[s]: Director of Public Health & Public Policy

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Significant	Nov 16	Not Met	Improving	Better	2014 & 2015 (Combined Calendar Years)	29% (min)	27.1%	2014 & 2015	ISD	No	No	AKM

Summary for Committee to note or agree

NHS Lothian’s performance over time against this target has been consistently above the All Scotland position and has followed a continued upwards trajectory in detection of stage 1 combined cases, as shown in the chart below. NHS Lothian has increased the percentage of breast, colorectal and lung cancers (combined) detected at stage 1 by 19.9% from the baseline years of 2010 & 2011 to the final reporting period of 2014 & 2015. Scotland as a whole saw an increase of 8.0% in the same period. In NHS Lothian over the 2014 & 2015 period 27.1% of breast, colorectal and lung cancers (combined) were detected at stage 1 compared with 25.1% for Scotland as a whole. NHS Lothian delivered the second highest percentage improvement of all the mainland Boards. However along with all other mainland Boards we fell short of the final targeted performance level of 29% of breast, colorectal and lung cancers (combined) being detected at stage 1.

We will not be in any position to update from a data perspective until June 2017. ISD release national annual figures. Or from a funding perspective, until we hear from Scottish Government on the outcome from the Board’s cancer implementation submission – no date given for feedback from SG.

Bowel screening annual report for 2014-16 (covering KPIs for the complete pathway from uptake through to detection and staging of disease), submitted along with cancer plan (March 2017). Performance against KPIs reviewed by national governance committee in October 2016. No flags or actions recommended for NHS Lothian.

Recent Performance – Numbers Against LDP Target

Figure 1: Current Performance for NHS Scotland and NHS Lothian – Higher % is Better

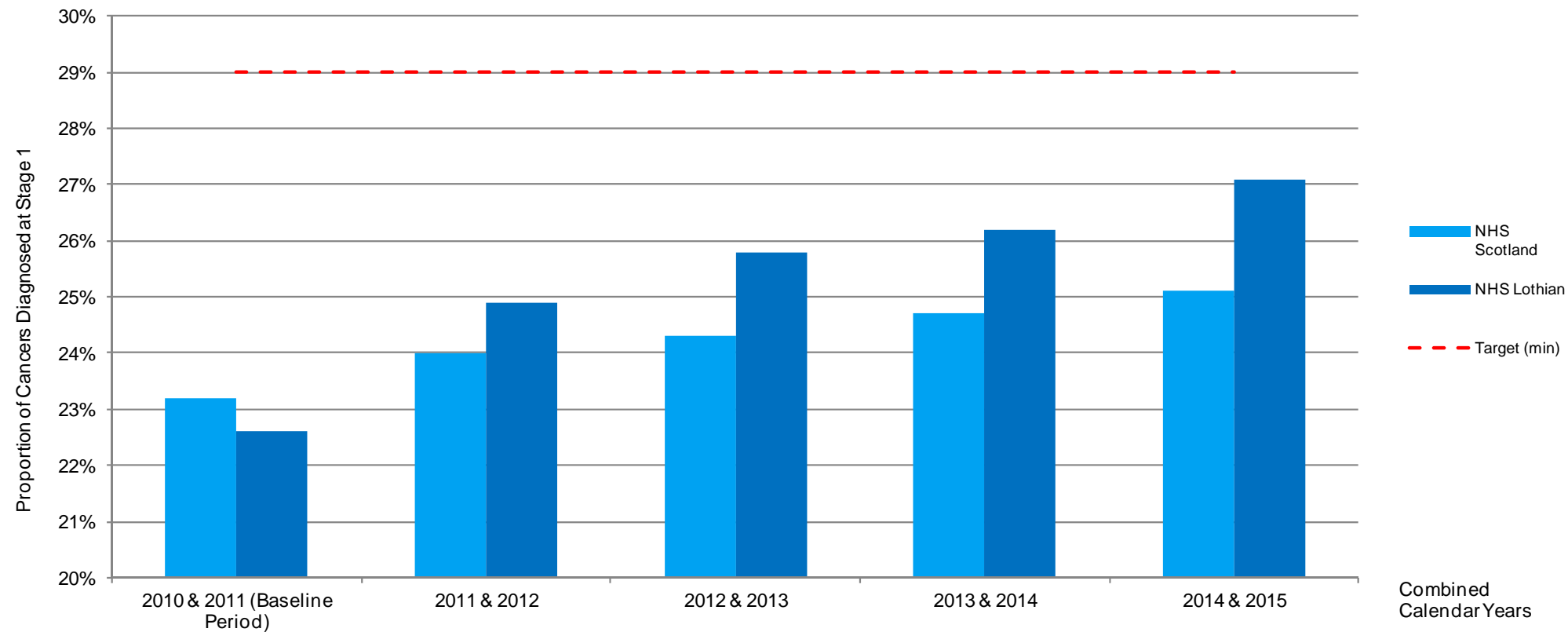


Table 1: Current Performance for NHS Scotland and NHS Lothian – Higher % is Better

	Combined Calendar Years				
	2010 & 2011 (Baseline Period)	2011 & 2012	2012 & 2013	2013 & 2014	2014 & 2015
NHS Scotland	23.2%	24.0%	24.3%	24.7%	25.1%
NHS Lothian	22.6%	24.9%	25.8%	26.2%	27.1%
Target	29.0%	29.0%	29.0%	29.0%	29.0%

Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:-

	Baseline Period (2010 & 2011) – Actual Figure	Reporting Period 4 (2014 & 2015) – Target Figure
NHS Scotland	23.2%	29.0%
NHS Lothian	22.6%	29.0%

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Investment in the Lothian DCE programme in 2016/17	31/3/16 outcome awaited	Stage 1 detection performance improvement, particularly via the breast and bowel screening programmes.		Ongoing

Comments

NHS Lothian's programme is aligned to the 5 DCE work streams; public awareness, informed decision making in screening, primary care detection and referral behaviour, increasing diagnostic capacity, data evaluation and outcomes. Key initiatives during 2015/16 included rollout of digital mammography, policy changes to cervical age range and frequency changes, new referral pathways for lung cancer, multi-disciplinary audit, implementation of the bowel screening quality and outcomes framework (sQoF) and support for targeted social marketing (television and radio platforms, use of social media and field activity e.g. football matches and shopping centres).

Reasons for Current Performance

Mitigating Actions: Impact on colorectal performance across all Boards will be subject to the conclusion of the bowel screening QoF (March 2015). Discussions remain ongoing with finance colleagues concerning budgets for 2016/17 - lack of funds are likely to compromise NHS Lothian's future performance.

Dementia – East Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard:
 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.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	TBC ¹⁶	Not Applicable	1. Worse 2. Worse	2014/15	TBC ¹⁷	1. 25% 2. 64%	2014/15	ISD	Yes	No	DS
East Lothian IJB Performance ¹⁸							1. Tbc 2. Tbc					

Summary for Committee to note or agree

ISD have published data against the standard for the first time on 24th January 2017. Data is reported at NHS Health Board level only against both elements of the standard (please see 'Target/Standard'. Performance against the Standard as a whole is also reported. Please note that the data reflects diagnosis on the year 2014/15.

Recent Performance – % against Standard

Table 1: NHS Board performance against the LDP Standard for financial year 2014/15 – Higher Rate is Better

Part 1:-	Estimated Incidence of Dementia ¹⁹	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS ²⁰	Delivered Successfully Against the Standard ²¹	% of Standard Achieved
NHS Lothian	2,391	609	25%		603	388	64%

¹⁶ ISD have stated "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." <https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Report.pdf>

¹⁷ Please see footnote above.

¹⁸ For a case to be counted in an IJB, that case must have a patient postcode of residence within the IJB and have been included in a submission from the Health Board (HB), within whose bounds the IJB resides. E.g. if an NHS Lothian HB submission includes a patient with an Edinburgh postcode, they will be included in Edinburgh data – but if the same case was instead treated by a Borders IJB or was resident in a non-Lothian IJB but treated by Lothian, then they would not appear in IJB data. This is because there is currently no data on which IJB actually treats a patient, so the best approach available is to identify patients by IJB of residence unless they were definitely treated outside their local HB. In theory a patient might be resident in one IJB but treated by another within a HB –but it is currently assumed that this never happens as there is no way of verifying one way or another.

¹⁹ These incidence figures were derived from taking most up to date NRS population estimates for 2014/15 and applying rates as indicated in the cited research.

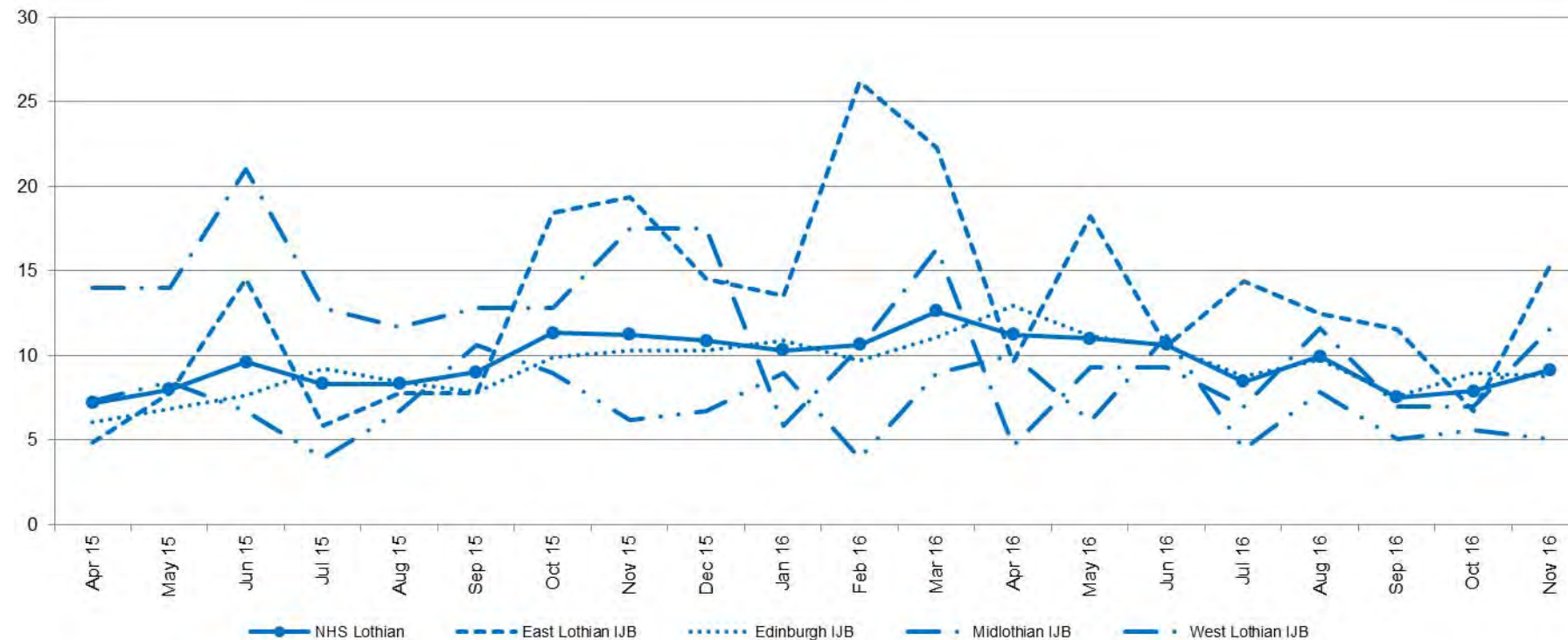
²⁰ Number of those referred for PDS, but excludes those currently undergoing PDS as uncertain at this point whether they will meet the requirements of the LDP Standard.

²¹ Those who have received 12 months PDS support or had PDS stopped due to patient death or move.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better²²

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
NHS Lothian	7.2	8.0	9.6	8.3	8.3	9.0	11.3	11.2	10.9	10.3	10.6	12.6	11.2	11.0	10.6	8.4	9.9	7.5	7.9	9.1
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	19.4	14.5	13.6	26.1	22.3	9.6	18.2	10.6	14.4	12.5	11.5	6.7	15.4
Edinburgh IJB	6.0	6.8	7.6	9.3	8.4	7.8	9.9	10.3	10.3	10.9	9.7	11.1	12.9	11.1	10.5	8.8	9.7	7.6	9.0	8.8
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	17.5	17.5	5.8	10.5	16.3	4.6	9.3	9.3	6.9	11.6	6.9	6.9	11.6
West Lothian IJB	7.3	8.4	6.7	3.9	6.7	10.6	9.0	6.2	6.7	9.0	3.9	9.0	10.0	6.1	11.1	4.5	7.8	5.0	5.6	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and IJBs, for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better²³



Timescale for Improvement – East Lothian Integrated Joint Board (IJB)

A trajectory has not been set due to the proposed changes in the methodology in relation to measuring expected prevalence of dementia.

Actions Planned and Outcome – East Lothian Integrated Joint Board (IJB)

Action	Due By	Planned Benefit	Actual Benefit	Status
Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.	Completed	Increase reported rate of referral for PDS.	The reported rate has decreased compared with the preceding month, with the rate for June 16 at 5.8. Although the East Lothian rate has exceeded the Scottish average in many previous months, the June figure is below the Scottish and other Lothian rates.	Completed
Improve recording of diagnosis in TRAK. <ul style="list-style-type: none"> Procedures agreed and implemented with local teams Routine reports to feedback performance to teams in place 	Ongoing	Increased recording of all diagnoses to allow comparison of actual versus expected rates for diagnosis of dementia.	Initial Position for % of patients on older adult services caseloads (with at least 1 attended appointment with a consultant) who had a diagnosis of dementia recorded in TRAK in May 2015 was 21%. Position reported in January 16 was 75%.	Will continue to monitor recording

²² The data previously published by ISD on the dementia standard reported the rate of referral for post diagnostic support based on 100,000 per population. The numerator for this was based on month of diagnosis rather than month of referral so there was always a lag time between month of publication and rate per month, with the rate continuing to increase for previous months in each subsequent publication. NHS Lothian's rate of referral for post diagnostic support was currently in line with the overall national rate; The rate was only published at Health Board level not by IJB/ locality level. This has been requested from ISD.

²³ Please see footnote above.

Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24 th Jan 2017).	July 2016	<ul style="list-style-type: none"> • Enable reporting of performance by IJB; • Increase local ownership of performance and improvement planning. 		Awaiting ISD guidance
Awaiting ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia. (This was published on 24 th Jan 2017).	TBC (ISD)	<ul style="list-style-type: none"> • Allow more accurate evaluation of performance against the standard at Board and partnership level. 		

Comments – East Lothian Integrated Joint Board (IJB)

Based on the most recently available data, East Lothian's rate for referral for Post Diagnostic Support (PDS*) is below the Lothian rate and the rate in two of the three HSCPs.

PDS referral rates still have a 4-month data lag as the February report only has figures available up to August 2016. There also remains some dubiety about the accuracy of the most recently available month's figure. The East Lothian data is also subject to high variability, fluctuating month on month, as demonstrated in the data table and the accompanying chart.

The data collected for ISD utilises the date of the dementia diagnosis as a proxy for the referral date and as such there is a lag time between the date of reporting and the actual "referrals" each month, so the numbers for any given month will increase as patients diagnosed are referred to the service in coming months.

Discussion is underway in the East Lothian Post Diagnostic Support Services Steering Group on current pressures on the service and potential approaches to improve performance.

East Lothian looks forward to future performance reporting at IJB level providing extra detail such as:

- Number of people expected to be diagnosed (in time period)
- Number of people having been diagnosed with dementia (in time period)
- Number of people offered PDS (in time period).

Reasons for Current Performance

Improving recording of diagnosis remains a priority.

*PDS service refers to the Alzheimer Scotland Support worker and other staff in East Lothian older adult services providing dementia post diagnostic support.

Dementia – Edinburgh Integration Joint Board (IJB)

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard:
 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.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	TBC ²⁴	Not Applicable	3. Worse 4. Worse	2014/15	TBC ²⁵	3. 25% 4. 64%	2014/15	ISD	Yes	Yes	RMG
		Edinburgh IJB Performance ²⁶				3. Tbc 4. Tbc						

Summary for Committee to note or agree

ISD have published data against the standard for the first time on 24th January 2017. Data is reported at NHS Health Board level only against both elements of the standard (please see 'Target/Standard'. Performance against the Standard as a whole is also reported. Please note that the data reflects diagnosis on the year 2014/15. To also note Lothian Health and Social Care Partnerships have questions about the published standard parameters given only 3 West of Scotland board areas were used to develop the performance standards²⁷.

Recent Performance – % against Standard

Table 1: NHS Board performance against the LDP Standard for financial year 2014/15 – Higher Rate is Better

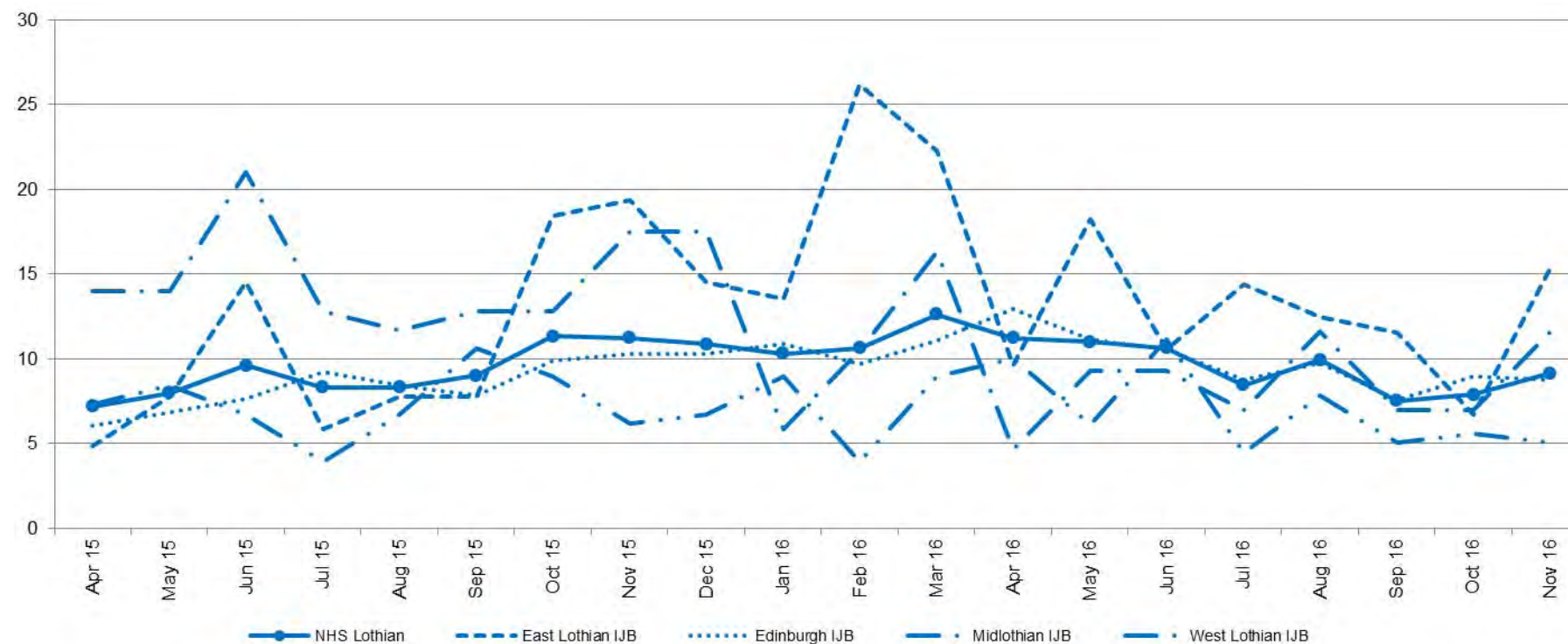
Part 1:-	Estimated Incidence of Dementia ²⁸	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS ²⁹	Delivered Successfully Against the Standard ³⁰	% of Standard Achieved
NHS Lothian	2,391	609	25%		603	388	64%

²⁴ ISD have stated "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." <https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Report.pdf>
²⁵ Please see footnote above.
²⁶ For a case to be counted in an IJB, that case must have a patient postcode of residence within the IJB and have been included in a submission from the Health Board (HB), within whose bounds the IJB resides. E.g. if an NHS Lothian HB submission includes a patient with an Edinburgh postcode, they will be included in Edinburgh data – but if the same case was instead treated by a Borders IJB or was resident in a non-Lothian IJB but treated by Lothian, then they would not appear in IJB data. This is because there is currently no data on which IJB actually treats a patient, so the best approach available is to identify patients by IJB of residence unless they were definitely treated outside their local HB. In theory a patient might be resident in one IJB but treated by another within a HB –but it is currently assumed that this never happens as there is no way of verifying one way or another.
²⁷ [Estimated and Projected Diagnosis Rates for Dementia in Scotland:2014 -2020](#)
²⁸ These incidence figures were derived from taking most up to date NRS population estimates for 2014/15 and applying rates as indicated in the cited research.
²⁹ Number of those referred for PDS, but excludes those currently undergoing PDS as uncertain at this point whether they will meet the requirements of the LDP Standard.
³⁰ Those who have received 12 months PDS support or had PDS stopped due to patient death or move.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better³¹

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
NHS Lothian	7.2	8.0	9.6	8.3	8.3	9.0	11.3	11.2	10.9	10.3	10.6	12.6	11.2	11.0	10.6	8.4	9.9	7.5	7.9	9.1
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	19.4	14.5	13.6	26.1	22.3	9.6	18.2	10.6	14.4	12.5	11.5	6.7	15.4
Edinburgh IJB	6.0	6.8	7.6	9.3	8.4	7.8	9.9	10.3	10.3	10.9	9.7	11.1	12.9	11.1	10.5	8.8	9.7	7.6	9.0	8.8
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	17.5	17.5	5.8	10.5	16.3	4.6	9.3	9.3	6.9	11.6	6.9	6.9	11.6
West Lothian IJB	7.3	8.4	6.7	3.9	6.7	10.6	9.0	6.2	6.7	9.0	3.9	9.0	10.0	6.1	11.1	4.5	7.8	5.0	5.6	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and IJBs, for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better³²



Timescale for Improvement – Edinburgh Integrated Joint Board (IJB)

A trajectory has not been set due to the proposed changes in the methodology in relation to measuring expected prevalence of dementia.

Actions Planned and Outcome – Edinburgh Integrated Joint Board (IJB)

Action	Due By	Planned Benefit	Actual Benefit	Status
Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.	Completed	Increase reported rate of referral for PDS.	The reported rate has increased. For example our rate for August 15 was 0.7, following capture of additional data it is now 9.3 and our rate is comparable with the Scottish average across most months.	Completed
Improve recording of diagnosis in TRAK. <ul style="list-style-type: none"> Procedures agreed and implemented with local teams Routine reports to feedback performance to teams in place 	Ongoing	Increased recording of all diagnosis to allow comparison of actual versus expected rates for diagnosis of dementia.	Initial Position for % of patients on older adult services caseloads (with at least 1 attended appointment with a consultant) who had a diagnosis of dementia recorded in TRAK in May 2015 was 21%. Position reported in January 16 was 75%.	Will continue to monitor recording.

³¹ The data previously published by ISD on the dementia standard reported the rate of referral for post diagnostic support based on 100,000 per population. The numerator for this was based on month of diagnosis rather than month of referral so there was always a lag time between month of publication and rate per month, with the rate continuing to increase for previous months in each subsequent publication. NHS Lothian's rate of referral for post diagnostic support was currently in line with the overall national rate; The rate was only published at Health Board level not by IJB/ locality level. This has been requested from ISD.

³² Please see footnote above.

Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24 th Jan 2017).	July 2016	<ul style="list-style-type: none"> • Enable reporting of performance by IJB; • Increase local ownership of performance and improvement planning. 		Awaiting ISD guidance
Awaiting ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia. (This was published on 24 th Jan 2017).	TBC (ISD)	<ul style="list-style-type: none"> • Allow more accurate evaluation of performance against the standard at Board and partnership level. 		

Comments – Edinburgh Integrated Joint Board (IJB)

Linked to Edinburgh Health and Social Care Partnership Strategic Plan Action 23A – improving support for people with dementia.

Awaiting further ISD guidance to report on Edinburgh IJB rates and further develop reporting on rates within 4 Edinburgh locality areas.

PDS referral rates still have a 7 month data lag as this April 2017 report only has figures available up to August 2016. Edinburgh data is also subject to variability, fluctuating month on month, as demonstrated in the data table and the accompanying chart.

The data collected for ISD utilises the date of the dementia diagnosis as a proxy for the referral date and as such there is a lag time between the date of reporting and the actual “referrals” each month, so the numbers for any given month will increase as patients diagnosed are referred to the service in coming months.

As noted in the last report, post diagnostic support is mainly delivered through current 2 year contract with Alzheimer Scotland for Edinburgh Post Diagnostic Support Service which includes 6 WTE link workers based in each of the 4 Edinburgh localities. Funded through the Integrated Care Fund until 31 March 2018 (contract £215,483 per annum). The funding source of Integrated Care Fund not yet confirmed beyond March 2018. Escalated to the IJB Risk Register. Process underway to determine how this function can be delivered as a flexible resource, responsive to demand on a continued locality basis going forward.

Incidence data from national study is now published by Scottish Government (refer to summary note on p1) and it is anticipated future Edinburgh data measures should include:

- Expected number of people diagnosed
- Actual number of people diagnosed
- Number of people offered post diagnostic support
- People completing post diagnostic support as % of those offered
- Number of people waiting.

Reasons for Current Performance

In order to have understanding of current performance, it is recognised there is a need to continue to improve recording of diagnosis and this remains a priority.

Published data in [ISD \(24.01.17\) Dementia Post Diagnostic Support: NHS Board Performance 2014/15](#) is based on 2014/15 NHS Lothian Health Board level returns – Alzheimer Scotland Edinburgh Post Diagnostic Support Service started January 2014 and reached 300 capacity by October 2014 which will have impacted on published yearly returns. Additionally Alzheimer Scotland HEAT Target (now LDP target) reporting commenced August 2014 and Edinburgh NHSL community mental health teams’ HEAT/LDP Target reporting commenced October 2015.

Dementia – Midlothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard:
 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.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	TBC ³³	Not Applicable	5. Worse 6. Worse	2014/15	TBC ³⁴	5. 25% 6. 64%	2014/15	ISD	Yes	Yes	EM
		Midlothian IJB Performance ³⁵				5. Tbc 6. Tbc						

Summary for Committee to note or agree

ISD have published data against the standard for the first time on 24th January 2017. Data is reported at NHS Health Board level only against both elements of the standard (please see 'Target/Standard'). Performance against the Standard as a whole is also reported. Please note that the data reflects diagnosis on the year 2014/15.

Recent Performance – % against Standard

Table 1: NHS Board performance against the LDP Standard for financial year 2014/15 – Higher Rate is Better

Part 1:-	Estimated Incidence of Dementia ³⁶	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS ³⁷	Delivered Successfully Against the Standard ³⁸	% of Standard Achieved
NHS Lothian	2,391	609	25%		603	388	64%

³³ ISD have stated "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." <https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Report.pdf>

³⁴ Please see footnote above.

³⁵ For a case to be counted in an IJB, that case must have a patient postcode of residence within the IJB and have been included in a submission from the Health Board (HB), within whose bounds the IJB resides. E.g. if an NHS Lothian HB submission includes a patient with an Edinburgh postcode, they will be included in Edinburgh data – but if the same case was instead treated by a Borders IJB or was resident in a non-Lothian IJB but treated by Lothian, then they would not appear in IJB data. This is because there is currently no data on which IJB actually treats a patient, so the best approach available is to identify patients by IJB of residence unless they were definitely treated outside their local HB. In theory a patient might be resident in one IJB but treated by another within a HB –but it is currently assumed that this never happens as there is no way of verifying one way or another.

³⁶ These incidence figures were derived from taking most up to date NRS population estimates for 2014/15 and applying rates as indicated in the cited research.

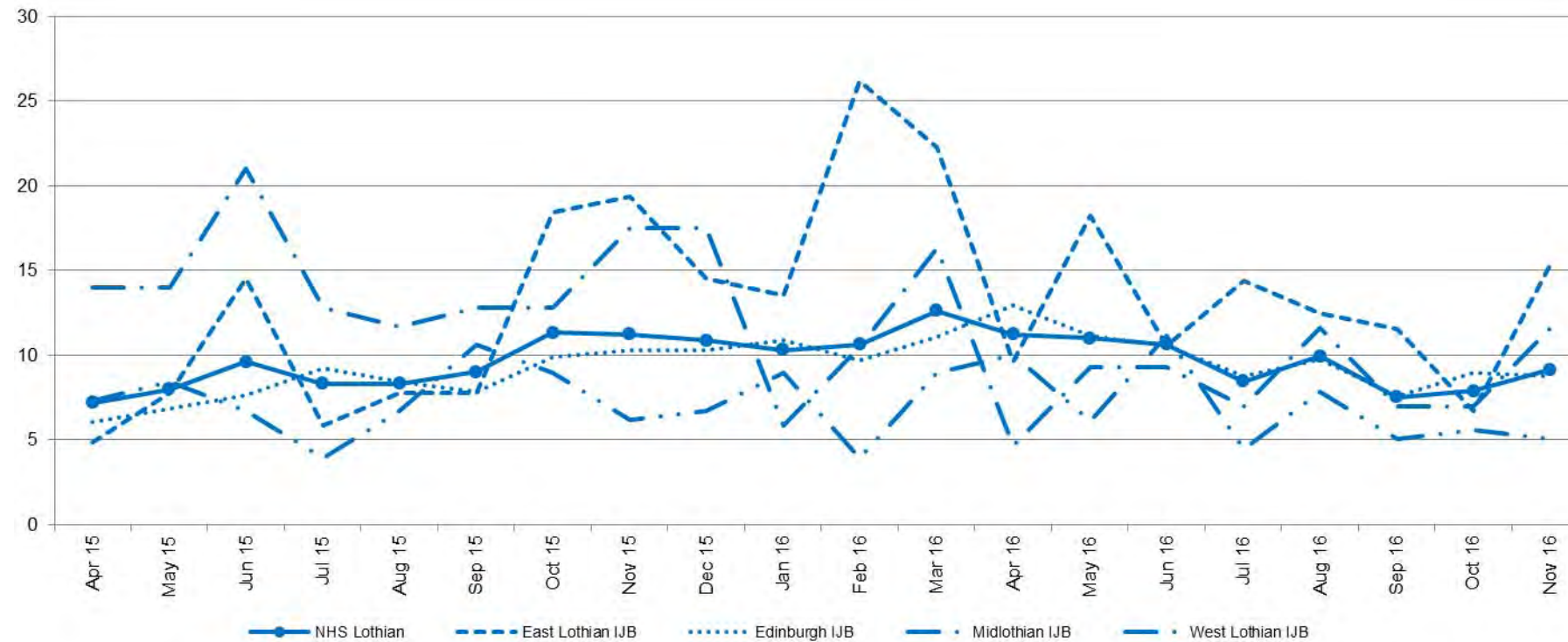
³⁷ Number of those referred for PDS, but excludes those currently undergoing PDS as uncertain at this point whether they will meet the requirements of the LDP Standard.

³⁸ Those who have received 12 months PDS support or had PDS stopped due to patient death or move.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better³⁹

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
NHS Lothian	7.2	8.0	9.6	8.3	8.3	9.0	11.3	11.2	10.9	10.3	10.6	12.6	11.2	11.0	10.6	8.4	9.9	7.5	7.9	9.1
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	19.4	14.5	13.6	26.1	22.3	9.6	18.2	10.6	14.4	12.5	11.5	6.7	15.4
Edinburgh IJB	6.0	6.8	7.6	9.3	8.4	7.8	9.9	10.3	10.3	10.9	9.7	11.1	12.9	11.1	10.5	8.8	9.7	7.6	9.0	8.8
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	17.5	17.5	5.8	10.5	16.3	4.6	9.3	9.3	6.9	11.6	6.9	6.9	11.6
West Lothian IJB	7.3	8.4	6.7	3.9	6.7	10.6	9.0	6.2	6.7	9.0	3.9	9.0	10.0	6.1	11.1	4.5	7.8	5.0	5.6	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and IJBs, for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better⁴⁰



Timescale for Improvement – Midlothian Integrated Joint Board (IJB)

A trajectory has not been set due to the proposed changes in the methodology in relation to measuring expected prevalence of dementia.

Actions Planned and Outcome – Midlothian Integrated Joint Board (IJB)

Action	Due By	Planned Benefit	Actual Benefit	Status
Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.	Completed	Increase reported rate of referral for PDS.	The reported rate has increased. For example our rate for August 15 was 0.7, following capture of additional data it is now 9.3 and our rate is comparable with the Scottish average across most months.	Completed
Improve recording of diagnosis in TRAK. <ul style="list-style-type: none"> Procedures agreed and implemented with local teams Routine reports to feedback performance to teams in place 	Ongoing	Increased recording of all diagnosis to allow comparison of actual versus expected rates for diagnosis of dementia.	Initial Position for % of patients on older adult services caseloads (with at least 1 attended appointment with a consultant) who had a diagnosis of dementia recorded in TRAK in May 2015 was 21%. Position reported in January 16 was 75%.	Will continue to monitor recording

³⁹ The data previously published by ISD on the dementia standard reported the rate of referral for post diagnostic support based on 100,000 per population. The numerator for this was based on month of diagnosis rather than month of referral so there was always a lag time between month of publication and rate per month, with the rate continuing to increase for previous months in each subsequent publication. NHS Lothian's rate of referral for post diagnostic support was currently in line with the overall national rate; The rate was only published at Health Board level not by IJB/ locality level. This has been requested from ISD.

⁴⁰ Please see footnote above.

Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24 th Jan 2017).	July 2016	<ul style="list-style-type: none"> • Enable reporting of performance by IJB; • Increase local ownership of performance and improvement planning. 		Awaiting ISD guidance
Awaiting ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia. (This was published on 24 th Jan 2017).	TBC (ISD)	<ul style="list-style-type: none"> • Allow more accurate evaluation of performance against the standard at Board and partnership level. 		

Comments – Midlothian Integrated Joint Board (IJB)

Following recent draft circulation, the ‘Evaluation of the effectiveness of the “8 Pillars” model of home-based support’ is due to be published shortly. Staffing and structural difficulties during the pilot period are commented upon within the report however it is encouraging to note that: ‘Midlothian had an established and a successful integrated team approach on which to model a single dementia co-located team and which created the vision of how the single team could operate...(and) ensures a holistic approach to patients with dementia across Midlothian’. Planning is already underway to encourage a more pro-active transition in respect of accessing support from 3rd sector partners during and at the end of the 12 month post-diagnostic support period, for example more facilitated meetings with the VOCAL carer support worker. Recent establishment of a pilot social work Duty System within the Dementia Service aims to pave the way for a more flexible, timely response at periods of crisis and when there is a need for specific intervention.

Reasons for Current Performance

The Dementia Service in Midlothian has continued to run with a vacancy of 1 FTE Alzheimer Scotland Link, which is impacting on capacity. Of particular note was a recent evaluation of clinic attendance rates undertaken by one of the CPN clinic co-ordinators. Following restructuring of clinic arrangements and appointment systems, evidence showed 63% less wastage in clinic time and improved attendance for the period July to December 2016, therefore we expect to see an increase in improvement as a result of this change.

Dementia – West Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard:
 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.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
To be reviewed	To be reviewed	TBC ⁴¹	Not Applicable	7. Worse 8. Worse	2014/15	TBC ⁴²	7. 25% 8. 64%	2014/15	ISD	Yes	Yes	JF
		West Lothian IJB Performance ⁴³				7. Tbc 8. Tbc						

Summary for Committee to note or agree

ISD have published data against the standard for the first time on 24th January 2017. Data is reported at NHS Health Board level only against both elements of the standard (please see 'Target/Standard'. Performance against the Standard as a whole is also reported. Please note that the data reflects diagnosis on the year 2014/15.

Recent Performance – % against Standard

Table 1: NHS Board performance against the LDP Standard for financial year 2014/15 – Higher Rate is Better

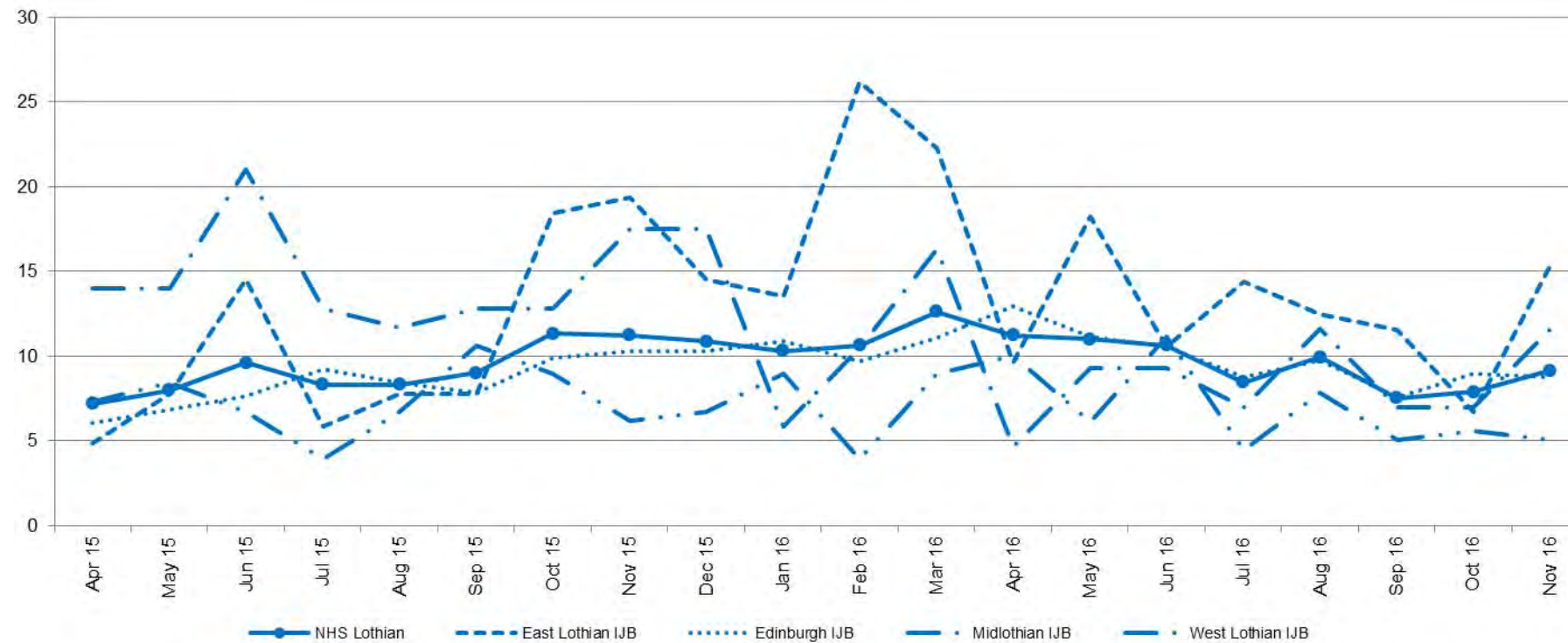
Part 1:-	Estimated Incidence of Dementia ⁴⁴	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS ⁴⁵	Delivered Successfully Against the Standard ⁴⁶	% of Standard Achieved
NHS Lothian	2,391	609	25%		603	388	64%

⁴¹ ISD have stated "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." <https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Report.pdf>
⁴² Please see footnote above.
⁴³ For a case to be counted in an IJB, that case must have a patient postcode of residence within the IJB and have been included in a submission from the Health Board (HB), within whose bounds the IJB resides. E.g. if an NHS Lothian HB submission includes a patient with an Edinburgh postcode, they will be included in Edinburgh data – but if the same case was instead treated by a Borders IJB or was resident in a non-Lothian IJB but treated by Lothian, then they would not appear in IJB data. This is because there is currently no data on which IJB actually treats a patient, so the best approach available is to identify patients by IJB of residence unless they were definitely treated outside their local HB. In theory a patient might be resident in one IJB but treated by another within a HB –but it is currently assumed that this never happens as there is no way of verifying one way or another.
⁴⁴ These incidence figures were derived from taking most up to date NRS population estimates for 2014/15 and applying rates as indicated in the cited research.
⁴⁵ Number of those referred for PDS, but excludes those currently undergoing PDS as uncertain at this point whether they will meet the requirements of the LDP Standard.
⁴⁶ Those who have received 12 months PDS support or had PDS stopped due to patient death or move.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better⁴⁷

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
NHS Lothian	7.2	8.0	9.6	8.3	8.3	9.0	11.3	11.2	10.9	10.3	10.6	12.6	11.2	11.0	10.6	8.4	9.9	7.5	7.9	9.1
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	19.4	14.5	13.6	26.1	22.3	9.6	18.2	10.6	14.4	12.5	11.5	6.7	15.4
Edinburgh IJB	6.0	6.8	7.6	9.3	8.4	7.8	9.9	10.3	10.3	10.9	9.7	11.1	12.9	11.1	10.5	8.8	9.7	7.6	9.0	8.8
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	17.5	17.5	5.8	10.5	16.3	4.6	9.3	9.3	6.9	11.6	6.9	6.9	11.6
West Lothian IJB	7.3	8.4	6.7	3.9	6.7	10.6	9.0	6.2	6.7	9.0	3.9	9.0	10.0	6.1	11.1	4.5	7.8	5.0	5.6	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and IJBs, for those Diagnosed with Dementia - Source: ISD – Higher Rate is Better⁴⁸



Timescale for Improvement – West Lothian Integrated Joint Board (IJB)

A trajectory has not been set due to the proposed changes in the methodology in relation to measuring expected prevalence of dementia.

Actions Planned and Outcome – West Lothian Integrated Joint Board (IJB)

Action	Due By	Planned Benefit	Actual Benefit	Status
Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.	Completed	Increase reported rate of referral for PDS.	The reported rate in West Lothian has fluctuated quite significantly since April 2015. This has led, in most recent months, to the West Lothian rate sitting below both the NHS Lothian rate and the national rate. However, the most recent month has seen an increase in performance. Work continues as part of the Frail Elderly Programme in West Lothian to look at how PDS is delivered in West Lothian. It is anticipated that this will be concluded by the end of April 2017.	Completed
Improve recording of diagnosis in TRAK. <ul style="list-style-type: none"> Procedures agreed and implemented with local teams Routine reports to feedback performance to teams in place 	Ongoing	Increased recording of all diagnosis to allow comparison of actual versus expected rates for diagnosis of dementia.	Initial Position for % of patients on older adult services caseloads (with at least 1 attended appointment with a consultant) who had a diagnosis of dementia recorded in TRAK in May 2015 was 21%. Position reported in January 16 was 75%.	Will continue to monitor recording

⁴⁷ The data previously published by ISD on the dementia standard reported the rate of referral for post diagnostic support based on 100,000 per population. The numerator for this was based on month of diagnosis rather than month of referral so there was always a lag time between month of publication and rate per month, with the rate continuing to increase for previous months in each subsequent publication. NHS Lothian's rate of referral for post diagnostic support was currently in line with the overall national rate; The rate was only published at Health Board level not by IJB/ locality level. This has been requested from ISD.

⁴⁸ Please see footnote above.

Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24 th Jan 2017).	July 2016	<ul style="list-style-type: none"> • Enable reporting of performance by IJB; • Increase local ownership of performance and improvement planning. 		Awaiting ISD guidance
Awaiting ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia. (This was published on 24 th Jan 2017).	TBC (ISD)	<ul style="list-style-type: none"> • Allow more accurate evaluation of performance against the standard at Board and partnership level. 		

Comments – West Lothian Integrated Joint Board (IJB)

NHS Lothian's rate for referral for Post diagnostic support has varied in comparison to the overall national rate. Within that West Lothian's performance has fluctuated but, in the most recent month reported, has shown an improvement. West Lothian IJB – through its Frail Elderly Programme – is looking at the delivery of post diagnostic support in West Lothian, particularly the model of delivery with a view to reducing waiting times and improving transition. This work is expected to be completed by April 2017. It is acknowledged that there are challenges with changing demographics and Scottish Government guidance on how PDS is to be delivered. At present, the model of delivery in West Lothian is a blended one with both NHS Lothian staff and a third sector organisation providing the link worker support. Work is continuing to identify trends going forward with a view to projecting capacity requirements.

Reasons for Current Performance

Improving recording of diagnosis remains a priority. As outlined above, there is greater scrutiny on post diagnostic support at present with a view to ensuring the model of delivery is fit for purpose going forward.

Patient Experience – Tell us Ten Things (TTT) Inpatient Survey (Question 10 – Overall Experience)

Healthcare Quality Domain: Person Centred

For reporting at **April 2017** meetings

Target/Standard: Score of 9.0 out of 10 for Question 10 (Overall Experience)

Responsible Director[s]: Executive Director: Nurse Director

NHS Lothian Performance:-

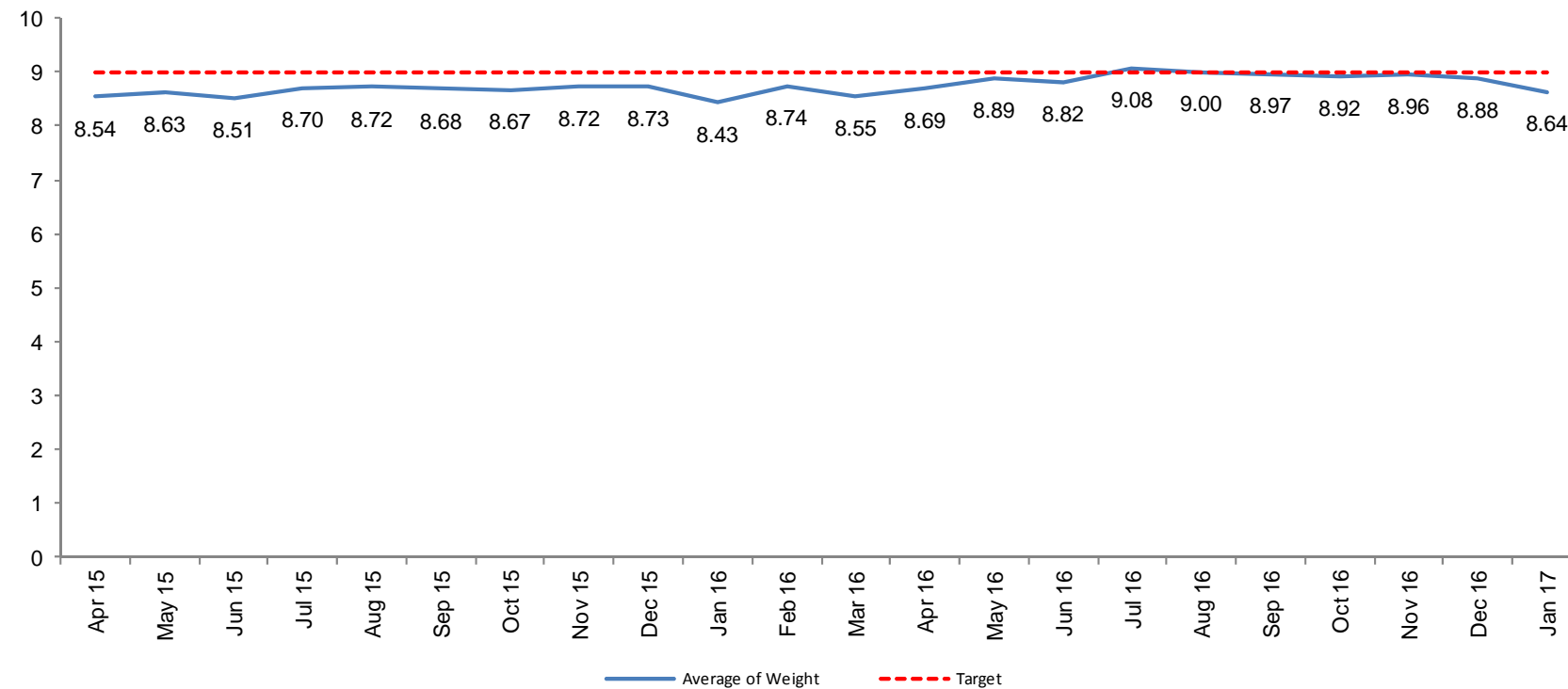
Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Nov 16	Not Met	Deteriorating	Not Applicable	Not Applicable	9.0/10 (min)	8.64	Jan 17	Tell Us Ten Things Database	Yes	Yes	AMcM

Summary for Committee to note or agree

To note.

Recent Performance – Numbers against Standard

Figure 1: NHS Lothian ‘Tell Us Ten Things’ Inpatient Survey Results – Higher Score is Better



Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:- N/A

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
Work in partnership with IT analytical services to provide a data capture, analyse and reporting system that is fit for purpose and supported within NHS Lothian. This report will be available in Tableau.	January 2017	To provide a seamless and robust data capture and reporting mechanism to wards, hospital sites and the Board to enable improvements to patient care. This will allow staff to be able to access the report at the point of data entry therefore not reliant on the Patient Experience Team sending out reports electronically.	IT analytical services continue to work on the development of a TTT dashboard on Tableau and a draft will be available the week beginning 20 March 2017.	Review March 2017
Executive Director of Nursing, Midwifery & AHPs leading on a collaborative of experienced Quality Improvement staff to improve and enhance patient experience regarding 'noise at night' based on feedback from TTT.	TBC	To improve and reduce noise at night therefore enhancing patient experience and wellbeing. Three wards are currently piloting additional actions they can take to reduce further noise at night. Feedback would be through direct patient feedback and TTT.		Review April 2017
Recruit volunteers to support clinical areas at the Western General Hospital to; promote the uptake of TTT questionnaires and support patients to complete when required.	April 2017	To improve the TTT return response rate and enhance patient experience. To enhance patient inclusion.	Volunteer Services Manager at WGH is in the process of recruiting volunteers to support TTT. The recruiting process can take 8-10 weeks and therefore in the interim is engaging with existing volunteers to support the uptake and engagement with TTT. Volunteers supporting Wards 33, 50, 54, 55 and the Royal Victoria Building have agreed to support TTT.	Review March 2017
RHSC testing a modified version of the TTT questionnaire for children and younger people. This work will be taken forward once a resolution has been achieved for the TTT reporting mechanism as detail in the first action above.	April 2017	To implement a TTT questionnaire in children and young people's setting. To obtain feedback and enhance the experience of children and younger people.		Review March 2017
Agreed with Director of Nursing Group an initial stretch target of 10% response return rate.	April 2016	To achieve a response return rate that provides a sample sufficient for quality improvement.	A sample size that gives sufficient feedback to make quality improvement changes.	Review April 2017
Deliver learning and education of patient experience to staffs at Corporate Induction, Continuing Professional Development for Health Care Support Workers, Nursing & Midwifery and Allied Health Professionals.	August 2017	To improve understanding and engagement of the TTT questionnaire across multidisciplinary disciplines within the organisation demonstrating how this can impact on enhancing the patient experience.		Review April 2017
One to one discussions with Senior Charge Nurses and small group working to improve engagement with TTT and carry out quality improvement small tests of change.	August 2017	Improved patient experience.		Review June 2017
Midlothian to test TTT survey in community hospital setting once a solution has been reached for the TTT database. This is currently on hold until a resolution can be sought for the TTT reporting mechanism as detailed in the first action above.	TBC	To trial suitability of TTT survey in a care of the elderly/long term care setting to ensure the survey meets the needs of the patients.		Review August 2017
Recruit to vacant post for the Project Manager. The financial resource for the Project Officer post has been transferred to Clinical Documentation and Patient Information.	TBC	To lead, implement and embed TTT within in-patient areas. Clear lines of responsibility for the data entry, analysis and reporting of TTT surveys and communicating with clinical management teams.		Review March 2017
Recruit to vacant post of Patient Experience Officer.	January 2017	To support clinical staff and teams improve the TTT questionnaire response return rates and carry out patient experience improvements. Improved engagement from clinical teams and through small tests of change enhance the patient experience.	The Patient Experience Officer is new to NHS Lothian and has been since 16 th January 2017. Induction has been undertaken. It is at early stages to demonstrate actual benefit.	Met
Improved circulation of TTT ward, hospital site and local reports to ensure Associate Nurse Directors receive these.	June 2016	Better informed Clinical Management Teams to achieve the TTT measures and enhance patient experience.		Met
Review of response return rates to highlight areas where there is a no or poor returns.	June 2016	To support Clinical Management Teams in the uptake of TTT questionnaires and to share best practice across hospital sites. This is to ensure a sufficient sample size to carry out small tests of change to make improvements in order to enhance the patient experience.	Although this has been met it is a continuous process.	Met
Discussions with Senior Charge Nurses / Clinical Nurse	June	To share best practice and carry out quality improvement actions to	Improvements within patient experience and examples include	Met

Managers to highlight return rates and consider local actions to improve responses.	2016	enhance patient experience.	improving noise at night.	
A submission has been made to the July HCG committee to align the measure to the national Person Centre Health & Care Programme (9/10).	Agreed			Met
Comments				
Due to staff changes the Patient Experience Team continue to work alongside IT analytical services to provide a seamless, robust data reporting mechanism.				

7 Risk Register

7.1 Not applicable.

8 Impact on Inequality, including Health Inequalities

8.1 The production of these updates 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 trends in performance and identifies remedial action, no impact assessment or consultation is expected.

10 Resource Implications

10.1 The resource implications are directly related to the actions required specified in the proforma.

Andrew Jackson, Ryan Mackie and Katy Dimmock
Analytical Services
27th March 2017
PerformanceReporting@nhslothian.scot.nhs.uk

Appendices

Appendix 1 – 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 3 rd 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 speciality within 7 days of discharge as a rate per 1000 total admissions to a surgical speciality. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Surgical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Standardised Medical Readmission rate within 7 days	This is the emergency readmissions to a medical speciality within 7 days as a rate per 1000 total admissions to a medical speciality. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Medical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Average Surgical Length of Stay - Adjusted	Ratio of 'observed' length of stay over 'expected' length of stay. This indicator is case mix adjusted by HRG* and speciality. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each speciality and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).
Hospital Scorecard - Average Medical Length of Stay - Adjusted	Ratio of observed length of stay over expected length of stay. This indicator is case mix adjusted by HRG* and speciality. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each speciality and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).
Complaints (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.

COMPLAINTS AND FEEDBACK

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

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

<ul style="list-style-type: none"> Note that the Healthcare Governance Committee received a presentation and report on the complaints improvement project, resulting in a 'moderate' level of assurance. 	2.1
<ul style="list-style-type: none"> Note the performance for January 2017 <ul style="list-style-type: none"> 3-day acknowledgements - 85% which is deterioration from December 2016 position (93%) 20-day performance - 78% which is an improvement from December (72%) 	2.2, 3.1 & Appendix 1
<ul style="list-style-type: none"> Note the current position and actions with the implementation of the new NHS Scotland Model Complaints Handling Procedure (CHP) from 1 April 2017 and the new set of key performance indicators (KPIs). 	2.3 & 3.2
<ul style="list-style-type: none"> Agree that the Chief Executive signs off the 'Guide to Implementation and Self-Assessment Checklist on behalf of NHS Lothian. 	3.2 & Appendix 2
<ul style="list-style-type: none"> Note that this work going forward will be progressed through the Feedback Improvement Quality Assurance Working Group chaired by Carolyn Hirst, reporting to a range of committees with a further report to the Board June 2017. 	2.6
<ul style="list-style-type: none"> Note that the Chief Executive and all Corporate Directors will have personal and team objectives for management of complaints and patient feedback for 2017/18 	2.7
<ul style="list-style-type: none"> The Medical and Nursing Directors, along with the Interim HR Director, are sponsoring work on how we engage staff on how they would like to see complaints being better managed and to seek feedback from patients and relatives. 	2.8
<ul style="list-style-type: none"> Note that the template for complaints about the Integrated Joint Boards has now been posted on the Scottish Public Services Ombudsman's Valuing Complaints web site. 	2.10 & 3.5

COMPLAINTS AND FEEDBACK

1 Purpose of the Report

- 1.1 The purpose of this report is to provide an update to NHS Lothian Board on current complaints performance, to provide details of the activities in place to support the implementation of the new model complaints handling procedure (CHP) and to update the Board on the ongoing work with the Scottish Public Services Ombudsman (SPSO). It is also to advise that there will be a new reporting format to the Board from June 2017 associated with the new model CHP, together with ongoing work on how best to ensure that the Board, the Healthcare Governance Committee and other committees of the Board receive the appropriate level of information and assurance in relation to complaint handling performance and learning from complaints.

2 Recommendations

- 2.1 Note that the Healthcare Governance Committee received a presentation and report on the overarching complaints improvement project, which resulted in a 'moderate' level of assurance.
- 2.2 Note the performance for January 2017 against the two complaint measures:
- 3-day acknowledgements - 85% which is deterioration from December 2016 position (93%)
 - 20-day performance - 78% which is an improvement from December (72%)
- 2.3 Note the current position and actions with regards to the requirement to implement the new NHS Scotland Model Complaints Handling Procedure (CHP) from 1 April 2017 and that a new set of key performance indicators (KPIs) will be developed (as set out at 3.2.8).
- 2.4 Agree that the Chief Executive signs off the 'Guide to Implementation and Self-Assessment Checklist on behalf of NHS Lothian (see Section 3.2 and Appendix 2). The draft NHS Lothian Complaints Procedure has been sent to Scottish Government looking for early feedback ahead of the deadline of 7 April.
- 2.5 Support the work being undertaken in partnership with the SPSO in Maternity and Royal Hospital for Sick Children (RHSC) and the objective of developing a Complaints Management Toolkit, which will include a diagnostic/investigation tool, a reporting template and a quality assurance process that could be used across the whole complaints system.
- 2.6 Note that a review of the NHS Lothian model of complaints handling and the resource to support this going forward will be progressed through the Feedback Improvement Quality Assurance Working Group chaired by Carolyn Hirst. There will be a report on progress to the Corporate Management Team in May 2017 and a report to the Healthcare Governance Committee and the Board in July and June 2017 respectively.

- 2.7 Note that all Corporate Directors, along with the Chief Executive will have personal and team objectives for management of complaints and patient feedback for the year 17/18.
- 2.8 Note that the Medical and Nursing Directors, along with the Interim HR Director, have agreed to sponsor two pieces of work around how we engage staff on how they would like to see complaints being better managed and to seek feedback from patients and relatives.
- 2.9 Note that it has been agreed that we will pilot the use of volunteers in the Western General site to encourage the greater use of Tell us Ten Things feedback.
- 2.10 Note that the template for complaints about the Integrated Joint Boards has now been posted on the Scottish Public Services Ombudsman's Valuing Complaints web site.

3 Discussion of Key Issues

3.1 Complaints and Feedback activity and performance

- 3.1.1 Appendix 1 includes a detailed breakdown of the complaints and feedback activity.
- 3.1.2 Staff in the Patient Experience Team (PET) have been working to improve the performance with the 3-day complaints acknowledgement measure (NHS Lothian – 85%). The data was reviewed in more detail and it was found that the prison services were having some difficulties with the 3-day acknowledgements. Of the 298 complaints received by NHS Lothian in January 2017, there were 114 complaints relating to prisons, of which 38 (33%) were acknowledged outwith the 3-day target time. Most of these complaints were resolved at source. PET have been working with HMP Addiewell staff to test a new acknowledgment process and this commenced at the end of January.
- 3.1.3 Staff across all parts of the organisation have been working to improve the 20-day response performance (NHS Lothian – 78%). There are several teams within the organisation where performance is as good or better than this position i.e.; Diagnostic, Anaesthetics, Theatres & Critical Care – 78%, Outpatient & Associated Services – 100%, Royal Edinburgh Hospital – 92%, HMP Edinburgh – 92%, HMP Addiewell – 97%. Local reports are sent to the teams on a weekly and monthly basis and shared via the Nurse Director's Group.
- 3.1.4 In addition, there have been meetings with the senior management teams across the organisation to discuss the detailed performance of each area and this has been discussed at the Corporate Management Team at their March 2017 meeting, with strong support to continue with these improvements and performance. Measures proposed include having personal and team objectives for management of complaints and patient feedback for all Corporate Directors and the Chief Executive year 2017/18. The Medical and Nursing Directors and Interim HR Director have also agreed to sponsor two pieces of work. One is around how we engage staff on how they would like to see complaints being better managed and the second relates to seeking feedback from patients and relatives.
- 3.1.5 In relation to seeking feedback, it has been agreed that we will pilot the use of volunteers in the Western General site to encourage the greater use of Tell us Ten Things.

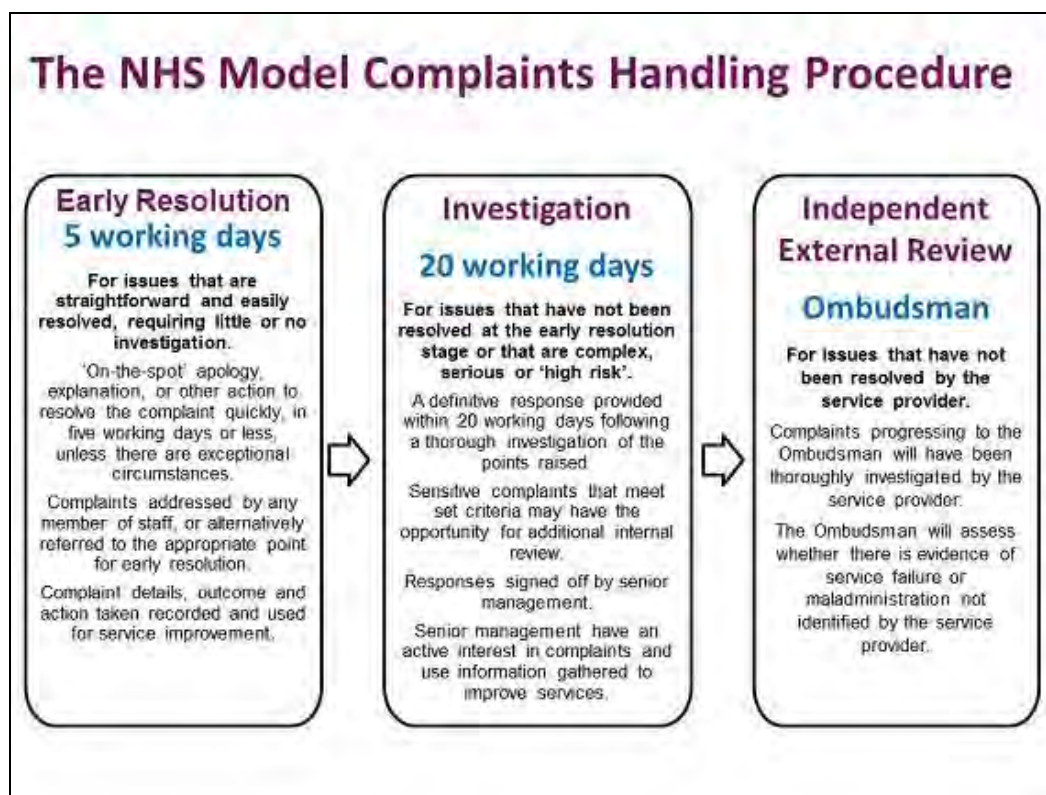
3.1.6 Following discussion at the January 2017 meeting of the Healthcare Governance Committee, it was agreed that the complaints and feedback data be presented separately from the patient experience data. Revised reports were presented at the March 2017 committee meeting. There will be further changes to the reporting format to support the implementation of the new model CHP.

3.2 New Model Complaints Handling Procedure

3.2.1 The Scottish Government and the SPSO published the new model CHP in October 2016. This new model CHP is intended to support a more consistently person-centred approach to complaints handling across NHS Scotland, and bring the NHS into line with other public service sectors by introducing a two stage process:

- Stage 1 – early resolution – 5 days
- Stage 2 – investigation – 20 days

3.2.2 The focus of the new CHP is intended to support NHS Boards and their service providers to support a quick and streamlined approach to complaints handling. The model below illustrates this.



3.2.3 The new CHP has a strong focus on:

- Encouraging early resolution and frontline ownership
- Focus on improvements resulting from learning
- Focus on quality alongside timeliness

- 3.2.4 The procedure reflects the broader ambition for the NHS in Scotland to be an open, learning organisation that listens and acts when unintended harm is caused. The procedure complements the Duty of Candour provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, and the development of a national approach to reviewing and learning from adverse events. It is also complemented by the Apologies (Scotland) Act 2016, which is intended to encourage apologies to be made, making it clear that apologising is not the same as admitting liability.
- 3.2.5 NHS Board Chief Executives are required to complete and sign a compliance statement by 7 April 2017, confirming that the Board has adopted both the new CHP and the public-facing CHP and has introduced the CHP across all services from 1 April 2017. They are also required to complete a self-assessment of the CHP against the requirements of the revised procedure. The Guide to CHP Implementation and the self assessment of compliance are included (Appendix 2).
- 3.2.6 Ahead of the 7 April implementation date, a NHS Lothian Complaints Management Policy in draft format, has been posted on the consultation zone of the intranet site to allow staff the opportunity to comment on this draft document. By the time of the April Board meeting the consultation will have closed. An early version of this policy was sent to Scottish Government and as a result of their feedback the procedure template provided by Scottish Government will be adopted, which is included with this paper (Appendix 3). PET is continuing to attend meetings raising staff awareness around the new CHP and the changes that will come. This includes meetings with the primary care contractors. As part of the national guidance we are required to make The “Public Facing Model Complaints Handling Procedure” (Appendix 4) available on the NHS Lothian internet site.
- 3.2.7 NHS Fife has been piloting the new model CHP. Early feedback from this pilot site has been generally positive. There was detailed discussion at the national Complaints Managers meeting at the March 2017 meeting. A recurring concern from this group was the ability to record frontline resolution by the clinical teams. Most Boards across Scotland see this as wider and long term programme of work to support culture and attitude for frontline resolution. It was agreed by all that early, local resolution takes place every day by the staff but has previously not been recorded.
- 3.2.8 As part of the new model CHP there are new key performance indicators (KPIs). There is some further work to be done to allow the appropriate extraction of information from DATIX to respond to these new KPI requirements. Following discussion at the National Complaints Managers’ meeting there remains uncertainty about any national reporting and the Scottish Government are working closing with National Services Scotland on this. The new KPIs are:
- Learning from complaints
 - Complaint process experience
 - Staff awareness and training
 - Total number of complaints received
 - Complaints closed at stage 1 and stage 2 as a percentage of all complaints closed
 - Complaints upheld, partially upheld and not upheld as a percentage of complaints closed in full at each stage
 - Average times
 - The number and percentage of complaints at each stage which were closed in full within the timescales of 5 and 20 working days.

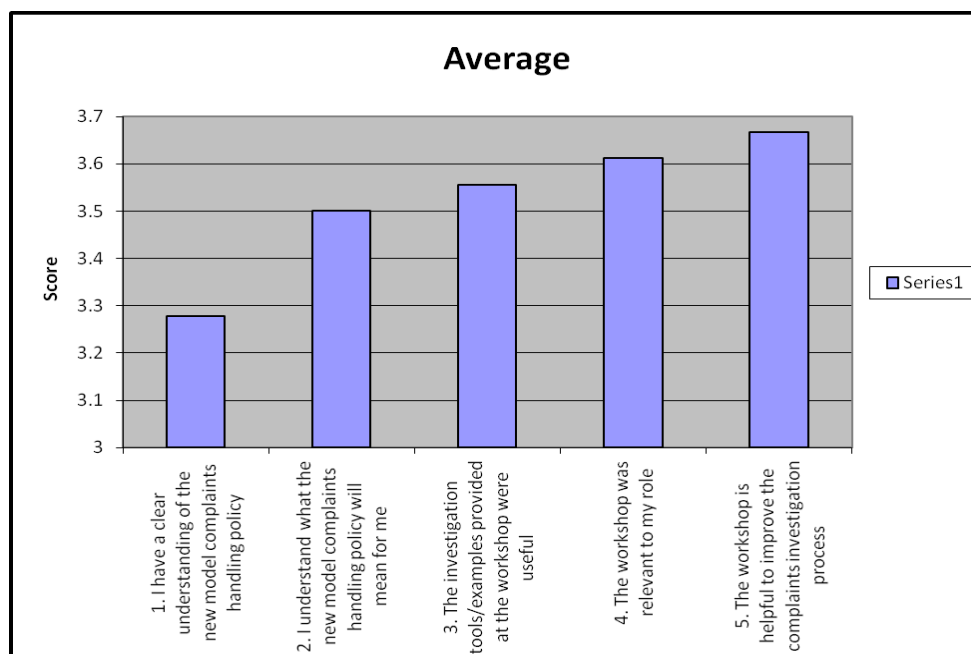
3.2.9 To ensure that momentum continues there have been several presentations and discussions with senior teams across the organisation. This has allowed conversation to focus on the new model CHP and the complaints performance against the existing 20-day performance and to ask for senior management and leadership support to improve the local performance in this measure.

3.2.10 There is a new model CHP for Social Work that is also due to be implemented in April 2017. In advance of this implementation date PET met this month with key colleagues from three of the four Health and Social Care Partnership (HSCPs). This was a very productive meeting and a draft flowchart has been developed to support staff to manage complaints across NHS Lothian and the four HSCPs. A further meeting to progress this is due to take place at the end of March 2017.

3.3 SPSO Support for NHS Lothian

3.3.1 Following the meeting in August 2016, the SPSO have offered assistance from their Learning and Improvement Unit (LIU). After discussions with the Associate Nurse Directors it has been agreed that the LIU support will work with the Maternity and Royal Hospital for Sick Children’s teams. There have been two staff sessions in February 2017 with a focus on developing an investigation template, a quality assurance framework and working towards developing an extended toolkit to support a comprehensive approach to complaints investigation and management. The LIU will continue to work with us over the next few months.

3.3.2 Staff feedback from these two sessions have been very positive and staff were asked to respond to the five questions below where 1 = strongly disagree / 4 = strongly agree.



3.4 SPSO Action Plan

3.4.1 Work is ongoing to implement the actions detailed in the SPSO action plan (Appendix 5). The Efficiency and Productivity Team are providing project management support. The original SPSO action plan has evolved so that there is now an overarching complaints improvement project, which will be overseen by a Project Board who will

report to the Feedback Improvement Quality Assurance Working Group. The aim is “To improve NHS Lothian’s complaints management and to improve NHS Lothian’s learning from complaints” and this will be delivered through four sub projects:

1. NHS Lothian Complaints Handling Policy and Procedure
2. SPSO Complaints Process
3. Support to NHS Lothian from the SPSO’s Learning & Improvement Unit
4. Learning from Complaints, Concerns, Compliments and Feedback

The complaints improvement project was presented to the March 2017 meeting of the Healthcare Governance Committee and provided the Committee with a moderate level of assurance in relation to its proposed implementation.

- 3.4.2 In addition to the four sub-projects set out in the complaints improvement project plan there is an important element concerning “relationship management” between the SPSO and NHS Lothian. The Chairman has met with the Ombudsman, Professor McMahon has written again to the Ombudsman seeking feedback on our progress against the action plan, and a further update will be provided to the SPSO at the end of March 2017. It is important to recognise that this is an ambitious cultural improvement programme that will require all staff at all levels of the organisation to take responsibility and contribute to the improvement project, and there is a move to have complaints performance as part of everyone’s personal and team objectives.

3.5 Integration Joint Boards – Complaints Handling Template

- 3.5.1 Integration Joint Boards (IJBs) are listed authorities under the Scottish Public Services Ombudsman (Scotland) Act 2002, and as such are expected to have a complaints handling procedure which complies with the Principles approved by Parliament in January 2011.

- 3.5.2 The SPSO has now developed a complaints handling template for IJBs (based on the Model CHP for Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland) which they say should simplify this process for IJBs.

- 3.5.3 The IJB complaints handling template can be found on the SPSO’s Valuing Complaints web site at:
<http://www.valuingcomplaints.org.uk/sites/valuingcomplaints/files/resources/Template-CHP-for-IJBs.pdf>

3.6 Programme Governance

- 3.6.1 The Executive Lead for this work is Alex McMahon, Executive Nurse Director. This work is also reported to the Healthcare Governance Committee as a standing item on the agenda. In addition, there is complaints and feedback data incorporated into the Performance and Quality Report.

4 Key Risks

- 4.1 This is an ambitious cultural programme and as such to achieve a person centred culture it needs to be woven into all aspects of NHS Lothian activity and measurement frameworks. There are ongoing conversations through the Corporate Management

Team as to how all senior managers can have a complaints element included as part of their personal and team objectives.

- 4.2 There is a high reputational risk to the organisation if we do not meet the expectations and requirements of the SPSO. In addition to this there is a risk associated with the implementation of the new model CHP and the potential lack of resources required for this and we are continuing to use bank staff to support this in the short term.
- 4.3 Short term sickness within the PET remains a challenge and was 8% in January 2017. We have recruited to the vacant Triage Post within the team from redeployment and to date this has worked well.

5 Risk Register

- 5.1 Enabling a person centred approach within all work streams including complaints management which is on the revised Corporate Risk Register. The risk was escalated to High / 20 in October 2016, following the meeting with the SPSO.

6 Impact on Inequality, Including Health Inequalities

- 6.1 The principles of this agenda will see the person at the centre and therefore all aspects of inequalities will be embedded in the core values of the work programmes agreed.

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

- 7.1 The agenda for person-centredness has at its core involving people and as this work progresses patients, carers and staff are central.

8 Resource Implications

- 8.1 This work has brought together the previous person centred team and CRaFT. The Patient Experience Team was remodelled on existing resources and was delivered by Organisational Change process, supported by HR and partnership.
- 8.2 During the last few months we have visited other NHS Boards and other public sector organisations to meet with their staff to understand how they support their complaints and feedback function. It is worth noting that the resource within NHS Lothian to support the complaint and feedback is significantly less than these other organisations. We are working with the Finance Director to identify what additional support is required. This is an ongoing conversation.

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Head of Patient Experience

29 March 2017

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List of Appendices

Appendix 1: Complaints and Performance

Appendix 2: Guide to Implementation and Self Assessment Checklist

Appendix 3: Draft Complaints Procedure

Appendix 4: Draft NHS Lothian Public Facing Complaints Handling Procedure
Appendix 5: SPSO Action Plan

Appendix 1 – Complaints and feedback performance and activity

The number of telephone calls is now being reviewed on a monthly basis and Chart A shows the number of incoming calls received on a month by month basis. During January, the team received 480 calls which is an increase of 16.25% from the previous month's telephone calls and were able to respond to 88.1% of incoming calls

The average connected call duration during January 2017 was 4:53 minutes and this equates to 40:46 hours spent on the telephone during January. The team has been able to respond to 88.1% of these incoming calls which is an decrease on the previous month (2.9%). One member of the triage team left the department in September 2016, this post has now been recruited (commenced post 20 February 2017) and it is hoped that following a period of induction and orientation for the individual an improvement in performance will be noted.

Discussions have taken place with the Telecoms Team so that we can record the associated outgoing calls, this will inform the future resource required to support the workload generated by telephone activity, this will commence in April.

Chart A

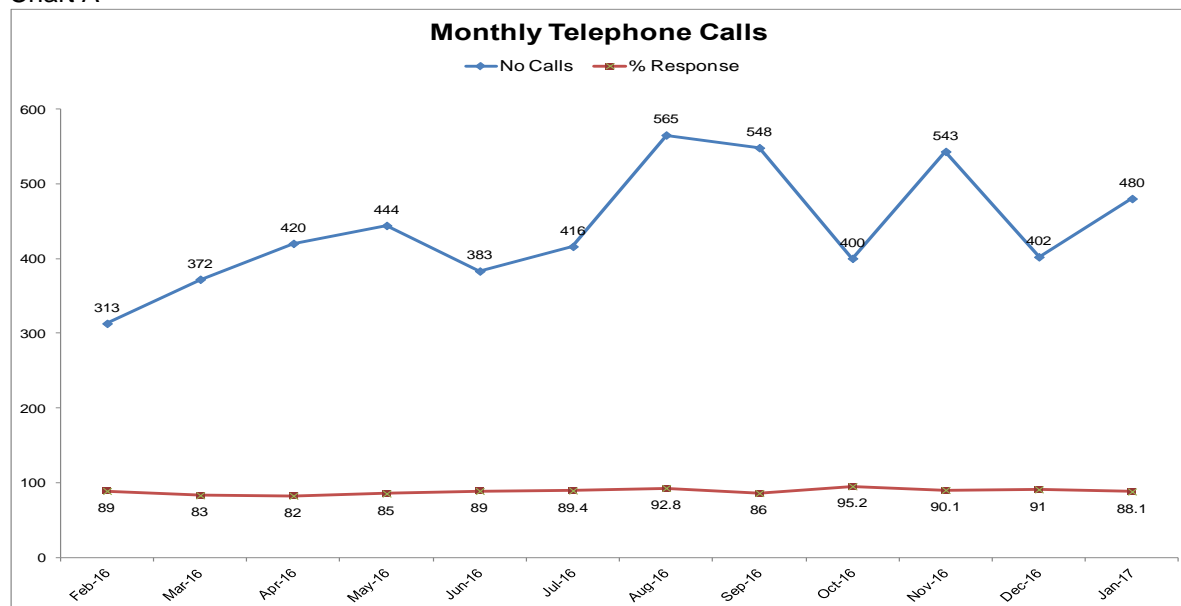


Chart 1 reflects all contacts received by the Patient Experience Team in January. There were 487 contacts (compliments, comments, concerns and complaints), which is a increase of 15.81% from the previous month (410).

Chart 2 shows that complaints remain the highest category of feedback (298), which is an increase of 12.42% on the previous month.

Chart 3 reflects the number of contacts that were acknowledged within 3 working days from receipt and performance is at 84%, this is an deterioration of 9% on the previous month.

Chart 4 reflects the number of complaints that were acknowledged within 3 working days from receipt and performance is at 85% which is a deterioration of 8% on the previous month.

Chart 5 reflects all contacts responded to within 20 working days and the performance in January was 80%, an improvement of 5% on the previous month.

Chart 6 reflects the number of complaints responded to within 20 working days and the performance in January was 78% which is an increase of 6% on the previous month's figure. It is noting that this is the best performance throughout the year.

Chart 1

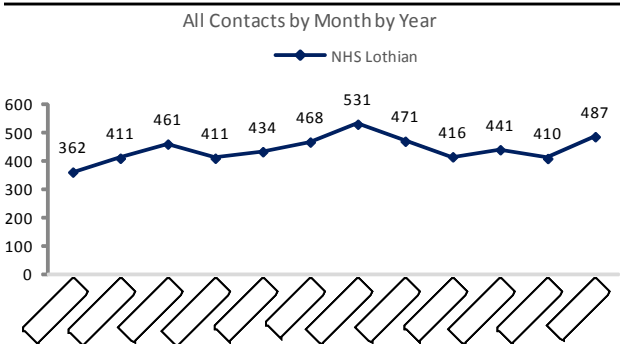


Chart 2

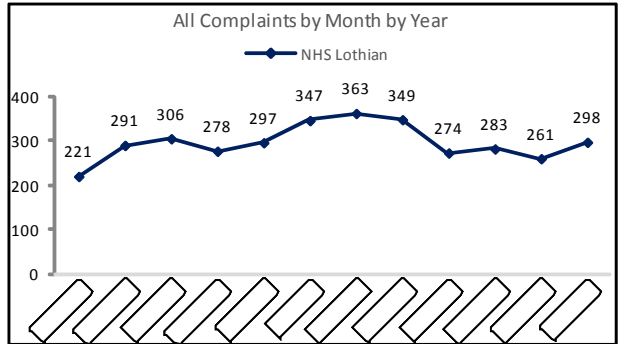


Chart 3

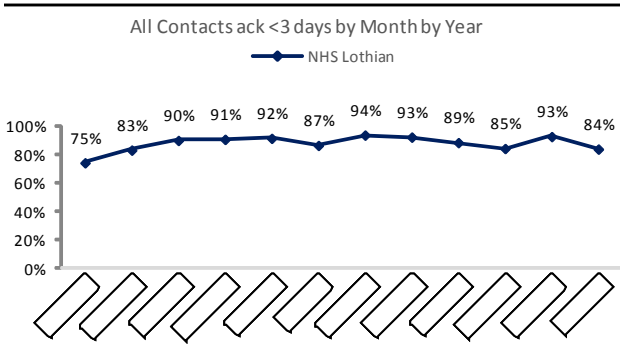


Chart 4

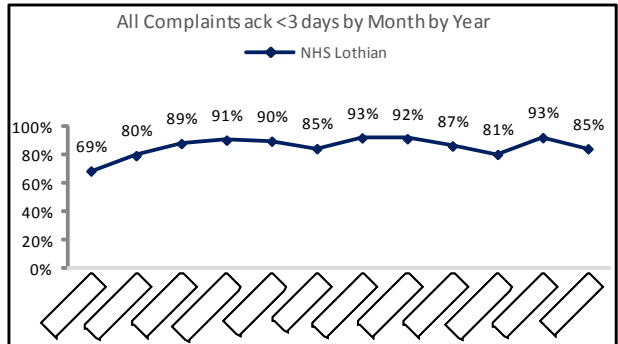


Chart 5

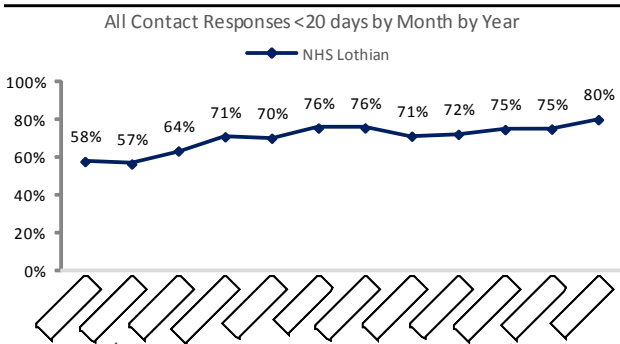
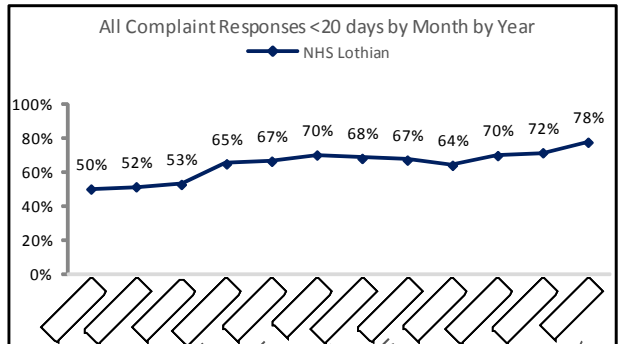


Chart 6



Reviewing the data in more detail there have been a number of CMTs / IJbs who have met 3-day acknowledgements by 100%:

- Allied Healthcare Professional
- Diagnostic, Anaesthetics, Theatres & Critical Care
- Outpatient & Associated Services
- St John's Hospital
- Women's Services

- Children's Services
- Corporate Services
- Edinburgh Health & Social Care Partnership
- West Lothian Health & Social Care Partnership
- East Lothian Health & Social Care Partnership

20-day performance

- Diagnostic, Anaesthetics, Theatres & Critical Care – 78%
- Outpatient & Associated Services – 100%
- Royal Edinburgh Hospital – 92%
- HMP Edinburgh – 92%
- HMP Addiewell – 97%

Table 3 demonstrates that during January there were 2 complaints and 1 one concern made in person to the Patient Experience Team. We continue to receive the majority of correspondence electronically (n=162), of which we received 90 complaints by email. The majority of feedback received during January were complaints (n=298). There continues to be discussion as to the definition of a complaint and a concern and the new NHS Scotland Complaints Handling Procedure (CHP) provides clarity around definitions.

Table 3. Complaints by Method Received and Type

January 2017	Complaint	Concern	Enquiry	Feedback	Comments	Compliment	Total
Comments card	6	1	1	0	0	1	9
email	90	21	12	3	1	35	162
In person	2	1	0	0	0	0	3
Letter	33	25	5	0	0	23	86
Other	1	1	1	0	0	1	4
Prison complaint form	110	38	0	0	0	1	149
Telephone call	56	10	0	2	0	1	69
Web complaints form	0	1	0	0	2	2	5
Total	298	98	19	5	3	64	487

The risk assessment tool has been in place since April 2016. Table 4 below demonstrates the assessments made against all complaints and concerns by the Patient Experience Team.

Table 4. Complaints by Month and Level of Risk

	Negligible	Minor	Moderate	Major	Extreme	Total
Apr 2016	51	90	21	4	0	166
May 2016	124	141	43	11	0	319
Jun 2016	146	153	47	9	1	356
Jul 2016	145	150	45	9	0	349
Aug 2016	231	98	44	7	1	381
Sep 2016	223	125	30	12	0	390
Oct 2016	194	120	29	4	1	348
Nov 2016	175	132	44	1	0	352
Dec 2016	177	108	46	2	0	333
Jan 2017	276	97	24	2	0	399
Total	1742	1214	373	61	3	3393

Table 5 demonstrates the issues that have been recorded using the ISD codes for January. The majority of issues raised concerned Treatment, followed by Staff and Waiting Times. There is a concern that as NHS Lothian manages its Treatment Time Guarantee (TTG) this may be reflected in the number of complaints regarding waiting times. These top 3 issues have been consistently observed since 2010/11. ISD codes are generally only applied to complaints and not other categories of feedback.

Table 5. Complaints by ISD Issue and Type

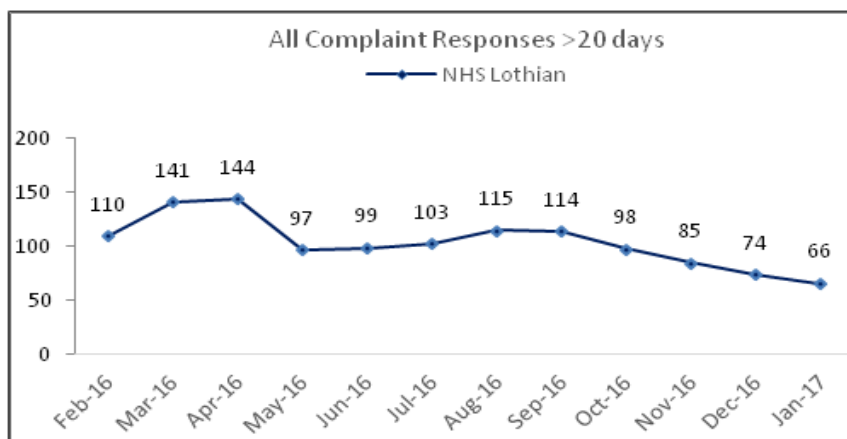
January 2017	Complaint	Concern	Enquiry	Total
Staff	112	2	0	114
Waiting times for	51	5	1	57
Delays in/at	3	0	0	3
Environment / domestic	10	1	0	11
Procedural issues	3	1	0	4
Treatment	157	15	0	172
Other	7	1	0	8
Total	343	25	1	369

Reviewing the complaints, concerns, enquires and comments that were closed in January (n=348):

- there were 9 complaints, 1 enquiry and 4 concerns where the complainant chose to withdraw their feedback.
- There were 126 complaints out of total of 270 that were not upheld (46.67%).
- 43 complaints out of 270 that were partially upheld (15.93%)
- There were 66 complaints out of 270 that were upheld (24.44%)

The Patient Experience have been monitoring the number of complaints over 20 days and chart C below demonstrates the total number of complaints recorded over 20 days and this is lowest that it has been since we started to record this. This information forms part of the weekly reports sent to the services/clinical teams.

Chart C



Scottish Public Services Ombudsman

The SPSO opened the following cases (1 April – 31 January 2016)

Table 9. SPSO cases opened by Management Team and Date SPSO Received (Month and year)

SPSO opened cases	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Total
Childrens Services	0	0	0	0	0	0	0	0	0	1	1
Corporate / Single System Services	0	0	0	0	0	0	0	3	0	0	3
Diagnostics, Theatres, Anaes & Critical Care	0	0	0	1	0	0	0	0	0	0	1
East Lothian HSCP	0	0	1	0	0	0	0	0	0	0	1
Edinburgh CHP Nursing	0	0	0	0	1	0	0	0	0	0	1
FHS - Independent Contractors	0	0	0	1	1	1	1	1	1	2	8
HMP Healthcare Services	2	0	0	0	0	1	1	0	1	2	7
Outpatient and Associated Services	0	0	0	0	0	0	1	1	0	0	2
RIE Hospital Site Management Team	1	1	1	0	3	1	5	3	0	1	16
Royal Edinburgh & Associated Services	0	0	2	0	0	1	2	2	0	0	7
STJ Hospital Site Management Team	2	0	1	2	0	1	0	0	0	1	7
UHSS - Facilities	0	0	0	1	0	0	1	0	0	0	2
West Lothian HSCP	0	0	0	1	1	0	1	0	0	1	4
WGH Hospital Site Management Team	0	0	0	1	2	0	2	1	1	1	8
Women Services	3	0	0	0	2	1	0	0	0	0	6
Total	8	1	5	7	10	6	14	11	3	9	74

The outcome of SPSO closed the following cases (1 April – 31 January 2016)

Table 10. SPSO cases closed by Management Team and Date SPSO Received (Month and year)

SPSO closed Cases	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Total
Children Services	1	0	0	1	0	0	0	1	0	0	3
Corporate / Single System Services	0	0	0	0	0	0	0	1	0	0	1
Diagnostics, Theatres, Anaes & Critical Care	1	0	0	1	1	0	0	0	0	0	3
East Lothian HSCP	1	0	0	0	0	0	0	0	0	0	1
FHS - Independent Contractors	0	0	0	0	2	1	1	1	1	1	7
HMP Healthcare Services	2	0	0	1	4	1	1	0	1	1	11
Lothian Unscheduled Care	0	0	0	0	0	1	0	0	0	0	1
Outpatient and Associated Services	0	0	0	0	1	0	1	0	1	0	3
RIE Hospital Site Management Team	1	0	4	4	0	1	2	3	0	0	15
Royal Edinburgh & Associated Services	2	0	1	0	1	0	3	2	0	0	9
STJ Hospital Site Management Team	1	0	0	0	0	0	0	0	2	2	5
UHSS - Facilities	0	0	0	0	0	0	1	0	0	0	1
West Lothian HSCP	0	0	0	0	0	0	0	1	1	1	3
WGH Hospital Site Management Team	1	0	0	0	1	1	1	2	1	2	9
Women Services	1	0	0	0	0	1	0	0	1	1	4
Total	11	0	5	7	10	6	10	11	8	8	76

Of the 8 SPSO complaints, 3 were recorded to DATIX and closed as detailed below

- SJH 1 recorded and closed as SPSO did not investigate
- West Lothian HSCP 1 recorded and closed as SPSO did not investigate
- GP 1 GP Practice

Table 11. Complaints outcomes by SPSO received cases by month

	Irresolvable other	Transferred to another	Upheld	Partly Upheld	Not Upheld	Total
January 2017						
General Practitioner (Ind Contrators)	0	2	0	0	0	2
HMP Healthcare Services	0	0	0	2	0	2
RIE Hospital Site Management Team	0	0	0	1	0	1
STJ Hospital Site Management Team	1	0	0	0	0	1
WGH Hospital Site Management Team	0	0	0	0	1	1
WL Mental Health	0	0	1	0	0	1
Total	1	2	1	3	1	8

THE NHS MODEL COMPLAINTS HANDLING PROCEDURE (MODEL CHP)

GUIDE TO IMPLEMENTATION

BACKGROUND

- The SHC's Listening and Learning report

ABOUT THE CHP

- Services provided on behalf of the NHS

IMPLEMENTING THE CHP

- Adopting the CHP
- Publication and accessibility
- Recording complaints

MONITORING COMPLIANCE AND PERFORMANCE

- Compliance
- Performance

ADVICE AND SUPPORT

- Training
- Valuing Complaints website
- Network of complaints handlers

BACKGROUND

The Scottish Health Council's report, 'Listening and Learning - How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland'¹, was commissioned by the Scottish Government and reported in April 2014. The report made a number of recommendations relating to complaints, including that that, as experts in this area, the Scottish Public Services Ombudsman's Complaints Standards Authority (CSA) should lead on developing a more succinctly modelled, standardised and person-centred complaints process for NHS Scotland, in collaboration with the public, NHS Boards and the Scottish Health Council.

The NHS model complaints handling procedure (CHP) has been developed through a partnership approach, led by a Steering Group involving the Scottish Public Services Ombudsman (SPSO), NHS professionals, the Scottish Government and other key stakeholders. It was produced within the framework of model CHPs previously published by SPSO across the wider public sector in Scotland and takes account of the 'Can I Help You good practice guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services'². The revised procedure will require amendments to the Regulations and Directions associated with the Patient Rights (Scotland) Act 2011. The Scottish Government intends these amendments to be made ahead of the proposed implementation date for the new procedure of 1 April 2017.

Recognising the 'Listening and Learning' report's recommendation to address inconsistencies in complaints management across different NHS services, the NHS model complaints handling procedure provides a standard template for NHS Boards and their service providers to adapt for use by their own organisations. By adapting the NHS model complaints handling procedure documents in this way, and preparing to adopt them by the proposed implementation date as set out in this implementation guide, NHS Boards and service providers will be supported to comply with the requirements of the Patient Rights (Scotland) Act 2011 and associated Regulations and Directions.

The NHS CHP is intended to support NHS Boards and their service providers to take a consistently person-centred approach to managing complaints in the NHS, which is aligned to the complaints procedures adopted across the wider public sector in Scotland. In particular, the aim is to implement a standard process, which ensures that NHS staff and

¹ http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx

² 'Can I Help You' (CIHY?) guidance <http://www.scotland.gov.uk/Publications/2012/03/6414>

people using NHS services can have confidence in complaints handling, and encourages NHS organisations to learn from complaints in order to continuously improve services.

ABOUT THE CHP

The model CHP is intended to be used by all NHS service providers. This includes any person with whom a relevant NHS body enters into a contract, agreement or arrangement to provide health care. This includes health care providers such as GPs, dentists, opticians, pharmacists, as well as other contractors such as cleaning or catering providers.

The CHP is presented in four sections which explain the end-to-end procedure to be followed in handling complaints:

1. Our complaints handling procedure
2. What is a complaint (including feedback, comments and concerns)?
3. The complaints handling process (early resolution and investigation)
4. Governance of the CHP.

There is also a 'public-facing' CHP which is included as a separate but integral section of the procedure. This provides standardised information on the complaints procedure to people who complain, ensuring that everyone receives the same information on complaints regardless of where they live or the NHS service provider they are involved with.

To be compliant with the Patient Rights (Scotland) Act 2011 and associated Regulations and Directions, as they are intended to be amended ahead of the proposed implementation date of 1 April 2017, NHS bodies should adopt both the CHP and the public-facing CHP.

Services provided on behalf of the NHS

Some NHS bodies use external Boards, Primary Care providers or contractors to deliver services. While these organisations are separate from the NHS body, it is still responsible for ensuring the services provided meet the required standard. It is for each NHS body to ensure that external service providers are meeting the requirements of the model CHP. This may be a straightforward matter where one NHS Board provides a service on behalf of another. It may be less clear when, for example, a private contractor is used. The NHS body on whose behalf a service is being provided must have mechanisms in place to ensure the service provider has a CHP in place which meets the requirements of the NHS model CHP. Alternatively the NHS body may agree to act on complaints handling performance issues where it considers this to be appropriate.

IMPLEMENTING THE CHP

Adopting the CHP

The model CHP is provided as a template for NHS bodies and service providers to adapt and adopt.

We recognise the importance of providing scope to adapt the model CHP to reflect, for example, each body's branding, organisational structure, operational processes and corporate style. This will vary considerably, from large Boards to sole practitioners of Primary Care provision. Primary Care providers will note that there are sections of the model CHP which do not relate to the services they provide, and where this is the case the Primary Care provider should amend the procedure appropriately. In respect of the section which includes the 'roles and responsibilities' of staff, Primary Care providers should reflect the roles and responsibilities of staff within their own organisations.

The model CHP has been structured to provide as much flexibility as possible, while still providing the required level of standardisation across NHS service providers. We appreciate that the way in which an NHS body presents its documented procedures is extremely important. The flexibility within the model CHP means that each NHS body can ensure that its own procedure reflects the organisation's corporate identity, branding, structure and language.

In order to meet the needs of all NHS bodies while maintaining standardisation where necessary, the text in the model CHP is presented in different ways. As NHS bodies adapt the model CHP for their own organisation, they must ensure that they reflect the level of flexibility provided for the different sections of the model CHP. The text is set out as follows:

- Text in italics reflects sections where there is an expectation that the NHS body will adapt the text based on their own organisational needs, such as the roles and responsibilities in relation to signing-off complaints;
- Text in square brackets [] indicates where NHS bodies may choose to provide additional material or clarification in their CHP, such as additional guidance or reference to local processes.

Care must be taken when amending the text of the model CHP, to ensure that it is not amended to the extent that its purpose or substance is changed in a way which does not

reflect the model CHP or the requirements of the Patient Rights Act (Scotland) 2011 and its associated Regulations and Directions.

It is also important that the information contained in the public-facing CHP is adopted in full by the NHS body. The information presented may be included in a form appropriate to the NHS body (for example, through leaflets or the authority's website) or as part of wider information on how people can provide feedback, comments and concerns as well as complaints. NHS bodies may also provide further information in relation to the CHP, but the information for all people who may complain should remain consistent with the published public-facing CHP.

Publication and accessibility

It is important to make people aware of their right to complain, and information about the procedure should be easily accessible at all times, not just made available when someone wishes to complain. Arrangements about how to make a complaint must be widely publicised, simple and clear, and made available in all areas of service provision. NHS bodies should, therefore, consider the most effective ways to ensure maximum accessibility, such as online information about how to access the procedure which should be clearly visible on the NHS body's website. Information for prisoners about how to complain should also be clearly presented within prison halls and in the prison healthcare setting. Traditional methods such as leaflets can also be helpful and NHS bodies should consider where these can most effectively be displayed.

People must, where appropriate, have the support they need to successfully navigate the complaints procedure. A range of methods for complaining by whatever means is easiest for the person should be provided and accepted to ensure accessibility to the procedure. This may include frontline staff assisting the person by writing the complaint for them.

NHS bodies should take into account special needs, such as for people with learning difficulties, people who are deaf or hard of hearing, elderly people, the visually impaired and non-English speakers. Where appropriate, suitable arrangements should be made for the specific needs of those who wish to complain, including provision of interpreting services, information in a variety of formats and languages, at suitable venues, and at suitable times. It is important to bear in mind that the CHP may be used by any member of the public, and access arrangements must reflect this.

Recording complaints

It has always been a requirement to record all complaints. This remains the case with the revised procedure. Recording and monitoring all complaints is essential to the quality management process, while analysing the causes of complaints and their outcomes provides valuable learning, and essential information to improve services.

MONITORING COMPLIANCE AND PERFORMANCE

Compliance

In accordance with the Complaints Directions, complaints statistics gathered through the quarterly reporting of complaints must be submitted by relevant NHS bodies to the Information Services Division at National Services Scotland, within three months of the year end. The information must be in an appropriate format to allow collation and publication of national complaints statistics.

Primary Care service providers are also required to record and report on complaints. NHS Boards should ensure that arrangements are in place for all contractors to comply with this requirement, so that they can include the information provided by service providers in their own reporting of complaints handling performance. This reporting should clearly differentiate between the Board and its contractors.

Compliance with the revised complaints procedure will be monitored by the Scottish Government with the support of the SPSO. The SPSO will also check that the procedure has been complied with in respect of any complaints it sees.

In 2017 the Scottish Government, supported by the SPSO's Complaints Standards Authority (CSA), will monitor whether or not NHS Boards have properly implemented the revised procedure from the proposed implementation date. Director letter (2016) 19 required Boards to provide their CHP to the Scottish Government by 7 April 2017, with confirmation that they have implemented the procedure from 1 April 2017. NHS Boards should also provide a self-assessment of how their CHP and public-facing CHP meet the requirements of the NHS model CHP. This information must be provided by completing the pro-forma in Appendix 1, which may be provided in advance of 1 April 2017. The Scottish Government will work with the CSA to assess the returns from NHS Boards, and to provide support to

those Boards that may require it. Boards and their service providers should continue to handle complaints in line with the [Patient Rights \(Complaints Procedure and Consequential Provisions\) \(Scotland\) Regulations 2012](#) and the [Patient Rights \(Feedback, Comments, Concerns and Complaints\) \(Scotland\) Directions 2012](#) until the new procedure is introduced.

The CHP and pro-forma return from Boards should be sent to Pauline.Bennett@gov.scot

All Primary Care service providers must also adopt the model CHP from the proposed implementation date. While Primary Care providers may adapt the model CHP to meet the requirements of the service provided, it is very important that it is not amended to the extent that its purpose or substance is changed in a way which does not reflect the model CHP or the requirements of the Patient Rights Act (Scotland) 2011 and its associated Regulations and Directions. Primary Care providers should use the pro-forma in Appendix 1 to self-assess their CHP against the full requirements of the model. Where the 'Requirement of CHP' does not apply to the Primary Care provider, they should document the reasons in the comments box of the assessment.

Performance

The Scottish Government intends to amend the Regulations and Directions associated with the Patient Rights (Scotland) Act 2011 to require NHS bodies to publish complaints handling performance information around a range of high-level performance indicators, which will help provide internal assurance of performance. These indicators will also provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

Key Performance Indicators

The Data Recording and Reporting Sub Group of the NHS Complaints Review Steering Group has developed a suite of key complaints performance indicators by which NHS Boards and service providers should measure and report performance.

The indicators provide the minimum requirement to self-assess and report on performance, and to undertake benchmarking activities. NHS bodies may, however, develop and report additional performance indicators considered to be relevant to the services provided.

The complaints performance indicators are:

1. Learning from complaints
2. Complaint process experience
3. Staff awareness and training
4. The total number of complaints received
5. Complaints closed at stage one and stage two as a percentage of all complaints closed
6. Complaints upheld, partially upheld and not upheld at each stage as a percentage of complaints closed in full at each stage
7. Average times
8. The number and percentage of complaints at each stage which were closed in full within the set timescales of 5 and 20 working days.
9. Number of cases where an extension is authorised

A further guidance note explaining the indicators in more detail will be prepared and published to help organisations adopt a robust self-evaluation approach to measuring complaints handling performance against the indicators.

Advice and Support

Training

The revised complaints procedure places a strong emphasis on early resolution of complaints, effective recording of complaints, and staff being properly trained and empowered to deal with complaints.

All staff need to have an understanding of how to deal with complaints and the appropriate knowledge and skills to do so effectively. This includes being aware of how to identify complaints, and when they are authorised to use a range of measures to achieve resolution, such as a meaningful apology where appropriate. Investigative staff must also have the skills and training to effectively investigate and reach robust decisions on more complex complaints.

It is for each NHS body to identify the training needs of appropriate staff to ensure they have the skills and confidence to use the authority delegated to them. The Scottish Government is supporting NHS Education for Scotland (NES) and the CSA to jointly develop a programme of training and events as well as awareness-raising materials to support implementation of the model CHP. This will complement the existing e-learning

modules, which cover skills for frontline staff and complaints investigators and which are freely available for all staff providing NHS services. Alongside this, the SPSO's training unit provides training courses on complaints investigation and complaint handling skills, such as listening, problem solving and conflict resolution. Further details of training and awareness-raising information may be obtained at [www.knowledge.scot.nhs.uk/making -a-difference](http://www.knowledge.scot.nhs.uk/making-a-difference) or www.valuingcomplaints.org.uk.

Valuing Complaints website (www.valuingcomplaints.org.uk)

Valuing Complaints is the SPSO's CSA website. It provides a centre for best practice in complaints handling. It contains information to help support improvement in public sector complaints handling, including model complaints handling procedures (CHPs) for Scotland, implementation and compliance guidance, and best practice and training resources.

Network of complaints handlers

Where model CHPs have been introduced in other Scottish Public sectors, these sectors have also taken the opportunity to introduce complaints network groups. The remit of these networks include identifying, developing and evaluating best practice, supporting complaints handling practitioners and providing a forum for benchmarking complaints performance.

The NHS Complaints Personnel Association Scotland (NCPAS) is a network that already recognises the need for consistency of information about the complaints procedure and the need for a single voice to represent the NHS in consultations relating to complaints. NCPAS has a role to play in providing a forum for practitioners to share their experiences and learning from complaints handling. Importantly, performance information derived from the key performance indicators will also help NCPAS to compare and contrast performance across the sector, and benchmark for improvements.

Appendix 1

Compliance statement and self-assessment

[NAME OF NHS Board]

[CONTACT DETAILS]

The information on this pro forma must be provided to the Scottish Government by **7 April 2017**. Please send the completed form and a copy of the Board's CHP to Pauline.Bennett@gov.scot

Please provide, at Section 1, confirmation that the Board has adopted both the CHP and the public-facing CHP and has introduced the CHP across all services (if provided after 1 April 2017), or is ready to do so (if provided ahead of this date).

At Section 2 please complete a self-assessment of your Board's CHP, or draft CHP for implementation from 1 April 2017, against the requirements of the revised procedure.

SECTION 1 - Statement from Senior Officer (CEO) of [NAME OF Board].

[please delete as applicable]	Please ✓
The Board has adopted both the NHS model CHP and the public-facing CHP and has introduced the CHP across all services from 1 April 2017.	
The Board will adopt both the CHP and the public-facing CHP and will introduce the CHP across all services from 1 April 2017.	

Signed:

Print Name:

Date:

SECTION 2 - [NAME OF Board] Self-assessment of compliance

Requirement of CHP	Met Yes/No	Comment
Does the CHP adopt the text and layout of the published model CHP, subject to necessary amendments, to reflect, for example, the organisational structure, operational processes and corporate style?	Yes	<i>Highlighted sections are generally sourced and adapted from the NHS Scotland Model CHP</i>
Does the customer facing CHP adopt the text and layout of the published model customer facing CHP, subject to necessary amendments?	Yes	
Does the CHP include an appropriate foreword from the Board's Chief Executive?	Yes	Page 2
Does the CHP provide an appropriate definition of a complaint?	Yes	Section 4, Pages 10-11, amendment Minor changes to previous definitions using NHS Scotland Model CHP
Does the CHP explain the types of issues which may be considered as a complaint?	Yes	Section 5, Page 14, amendment This is a new requirement with a non-exhaustive list provided in NHS Scotland Model CHP.
Does the CHP explain the types of issues which may not be considered through the CHP?	Yes	Section 5, Pages 14-15, new This is a new requirement with a non-exhaustive list provided in NHS Scotland Model CHP.
Does the CHP include sections to help staff to distinguish between feedback, comments, concerns and complaints?	Yes	Appendix 3, Page 30, new The diagram is sourced directly from NHS Scotland Model CHP. The procedure will give additional guidance
Where appropriate, does the CHP contain the required references to Primary Care service providers?	Yes	Section 4.1, Page 11, amendment Highlighted text in this section has been sourced from NHS Scotland Model CHP. This section has been amended.
Where appropriate, does the CHP contain the required references to complaints from prisoners?	Yes	Section 6.1, Page 16, new This is a new section sourced from NHS Scotland Model CHP
Does the CHP include guidance in relation to financial compensation?	Yes	Section 15, Pages 24-25 , new This is a new section sourced from NHS Scotland Model CHP.
Does the CHP include appropriate guidance on handling anonymous complaints?	Yes	Section 6.2, Page 16, new This is a new section sourced from NHS Scotland Model CHP
Does the CHP include guidance on Whistleblowing?	Yes	Section 18, Page 26, new This is a new section sourced from NHS Scotland Model CHP

Requirement of CHP	Met Yes/No	Comment
Does the CHP include guidance on significant adverse event reviews?	Yes	Section 12, Page 22-23, new This is a new section. It links to existing SAER policy.
Does the CHP include guidance on Patient Opinion?	Yes	Section 6.3, Page 16, new Also in executive Summary, Appendix 4 and further detail in the procedure
Does the CHP clarify who can make a complaint?	Yes	Section 6, Page 15, amendment Also included in the public facing document.
Does the CHP provide guidance in respect of circumstances where the person raising the issue does not want to complain?	No	Further detail is also in the procedure / toolkit document
Does the CHP cover complaints involving more than one NHS service or organisation?	Yes	Section 4.2, Page 12, new New section sourced from NHS Scotland Model
Does the CHP include reference to handling social care complaints?	Yes	Section 4.3, Page 13, New Sourced directly from NHS Scotland Model CHP
Does the CHP include a description of the early resolution stage of the procedure?	Yes	Section 8, Page 18, new The complaints management section has been changed entirely from old procedure using NHS Scotland model.
Does the CHP explain how a person may make a complaint?	Yes	Contained in the public facing CHP and procedure document
Does the CHP explain the issues to be considered on the receipt of a complaint?	Yes	Section 7, Page 17, amendment Further details contained with the Procedure / Toolkit
Does the CHP include the correct timeline at early resolution?	Yes	Section 8, Page 18, new
Does the CHP explain the basis for an extension to the timeline at early resolution?	Yes	Section 8.2, Pages 19, new This is included in the operational procedure.
Does the CHP explain the action to take in closing the complaint at the frontline resolution stage?	Yes	Section 8, Page 18, new More details will be included in operational procedure
Does the CHP explain when to escalate a complaint to the investigation stage?	Yes	Section 8, Page 18, new Further detail is also in the procedure/toolkit document
Does the CHP include a description of the investigation stage of the procedure?	Yes	Section 8, Page 18, new Further detail is also in the procedure/toolkit document

Requirement of CHP	Met Yes/No	Comment
Does the CHP explain what to do when a complaint is received at the investigation stage?	Yes	Section 8, Page 18, new Further detail is also in the procedure / toolkit document
Does the CHP include reference to making contact with the person making the complaint at the start of the investigation?	Yes	Contained with the Procedure/Toolkit
Does the CHP explain the requirement to acknowledge the complaint within three working days at the investigation stage?	Yes	Section 8, Page 18, new
Does the CHP explain the requirement to provide a full response to complaints within 20 working days at the investigation stage?	Yes	Section 8, Page 18, new
Does the CHP detail the information to be provided when acknowledging a complaint?	Yes	Contained with the Procedure / Toolkit
Does the CHP include reference to meeting with the person making the complaint during the investigation?	Yes	The detail of this is contained in the Procedure / Toolkit
Does the CHP explain the basis for an extension to the timeline at the investigation stage?	Yes	Section 8.2, Page 18, new
Does the CHP explain the required action when closing the complaint at the investigation stage?	Yes	The high level actions are contained within the CHP and the detailed actions are in the procedure / toolkit document.
Does the CHP include guidance in relation to meetings and post decision correspondence with the person making the complaint?	Yes	The detail of this is contained in the procedure / toolkit document
Does the CHP explain the requirement to provide information about the SPSO at the conclusion of the investigation?	Yes	Section 8, Page 18, new
Does the CHP explain the roles and responsibilities of all staff involved in complaints handling?	Yes	Section 2, Page 8-10, new
Does the CHP cover complaints about senior staff?	Yes	Section 8.1, Page 18, new

Requirement of CHP	Met Yes/No	Comment
Does the CHP include the requirement to record all appropriate details in relation to the complaint?	Yes	Contained with the Procedure / Toolkit
Does the CHP include the arrangements in place to monitor complaints?	Yes	Section 13, Page 23, amendment Amended text sourced from NHS Scotland Model CHP.
Does the CHP commit to reporting complaints as is documented in the model CHP?	Yes	Section 13, Page 23, amendment
Does the CHP include the requirement for senior management to review the information gathered from complaints regularly, and consider how services could be improved or internal policies and procedures updated?	Yes	Section 11, Page 21, amendment Further detail included in the procedure/toolkit document
Does the CHP include the requirement to learn from complaints?	Yes	Section 11, Page 21, amendment further detail included in the procedure/toolkit document
Does the CHP include the requirement to publish performance in handling complaints annually?	Yes	Section 12, Page 18, amendment
Does the CHP include arrangements for the National Monitoring of complaints?	Yes	Appendix 4
Does the CHP include arrangements for performance reporting by Primary Care service providers?	Yes	Section 13, Page 24 & Appendix 4
Does the CHP refer to legal requirements in relation to confidentiality issues?	Yes	Section 16, Page 25
Does the CHP reference the data Protection Act 1998?	Yes	Section 16, Page 25, new
Does the CHP refer to dealing with problem behaviour?	Yes	Section 10, Page 20, amendment Highlighted text from NHS Scotland model CHP
Does the CHP refer to supporting the person making the complaint?	Yes	Section 7, Page 17, amendment Now refers to Patient Advice and Support Services (PASS) instead of CAB/IASS
Does the CHP refer to the Patient Advice and Support Service?	Yes	Section 7, Page 17, amendment
Does the CHP set a time limit of six	Yes	Section 9, Page 20

Requirement of CHP	Met Yes/No	Comment
months to consider the complaint, unless there are special circumstances for considering complaints beyond this time?		

1. Primary Care service providers

Primary Care service providers include General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners, Ophthalmic Medical Practitioners and Community Pharmacists. All are included in references to health service providers throughout this model Complaints Handling Procedure, and the requirements of this procedure apply to all Primary Care service providers.

Most, but not all, Primary Care service providers are independent contractors who provide NHS health services on behalf of NHS Health Boards. However, Boards are required by law to ensure that each of their service providers have adequate arrangements in place for handling and responding to patient feedback and comments, concerns and complaints.

Boards are therefore required to ensure that each of their service providers have self-assessed their compliance with the revised procedure, and reported this to the Board. The CSA can provide additional advice and assistance to Boards, to help them to do this as straightforwardly as possible.



The NHS Scotland Complaints Handling Procedure

April 2017



Scottish Government
Riaghaltas na h-Alba
gov.scot

SPSO Scottish
Public
Services
Ombudsman

National Health Service Scotland Complaints Handling Procedure

Foreword

Our complaints handling procedure reflects NHS Lothian's commitment to welcoming all forms of feedback, including complaints, and using them to improve services, to address complaints in a person-centered way and to respect the rights of everyone involved. It will support our staff to resolve complaints as close as possible to the point of service delivery and to respond thoroughly, impartially and fairly by providing evidence-based decisions based on the facts of the case.

This procedure has been developed by NHS complaints handling experts working closely with the Scottish Public Services Ombudsman (SPSO). We have a standard approach to handling complaints across the NHS, which complies with the SPSO's guidance on a model complaints handling procedure, meets all of the requirements of the Patient Rights (Scotland) Act 2011, and accords with the Healthcare Principles introduced by the Act. This procedure aims to help us 'get it right first time'. We want quicker, simpler and more streamlined complaints handling with local, early resolution by capable, well-trained staff.

We aim to provide the highest quality services possible to people in our communities through the delivery of safe, effective and person-centered care. Whenever the care we provide can be improved, we must listen and act. Complaints give us valuable information we can use to continuously improve our services. They provide first-hand accounts of people's experiences of care that help us to identify areas of concern, achieve resolution wherever possible and take action so that the same problems do not happen again.

Our complaints handling procedure helps us to build positive relationships with people who use our service and rebuild trust when things go wrong. It has the person making the complaint, their families and carers, at the heart of the process. We will address complaints effectively, resolve them as early as we can, and learn from them so that we can improve services for everyone.

Whilst the NHS Lothian is responsible for the delivery of health services, the Health and Social Care Partnership has responsibility for the planning and direction of services in their area which have been delegated to them. The integration of health and social care requires staff from the health board, local authority and third sector organisations to work together in order to provide joined up, person-centered services.

From 1 April 2017, there will be an alignment of the complaints handling procedures for health and social care and this will provide consistency and clarity around the handling of integrated complaints.

Tim Davison, Chief Executive

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Board Statement on the Complaints Handling Procedure

“We are committed to welcoming all forms of feedback, including complaints, and using them to improve services. We strive to address complaints in a patient-centered way and to respect the rights of all involved. NHS Lothian is committed to providing safe, effective and high quality services. We do however recognize that at times, things can go wrong. When concerns or complaints are raised, NHS Lothian has a responsibility to acknowledge these, put things right as quickly as possible, to learn lessons, prevent reoccurrence and identify improvements.”

Our Complaints Handling Procedure

The Patient Rights (Scotland) Act 2011, together with supporting legislation, introduced the right to give feedback, make comments, raise concerns and to make complaints about NHS services. It also places a duty on NHS boards to actively encourage, monitor, take action and share learning from the views they receive. The Scottish Health Council's 2014 report *Listening and Learning - How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland* recommended that a revised, standardised complaints process for NHS Scotland should be developed, building on the requirements of the legislation, and ‘Can I Help You?’ guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services. This document delivers on that recommendation by explaining how our staff will handle NHS complaints. Another document, the public facing complaints handling procedure, provides information for the person making the complaint about our complaints procedure.

This procedure, which is based on the NHS Model Complaints Handling Procedure, explains the processes that we will follow in responding to complaints. It contains references and links to more details on parts of the procedure, such as how to record complaints, and the criteria for signing off and agreeing time extensions. The procedure also explains how to process, manage and reach decisions on different types of complaints.

The procedure supports us to meet the requirements of the Patient Rights (Scotland) Act 2011, and associated Regulations and Directions. It has been developed to take account of the *SPSO Statement of Complaints Handling Principles* and best practice guidance on complaints handling from the Complaints Standards Authority at the SPSO.

<http://www.valuingcomplaints.org.uk>

In accordance with the legislation, we will take steps to ensure that the people using our services, their families and unpaid carers are aware of how they can give feedback or make a complaint, and the support that is available for them to do so. We will ensure that

our own staff and service providers are aware of this procedure, and that our staff know how to handle and record complaints at the early resolution stage.

Where apologies are made under the procedure, the Apologies (Scotland) Act applies to those apologies. The procedure is intended to operate alongside the duty of candour in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and related Regulations, once this is in force.

This complaints handling procedure is based on the human rights principles of:

- Participation: everyone has the right to participate in decisions which affect them, including issues of accessibility and the provision of information that people can understand.
- Accountability: service providers have a duty to the public, patients and staff to investigate complaints and seek effective remedies.
- Non-discrimination and equality: the complaints process is available to everyone and vulnerable or marginalised groups are supported to participate in the process.
- Empowerment: everyone should be aware of their rights, the complaints process and be involved in the process to reach an effective remedy.
- Legality: the complaints process identifies and upholds the human rights of staff, patients and others, and is in accordance with the requirements of all relevant legislation. It aims to provide a quick, simple and streamlined process for resolving complaints early and locally by capable, well-trained staff.

What is a complaint?

NHS Lothian's definition of a complaint is:

'An expression of dissatisfaction by one or more members of the public about the Board's action or lack of action, or about the standard of service provided by or on behalf of the Board.'

A complaint may relate to:

- care and/or treatment;
- delays;
- failure to provide a service;
- inadequate standard of service;
- dissatisfaction with the Board's policy;
- treatment by or attitude of a member of staff;
- scheduled or unscheduled ambulance care;
- environmental or domestic issues;
- operational and procedural issues;
- transport concerns, either to, from or within the healthcare environment;

- the Board's failure to follow the appropriate process;
- lack of information and clarity about appointments; and
- difficulty in making contact with departments for appointments or queries.
- Disagreement with decision made in relation to adult social work services

This list does not cover everything.

[Appendix 1](#) provides a range of examples of complaints we may receive, and how these may be handled.

Not all issues may be for NHS **Boards** to resolve. In cases where an individual is unsatisfied with standards of conduct, ethics or performance by an individual health professional, it may be for the respective professional body to investigate. These include, for example the Nursing and Midwifery Council, the General Medical Council, the General Dental Council, the Royal Pharmaceutical Society, and the General Optical Society. Where serious concerns about a registered healthcare worker are identified, a referral to the appropriate professional regulator should be made.

Members of the public, including patients, the general public and those acting on behalf of patients and others may raise issues with relevant NHS bodies or their health service providers, which need to be addressed, but which are not appropriate for an investigation under this Complaints Handling Procedure. Further guidance is provided in the section covering feedback, comments and concerns below.

This complaints procedure does not apply to the following complaints, as set out in Regulations:

- a complaint raised by one NHS **Board** about the functions of another NHS **Board**;
- a complaint raised by a service provider about any matter connected with the contract or arrangements under which that service provider provides health services;
- a complaint raised by an employee of an NHS **Board** about any matter relating to that employee's contract of employment;
- a complaint which is being or has already been investigated by the Scottish Public Services Ombudsman (SPSO);
- a complaint arising out of an alleged failure to comply with a request for information under the Freedom of Information (Scotland) Act 2002(a);
- a complaint about which the person making the complaint has commenced legal proceedings (whether or not these have concluded), or where the feedback and complaints officer considers that legal proceedings are so likely that it would not be appropriate to investigate the complaint under this procedure;
- a complaint about which an NHS **Board** is taking or proposing to take disciplinary proceedings against the person who is the subject of the complaint; and

- a complaint, the subject matter of which has previously been investigated and responded to.

In these cases, there is a separate procedure available which is better placed to carry out the investigation, indeed in many cases a separate investigation may already be underway. If a complaint is raised which is within one of these categories, you must write to the individual, explaining the reason that this complaints procedure does not apply and the procedure the individual should use to raise the matter with the appropriate person or body. You may send this explanation electronically, provided that the person making the complaint has consented to this in writing, and has not withdrawn their consent.

This complaints procedure offers a person-centred and effective way of ensuring that complaints are thoroughly investigated and that areas for learning and improvement are identified and actioned. You should offer to resolve someone's complaint using the NHS complaints procedure, even where the person has stated (in writing or otherwise) that they intend to take legal proceedings. If, however, you are satisfied that the person has considered the NHS complaints procedure but nonetheless clearly intends to take legal action, then you may decide not to apply this complaints procedure to that complaint.

Additionally, this complaints procedure should not be used in the following circumstances:

- to consider a routine first-time request for a service;
- a request for a second opinion in respect of care or treatment;
- matters relating to private health care or treatment;
- matters relating to services not provided by or funded by the NHS.

You must not treat these issues as complaints, rather you should explain how the matter will be handled, and where appropriate direct the person raising the issue to use the applicable procedure where there is one. You must always consider how best to investigate, respond to and, where appropriate, resolve the issue.

We value all forms of feedback

We encourage all forms of feedback, positive and negative, and use it to continuously improve our services. The Patient Rights (Scotland) Act 2011 introduces a right for people to give feedback or comments to, or raise concerns or complaints with, NHS Boards and service providers. Feedback, comments and concerns are not complaints. They should be handled in line with the Patient Rights (Scotland) Act 2011, and the associated Regulations and Directions. Further guidance on handling and learning from feedback, comments and concerns is available in the 'Can I Help You' good practice guidance document.

It is necessary for staff to be able to distinguish between feedback, comments, concerns and complaints to ensure that any issues raised are handled through the appropriate

procedures. Where an issue raised is clearly not a complaint, staff should make arrangements to have the issue handled through the appropriate process and feed this back to the person raising the issue. The following paragraphs provide more information on feedback, comments and concerns.

Feedback

Feedback may be in the form of views expressed orally or in writing as part of a survey, patient questionnaires, through the Patient Advice and Support Service (PASS), or initiatives such as patient experience surveys or via stakeholder electronic portals. The feedback may describe the person or carer's individual experience of using NHS services and may include suggestions on things that could have been done better or identify areas of good practice.

Comments

Comments may be comments, compliments, feedback or observations offered orally or in writing for example on ward or hospital suggestion cards or through PASS, which reflect how someone felt about the service.

Concerns

Concerns may be expressed in relation to proposed treatment or about any aspect of the service, from timing of appointments to getting to hospital for the proposed treatment or the actual treatment received. An example may be where someone has been referred to a consultant and is concerned about what this means. Concerns of this nature fall short of a complaint as the person is not expressing dissatisfaction, but wishes to be fully informed about what is to happen.

People may need reassurance or further explanation and information to help them understand why the healthcare provider is suggesting a particular course of action. Staff should be alert to this and ensure that explanations are given and advice on additional support services is available and accessible to everyone.

It is particularly important for staff to use their discretion and judgement in supporting people to decide whether a matter is a concern or a complaint. The best way to do this is by talking to the person raising the issue to explain how concerns and complaints are handled and responded to. There may be circumstances where the nature of the concern is sufficiently serious to warrant full investigation under this complaints procedure. Even where the person states that they do not want to complain, if you are satisfied that the matter is clearly a complaint you should record it as such. If staff members are in any doubt they should seek advice from the ~~Feedback~~ **Patient Experience Team**.

The manner in which the matter is communicated to **NHS Lothian** will often help you to decide if it is a concern or a complaint. A matter may be communicated in a matter of fact

way, for example 'I am a little surprised at being in a mixed sex ward. I think you should put me in an all-female ward'. This is likely to be recorded as a concern. However, the same matter may be reported as 'I am very angry that you have put me in a ward with all these men. I feel humiliated and I refuse to accept this. Get me into an all-female ward now or I will call my son to come and take me home'. Given the way this matter is reported, you may decide that it is a complaint. [Appendix 3](#) includes a 'Feedback, Comments, Concerns or Complaints Assessment Matrix' which can be used where necessary to help you differentiate between these and decide how to proceed.

A concern should be responded to within five working days. It is important that, where you determine that a matter is a concern (rather than a complaint) and the person raising the issue remains unhappy with your response to that concern, you handle any subsequent action as a complaint. As you will already have attempted to resolve the person's concern, the early resolution stage of the complaints procedure is not an appropriate stage to consider the matter further. The matter should, therefore, be handled directly at the investigation stage of the complaints procedure.

[Appendix 2](#) provides examples of matters that may be considered as concerns.

Publication

In accordance with the Complaints Directions, relevant NHS bodies must publish annual summaries of the action which has been or is to be taken to improve services as a result of feedback, comments and concerns received in the year. **This will be published on NHS Lothian website.** <http://www.nhs.Lothian.scot.nhs.uk>

Primary Care service providers

Primary Care service providers should take every opportunity to resolve complaints quickly and locally, and at the point of contact wherever possible. Early resolution is the most effective way of resolving the majority of complaints and should be attempted where the issues involved are straightforward and potentially easily resolved, requiring little or no investigation. Resolving complaints early and locally helps to minimise costs as well as resolving a person's dissatisfaction. The fewer people involved in responding to a complaint, and the quicker a response is given, the lower the cost of that complaint to the Primary Care service provider in terms of resources and potential redress.

However, where the person making the complaint feels unable to make direct contact with the Primary Care service provider the complaint can, in exceptional circumstances, be made to the appropriate relevant NHS **Board** directly (this will normally be the NHS Board). The NHS **Board** should nominate the **Complaints & Feedback Team** Manager or other suitable officer to carefully consider the reasons for asking the body to handle the complaint. Where the **Board** considers it appropriate, the person making the complaint should be encouraged to contact the Primary Care service provider by explaining the value

of early and local resolution. Where the NHS body recognises that it would not be appropriate, or possible, for the person making the complaint to complain directly to the Primary Care service provider (for example there has been an irreconcilable breakdown in the relationship between the respective parties), contact should be made with the Primary Care service provider to agree the way in which the complaint will be managed, and the person making the complaint should be advised accordingly. At this point, consideration may be given to mediation, if both parties agree. Where agreement cannot be reached it will be for the relevant NHS **Board** to determine how the complaint should be managed. The person making the complaint must be advised of the arrangements that are made.

In handling complaints we will have regard to the General Medical Council (GMC)'s standards to help to protect patients and improve medical education and practice in the UK. Specifically that 'patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology'. Therefore, the person making the complaint can expect an apology to include what happened, what action we will take to resolve the matter and what will be done to prevent a similar occurrence happening in the future.

In handling complaints we will have regard to the other regulatory bodies on responding to complaints and concerns, Standards of conduct, ethics and performance and other Standards and Guidance issued by them.

Complaints from prisoners

As with all complaints, we aim to resolve prisoner complaints quickly, and close to the point of service delivery. Healthcare teams within prisons will, therefore, be trained and empowered to respond to complaints at each stage of this procedure, wherever possible.

*We will ensure that healthcare staff working with their local prisons are fully aware of this complaints procedure, and that appropriate information on how to complain is freely available to ensure that prisoners have the same access to the NHS complaints procedure as other people. When a prisoner expresses dissatisfaction about the service they have or have not received, or about the standard or quality of that service, we will ensure quick and easy access to the complaints procedure is available to them **and the prisoner healthcare staff try to resolve these locally and as quickly as possible.***

Financial compensation

The NHS complaints procedure does not provide for financial compensation. The independent Patient Advice and Support Service may be able to advise anyone who is seeking compensation where to get information about specialist solicitors who handle medical negligence claims.

It may also be appropriate to advise those who seek financial compensation that they may contact Action against Medical Accidents (AvMA), or the Law Society of Scotland. AvMA provides free independent advice and support to people affected by medical accidents while the Law Society of Scotland can provide contact details of law firms throughout Scotland that may specialise in claims for medical compensation.

Handling anonymous complaints

We value all complaints. This means we treat all complaints including anonymous complaints seriously and will take action to consider them further, wherever this is appropriate. All anonymous complaints are subject to this procedure. A senior manager should make a decision on appropriate action to take based on the nature of information provided about the anonymous complaint and any other relevant factors, for example consent issues. If, however, an anonymous complaint does not provide enough information to enable us to take further action, or to contact the complainant, we may decide that we are unable to complete the investigation. Any decision not to investigate an anonymous complaint must be authorised by a senior manager.

Information about, and decisions made regarding all anonymous complaints will be recorded on the complaints recording system (to the extent that the information is available) to allow consideration of any action necessary. If we pursue an anonymous complaint further, we will record the issues (to the extent that the information is available), actions taken and outcome. This will help to ensure the completeness of the complaints data we record and allow us to take corrective action where appropriate.

Whistleblowing

The NHS Scotland Staff Governance Standard places a specific obligation upon NHS employers to ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their Board, particularly in relation to patient safety. The Implementing & Reviewing Whistleblowing Arrangements in NHS Scotland Partnership Information Network (PIN) Policy, sets out the rights of staff in relation to whistleblowing. All NHS Scotland Boards have in place local whistleblowing policies based on the national PIN and staff should raise any concerns they have about patient safety or malpractice through this and not through the complaints handling procedure.

Alternatively, staff may contact the NHS Scotland Confidential Alert Line. The principal purpose of the Alert Line is to provide an additional level of support to NHS Scotland employees, should they feel unsure about how or whether to report cases of patient safety or malpractice directly to their Board, or, if they feel they have exhausted procedures in place. The Alert Line also provides a safe space where staff who feel they may be victimised as a result of whistleblowing, may, if appropriate, have their concerns passed to a Board or Regulatory Body on their behalf. The Alert Line can be contacted on Freephone 0800 008 6112.

Significant Adverse Events Review

Healthcare Improvement Scotland (HIS) defines an adverse event as an event that could have caused (a near miss), or did result in, harm to people or groups of people. The response to each adverse event should be proportionate to its scale, scope, complexity and opportunity for learning. Our Board has its own procedures to manage adverse events, and in the case of 'multi board' adverse events HIS has developed a guidance tool to sit within the national adverse events framework toolkit.

A complaint handled at the investigation stage of the complaints handling procedure may clearly meet the Board's criteria for managing significant adverse events. For example, where the complaint is about the safety of care, and the Board has a duty to proceed with an adverse event review, irrespective of whether a complaint has been made. Where, based on a complaint, it is deemed appropriate to undertake a Significant Adverse Events Review (SAER), we will advise the person making the complaint of this decision. It is for **Site Directors / Associate Nurse/Medical Directors** to decide whether the complaint investigation should continue in parallel with the SAER, or whether it is appropriate to allow the SAER to take account of the complaint(s) as part of the review. It is important to note that the SAER does not replace the complaints investigation, although the investigation timeline may have to be extended. We will explain the basis for making the decision, and advise the patient of the revised timescales. We will also tell them they will have the right to ask SPSO to consider their complaint further if they remain dissatisfied at the conclusion of the adverse event review process. We will let the person know the outcome of the review, taking account of the best practice guidance for closing a complaint at the investigation stage and record all the details on the system for recording complaints.

Further details on the management of adverse events can be found:

<http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/AdverseEventReview/Pages/rca2.aspx>

Care Opinion

Care Opinion (**formerly known as Patient Opinion**) provides an independent online service which allows patients, their families and carers to provide feedback, good or bad, on their experiences of health care **and adult social care** provision. The service enables people to post their experience online, and to engage in a dialogue with health care **and adult social care** providers that is focussed on service improvement.

Feedback from **Care Opinion** will include general feedback, comments, concerns and complaints. Where the feedback clearly meets the Board's definition of a complaint, and ~~there is~~ **where there is** insufficient information provided to handle the matter through the complaints procedure **we will respond via Care Opinion asking the person to contact the**

Patient Experience Team so that the complaint ~~should~~ **can** be recorded and handled as a complaint.

Who can make a complaint?

Anyone who is or is likely to be affected by an act or omission of an NHS **Board** or health service provider can make a complaint. Sometimes a person making the complaint may be unable or reluctant to do so on their own. We will accept complaints brought by third parties as long as the person making the complaint has authorised the person to act on their behalf.

Where a complaint is made on behalf of another person, in accordance with the common law duty of confidentiality and data protection legislation, we must ensure that, in addition to authorising another person to act on their behalf, the person has also consented to their personal information being shared as part of the complaints handling process. In circumstances where no such consent has been given, the **Board** would have to take that into account when handling and responding to the complaint (and is likely to be constrained in what it can do in terms of investigating any such complaint).

What if the person raising the issue does not want to complain?

If a person expresses dissatisfaction in line with our definition of a complaint but does not want to complain, tell them that we do consider all expressions of dissatisfaction, and that complaints offer us the opportunity to improve services where things have gone wrong. Encourage the person raising the issue to submit a complaint and allow us to deal with it through the complaints handling procedure. This will ensure that they are updated on the action taken and get a response to their complaint.

If, however, the person insists they do not wish to complain, you should record the complaint as being resolved at the early resolution stage of this procedure. This will ensure the completeness of the complaints data recorded and will still allow us to fully consider the matter and take corrective action where appropriate. Doing so will also ensure that the person has the opportunity to pursue the complaint at the investigation stage of the procedure should they subsequently raise the matter again.

Complaints involving more than one NHS service or Board

If someone complains about the service of another NHS Board or Primary Care service provider, and our Board has no involvement in the issue, the person should be advised to contact the relevant Board or service provider directly.

Where the complaint spans two (or more) NHS Board, for example one Board using the services of another to provide care and treatment, you must tell the person making the complaint who will take the lead in dealing with the complaint, and explain that they will get only one response covering all issues raised. The NHS Boards involved should be mindful

of the timescale within which the response should be issued and work jointly to achieve this.

There may be occasions where a complaint relates to two (or more) NHS Boards, however, each aspect of the complaint relates specifically to one, or other of the Boards. This could be, for example a complaint about pre-hospital care and a complaint about a delay in being seen in the accident and emergency department. Where this occurs it is important to communicate clearly with the person making the complaint to explain, and agree how the complaint will be handled. Where this applies each Board should record, handle and respond to the complaint about the service they provided and let the complainant know that they will receive two separate responses.

A complaint may relate to the actions of two or more of the Board's services. Where this is the case, you must tell the person making the complaint who will take the lead in dealing with the complaint, and explain that they will get only one response from the Board covering all of the issues they have raised.

Overlap with other duties on NHS Boards

NHS Boards are subject to a range of other duties in respect of honesty and openness about the services and care they provide. The Apologies (Scotland) Act 2016 is intended to encourage apologies being made by making it clear that apologising is not the same as admitting liability. An apology means any statement made indicating that the person is sorry about or regrets an act or omission or outcome. It also covers an undertaking to look into what happened with a view to preventing it happening again. In meeting the requirements of this complaints procedure we will apologise where appropriate and make sure that we are open and honest with people when an unintended or unexpected incident resulting in death or harm has happened. Most apologies made in the course of provision of NHS services, or in the course of resolving or investigating a complaint about an NHS service, will be subject to the provisions of the Apologies (Scotland Act) 2016.

The Duty of Candour procedure¹ may also be applied in circumstances which give rise to a complaint. This procedure will ensure that people will be told what happened, receive an apology, be told what will be done in response and how actions will be taken to stop a future reoccurrence.

Apologies which are made in accordance with the Duty of Candour procedure will, by virtue of section 23 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, also not amount to an admission of negligence or breach of duty.

¹ NB - the duty of candour procedure is not in operation at the date of publication of this model CHP. It will apply once the relevant provisions of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 are brought into force.

Care Inspectorate

The Care Inspectorate can investigate complaints about social care services provided by registered care providers, even if they have not yet gone through the local complaints handling procedure, and customers should be informed of this option.

Complaints that span health and social care services

From 1 April 2017, the health and social work complaints handling procedures will be aligned and will therefore have the same stages and timescales, with the exception of timescale extensions.

If a person raises a complaint about a health service and a social care or social work service the response will depend on whether these services are being delivered through a single, integrated health and social care partnership.

Where these services are integrated, you must work together with the health and social care partnership staff to resolve the complaint. A decision must be taken, by following the procedure that the health and social care partnership has in place, as to whether the NHS or local authority will lead on the response. You must ensure that all parties are clear about this decision. It is important, wherever possible, to give a single response from the lead organisation, though ensure both organisations contribute to this. However, in complex cases where a single response is not feasible, you should explain to the person making the complaint the reasons why they will receive two separate responses, and who they can get in contact with about the social work aspects of their complaint.

~~Where health and social work or social care services are not integrated, for example the relevant local authority provides a social work or social care service, independent of any health service provision, the person will need to direct their communications about social care or social work separately to the local authority. You must tell the person making the complaint which issues you will respond to, and direct them to the appropriate person to handle those relating to social work and care.~~

~~In either case,~~ it is important to bear in mind that:

- the Care Inspectorate can investigate complaints about social care services provided by registered care providers, even if they have not yet gone through the local complaints handling procedure, and customers should be informed of this option; and
- social work services must handle complaints according to the social work complaints handling procedure, which is largely in line with this complaints handling procedure.

Integration Joint Boards must have a separate complaints handling procedure for handling complaints about their functions. This will be broadly in line with this complaints handling procedure.

The complaints handling process

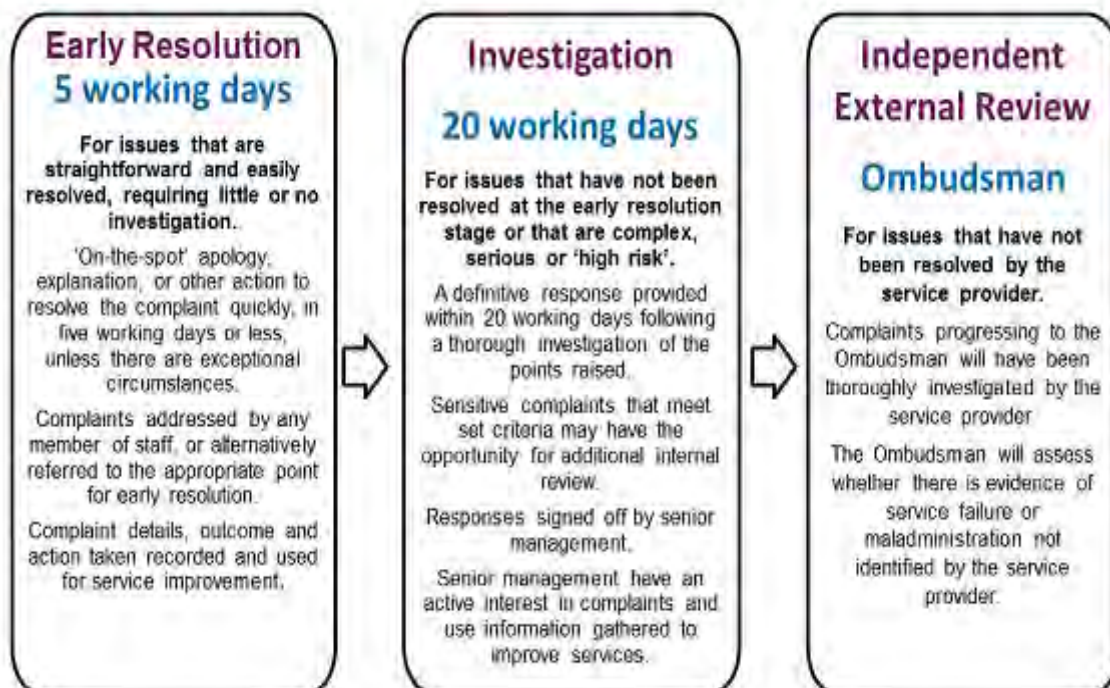
Our complaints handling procedure aims to provide a quick, simple and streamlined process for resolving complaints early and locally by capable, well-trained staff.

NHS Lothian is developing an operational toolkit to support this new model complaints handling procedure and will be available on the intranet.

Our complaints process provides two opportunities to resolve complaints internally:

- early resolution; and
- investigation.

The NHS Model Complaints Handling Procedure



For clarity, the term 'early resolution' refers to the first stage of the complaints process. It does not reflect any job description or role within NHS Lothian but means seeking to resolve complaints at the initial point of contact where possible.

What to do when you receive a complaint

- 1 On receiving a complaint, you must first decide whether the issue can indeed be defined as a complaint. The person making the complaint may express dissatisfaction about more than one issue. This may mean you treat one element as a complaint, while directing the person to pursue another element through an alternative route (see [Appendix 2](#)).
- 2 If you have received and identified a complaint, record the details on our complaints system.
- 3 Next, decide whether or not the complaint is suitable for early resolution. Some complaints will need to be fully investigated before you can give a suitable response. You must handle these complaints immediately at the investigation stage.
- 4 Where you think early resolution is appropriate, you must consider four key questions:
 - what exactly is the person's complaint (or complaints);
 - what do they want to achieve by complaining;
 - can I achieve this, or explain why not; and
 - if I cannot resolve this, who can help with early resolution?

What exactly is the person's complaint (or complaints)?

Find out the facts. It is important to be clear about exactly what the person is complaining of. You may need to ask for more information and probe further to get a full picture.

What do they want to achieve by complaining?

At the outset, clarify the outcome the person wants. Of course, they may not be clear about this, and you may need to probe further to find out what they want, and whether the expected outcome can be achieved. It may also be helpful to signpost people who complain to PASS at this point as advisers can often help clients think about their expectations and what is a realistic/reasonable outcome to expect.

Can I achieve this, or explain why not?

If you can achieve the expected outcome by providing an on-the-spot apology or explain why you cannot achieve it, you should do so.

The person making the complaint may expect more than we can provide, or a form of resolution that is not at all proportionate to the matter complained about. If so, you must tell them as soon as possible. An example would be where someone is so dissatisfied with their experience in 'Accident and Emergency' that they want the Chief Executive to be sacked.

You are likely to have to convey the decision face to face or on the telephone. If you do this, you are not required to write to the person as well, although you may choose to do so. It is important, however, to record full and accurate details of the decision reached and passed to the person, and to ensure that they understand the outcome. You must also advise them of their right to have the complaint escalated to stage 2 of the complaints procedure if they are not satisfied with the outcome at the early resolution stage.

If I cannot resolve this, who can help with early resolution?

If you cannot deal with the complaint because, for example, you are unfamiliar with the issues or area of service involved, tell the person this and pass details of the complaint to someone who can attempt to resolve it. Keep the person making the complaint informed about what has happened to their complaint and who is responsible for taking it forward.

Stage one: early resolution

Early resolution aims to resolve straightforward complaints that require little or no investigation at the earliest opportunity. This should be as close to the point of service delivery as possible. Any member of staff may deal with complaints at this stage. In practice, early resolution means resolving the complaint at the first point of contact with the person making the complaint. This could mean a face-to-face discussion with the person, or it could mean asking an appropriate member of staff to deal directly with the complaint. In either case, you may settle the complaint by providing an on-the-spot apology where appropriate, or explaining why the issue occurred and, where possible, what will be done to stop this happening again. You may also explain that, as a Board that values complaints, we may use the information given when we review service standards in the future.

Anyone can make a complaint. They may do so in writing, in person, by telephone, by email or online, or by having someone complain on their behalf. You must always consider early resolution, regardless of how you have received the complaint.

[Appendix 1](#) gives examples of the types of complaint we may consider at this stage, with suggestions on how to resolve them.

All complaints will be logged centrally by the Patient Experience Team. A decision will be made if this is a Stage 1 or Stage 2 complaint. The relevant clinical management team / health and social care partnership (CMT / HSCP) will be asked to investigate.

Timelines

Early resolution must usually be completed within **five working days**, although in practice we would often expect to resolve the complaint much sooner.

Extension to the timeline

In exceptional circumstances, where there are clear and justifiable reasons for doing so, you may agree an extension of no more than five additional working days with the person making the complaint. This must only happen when an extension will make it more likely that the complaint will be resolved at the early resolution stage.

For example, you may need to get more information from other services to resolve the complaint at this stage. However, it is important to respond within the applicable time to the person making the complaint, either resolving the matter and agreeing with the person that this has been achieved, or explaining that their complaint is to be investigated.

When you ask for an extension, you must get authorisation from the appropriate senior manager, who will decide whether you need an extension to effectively resolve the complaint. Examples of when this may be appropriate include staff or contractors being temporarily unavailable. You must tell the person making the complaint about the reasons for the delay, and when they can expect your response.

Where, however, the issues are so complex, and it is clear that they cannot be resolved within an extended five day period, you should escalate the complaint directly at the investigation stage.

It is important that extensions to the timeline do not become the norm. Rather, the timeline at the early resolution stage should be extended only rarely. All attempts to resolve the complaint at this stage must take no longer than **ten working days** from the date you receive the complaint.

The proportion of complaints that exceed the five working days timeline at the early resolution stage will be evident from reported statistics. These statistics must go to our senior management team on a ~~quarterly~~ **monthly** basis.

[Appendix 5](#) provides further information on timelines.

Closing the complaint at the early resolution stage

When you have informed the person making the complaint of the outcome at early resolution, you are not obliged to write to them, although you may choose to do so. You must ensure that our response to the complaint addresses all areas that we are responsible for and explains the reasons for our decision. It is also important to keep a full and accurate record of the decision reached and given to the person. The complaint

should then be closed and the complaints system updated accordingly. In closing the complaint, the date of closure is the date that the outcome of the complaint at the early resolution stage is communicated to the person making the complaint.

When to escalate to the investigation stage

A complaint must be handled at the investigation stage when:

- early resolution was tried but the person making the complaint remains dissatisfied and requests an investigation into the complaint. This may be immediately on communicating the decision at the early resolution stage or could be some time later; or
- satisfactory early resolution will not be possible as the complainant has clearly insisted that an investigation be conducted.

Complaints should be handled directly at the investigation stage, without first attempting early resolution, when:

- the issues raised are complex and require detailed investigation; or
- the complaint relates to serious, high-risk or high-profile issues.

When a complaint is closed at the early resolution stage, but is subsequently escalated to the investigation stage of the procedure, it is important that the complaint outcome is updated on the complaints system, and the complaint moved to stage 2. A new complaint should not be recorded.

It is also important to take account of the time limit for making complaints when a person asks for an investigation after early resolution has been attempted. The timescale for accepting a complaint as set out in the Regulations is within six months from the date on which the matter of the complaint comes to the person's notice.

While attempting early resolution always take particular care to identify complaints that on fuller examination might be considered serious, high risk or high profile, as these may require particular action or raise critical issues that need senior management's direct input.

Stage two: investigation

Not all complaints are suitable for early resolution and not all complaints will be satisfactorily resolved at that stage. Complaints handled at the investigation stage of the complaints handling procedure are typically serious or complex, and require a detailed examination before we can state our position. These complaints may already have been considered at the early resolution stage, or they may have been identified from the start as needing immediate investigation.

An investigation aims to establish all the facts relevant to the points made in the complaint and to give the person making the complaint a full, objective and proportionate response that represents our final position.

What to do when you receive a complaint for investigation

It is important to be clear from the start of the investigation stage exactly what you are investigating and to ensure that both the person making the complaint and the service understand the investigation's scope.

If this has not been considered at the early resolution stage, you should discuss and confirm these points with the person making the complaint at the outset, to establish why they are dissatisfied and whether the outcome they are looking for sounds realistic. In discussing the complaint with the person, consider three key questions:

1. What specifically is the person's complaint or complaints?
2. What outcome are they looking for by complaining?
3. Are the person's expectations realistic and achievable?

It may be that the person making the complaint expects more than we can provide. If so, you must make this clear to them as soon as possible.

Where possible you should also clarify what additional information you will need to investigate the complaint. The person making the complaint may need to provide more evidence to help us reach a decision.

You should find out what the person's preferred method of communication is, and where reasonably practicable communicate by this means.

Details of the complaint must be recorded on the system for recording complaints. Where applicable, this will be done as a continuation of the record created at early resolution. The details must be updated when the investigation ends.

If the investigation stage follows attempted early resolution, you must ensure you have all case notes and associated information considered at the early resolution stage. You must also record that this information has been obtained.

Contact with the person making the complaint at the start of the investigation

To effectively investigate a complaint, it is often necessary to have a discussion with the person making the complaint to be clear about exactly what the complaint or complaints relate to, understand what outcome the person making the complaint is looking for by complaining, and assess if these expectations are realistic and achievable. This may be by a telephone discussion or it may be appropriate to arrange a meeting between

appropriate NHS staff and the person making the complaint. This will provide the opportunity to explain how the investigation will be conducted, and to manage the person's expectations in regard to the outcomes they are looking for.

Timelines

The following deadlines are set out in the Regulations for cases at the investigation stage:

- complaints must be acknowledged within three working days; and
- you should provide a full response to the complaint as soon as possible but not later than 20 working days, unless an extension is required.

Acknowledgements

The Complaints Directions set out what must be included in a written acknowledgement of a complaint, which is as follows:

- contact details of the feedback and complaints officer;
- details of the advice and support available including the PASS;
- information on the role and contact details for the SPSO;
- a statement confirming that the complaint will normally be investigated, and the report of the investigation sent to the complainant, within 20 working days or as soon as reasonably practicable; and
- a statement advising that, should it not be possible to send a report within 20 working days, the person making the complaint will be provided with an explanation as to why there is a delay and, where possible, provided with a revised timetable for the investigation.

When advising the person making the complaint about the role and contact details of the SPSO, it should also be explained that if they remain dissatisfied at the end of the complaints process, they can ask the SPSO to look at their complaint, and that further information about this will be provided with the final decision on the complaint.

When issuing the acknowledgement letter you should issue it in a format which is accessible to the person making the complaint. You should also consider including the following points, where relevant to the complaint:

- thank the person making the complaint for raising the matter;
- summarise your understanding of the complaint made and what the person making the complaint wants as an outcome (this information will be available to you from your actions at 'What to do when you receive a complaint' as documented above);
- where appropriate the initial response should express empathy and acknowledge the distress caused by the circumstances leading to the complaint;
- outline the proposed course of action to be taken or indicate the investigations currently being conducted, stressing the rigour and impartiality of the process;

- offer the opportunity to discuss issues either with the investigation officer, the complaints staff or, if appropriate, with a senior member of staff;
- request that a consent form is completed where necessary;
- provide information on alternative dispute resolution services and other support service such as advocacy; and
- provide a copy of the 'Public Facing Complaints Handling Procedure' if this has not already been issued.

You may send the letter electronically, provided that the person making the complaint has consented to this in writing, and has not withdrawn their consent.

During the course of the investigation, you should, where possible ensure that the person making the complaint, and anyone involved in the matter which is the subject of the complaint, is informed of progress and given the opportunity to comment.

Meeting with the person making the complaint during the investigation

To effectively investigate the complaint, it may be necessary to arrange a meeting with the person making the complaint. Where a meeting takes place, we will always be mindful of the requirement to investigate complaints within 20 working days wherever possible. There is no flexibility within the Patient Rights (Scotland) Act 2011 to 'stop the clock' in the complaints handling process. This means that where required, meetings should always be held within 20 working days of receiving the complaint wherever possible. As a matter of good practice, where meetings between NHS staff and the person making the complaint do take place, a written record of the meeting should be completed and provided to the person making the complaint. Alternatively, and by agreement with the person making the complaint, you may provide a record of the meeting in another format, to suit their communications needs and preferences. You should discuss and agree with the person making the complaint, the timescale within which the record of the meeting will be provided.

Extension to the timeline

It is important that every effort is made to meet the timescales as failure to do so may have a detrimental effect on the person making the complaint. Not all investigations will be able to meet this deadline, however, and the Regulations allow an extension where it is necessary in order to complete the investigation. For example, some complaints are so complex that they require careful consideration and detailed investigation beyond the 20 working day limit. However, these would be the exception and you must always try to deliver a final response to a complaint within 20 working days.

If there are clear and justifiable reasons for extending the timescale, **Head of Patient Experience and relevant Associate Nurse Director** will set time limits on any extended investigation, as long as the person making the complaint agrees. You must keep them

updated on the reason for the delay and give them a revised timescale for completion. If the person making the complaint does not agree to an extension but it is necessary and unavoidable, then senior management must consider and confirm the extension.

The reasons for an extension might include the following:

- essential accounts or statements, crucial to establishing the circumstances of the case, are needed from staff, patients or others but they cannot help because of long-term sickness or leave;
- you cannot obtain further essential information within normal timescales;
- operations are disrupted by unforeseen or unavoidable operational circumstances, for example industrial action or severe weather conditions; or
- the person making the complaint has agreed to mediation as a potential route for resolution.

These are only a few examples, and you must judge the matter in relation to each complaint.

As with complaints considered at the early resolution stage, the proportion of complaints that exceed the 20-day limit will be evident from reported statistics. These statistics must go to **the relevant CMT / HSCP** on a ~~quarterly~~ **monthly** basis.

If you are handling a complaint spanning health and social care services and the health aspects have been resolved but the social care aspects require an extension to continue investigation, you must tell the person that you are not yet in a position to respond to all aspects of the complaint and tell them when you will do so.

[Appendix 5](#) provides further information on timelines.

Mediation

Some complex complaints, or complaints where the person making the complaint and other interested parties have become entrenched in their position, may require a different approach to resolution. Where appropriate, you may consider using services such as mediation or conciliation, using suitably trained and qualified mediators to try to resolve the matter and to reduce the risk of the complaint escalating further.

Mediation will help both parties to understand what has caused the complaint, and so is more likely to lead to mutually satisfactory solutions. It can be particularly helpful in the context of complaints about primary care providers, and the Directions set out that Boards *must* provide alternative dispute resolution services in these circumstances, if both the person making a complaint about a primary care provider, and the person subject to the complaint, agree that it should be provided.

If you and the person making the complaint agree to mediation an extension to the investigation period is likely to be necessary and, revised timescales should be agreed.

Closing the complaint at the investigation stage

In terms of best practice, for relevant NHS **Boards**, the complaints process should always be completed by the Feedback and Complaints Manager (or someone authorised to act on his or her behalf) reviewing the case. They must ensure that all necessary investigations and actions have been taken. For other health service providers this will be the Feedback and Complaints Officer or a senior officer nominated to perform this review. Where the complaint involves clinical issues, the draft findings and response should be shared with the relevant clinicians to ensure the factual accuracy of any clinical references. Where this is appropriate the relevant clinicians should always have regard to the timescales within which the decision should be issued.

You must let the person making the complaint know the outcome of the investigation, in writing, and also, if applicable, by their preferred alternative method of contact. Our response to the complaint must address all areas that we are responsible for and explain the reasons for our decision. You must record the decision, and details of how it was communicated to the person making the complaint, on the system for recording complaints. In accordance with the Complaints Directions, the report must include the conclusions of the investigation and information about any remedial action taken or proposed as a consequence of the complaint. The report must be signed by an appropriately senior person *such as a Site Director, Chief Officer, Nurse / Medical Director or the Chief Executive*. You may send this report electronically, provided that the person making the complaint has consented to this in writing, and has not withdrawn their consent.

The quality of the report is very important and in terms of best practice should:

- be clear and easy to understand, written in a way that is person-centred and non-confrontational;
- avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided;
- address all the issues raised and demonstrate that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- highlight any area of disagreement and explain why no further action can be taken;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- indicate that if they are not satisfied with the outcome of the local process, they may seek a review by the Scottish Public Services Ombudsman. Details of how to contact the Ombudsman's office should be included in the response.

Meetings and post decision correspondence with the person making the complaint

As previously noted, it is often appropriate to meet with the person making the complaint at the outset of the investigation in order to fully understand the complaint, what the person making the complaint wants to achieve by complaining, and to explain how the complaint will be handled.

A request for a meeting may also be received once the person making the complaint receives the decision on their complaint. The circumstances in which a meeting may be requested after the decision letter has been received include:

1. The person requests further explanation or clarification of the decision or suggests a misunderstanding of the complaint in terms of the response.
2. The person does not agree with some, or all of the response in terms of the investigation's findings or conclusions or with the decision on the complaint.
3. A combination of points 1 and 2 above, where for example the person suggests the complaint has not been fully understood, and the decision is erroneous even in the aspects that have been properly considered.

It should be made clear that such a meeting is for explanation only and not a reinvestigation or reopening of the complaint.

Independent external review

Once the investigation stage has been completed, the person making the complaint has the right to approach the SPSO if they remain dissatisfied.

The SPSO considers complaints from people who remain dissatisfied at the conclusion of our complaints procedure. The SPSO looks at issues such as service failures and maladministration (administrative fault), clinical decisions and the way we have handled the complaint.

The SPSO recommends that you use the wording below to inform people of their right to ask SPSO to consider the complaint.

Information about the SPSO

The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about public services in Scotland. This includes complaints about the NHS and Adult Social Care in Scotland. If you remain dissatisfied with an NHS board or service provider after its complaints process has concluded, you can ask the SPSO to look at your complaint. The SPSO cannot normally look at complaints:

- where you have not gone all the way through the complaints handling procedure
- more than 12 months after you became aware of the matter you want to

complain about, or

- that have been or are being considered in court.

The SPSO's contact details are:

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Freepost SPSO
(You don't need to use a stamp)

Freephone: **0800 377 7330**

Online contact www.spsso.org.uk/contact-us

Website: www.spsso.org.uk

Mobile site: <http://m.spsso.org.uk>

Governance of the Complaints Handling Procedure

Roles and responsibilities

Our staff are trained and empowered to make decisions on complaints at the early resolution stage of this procedure. Our final position on a complaint, following a stage 2 investigation, must be signed off by an appropriate senior officer and we will confirm that this is our final response. This ensures that our senior management own and are accountable for the decision. It also reassures the person making the complaint that their concerns have been taken seriously.

Overall responsibility and accountability for the management of complaints lies with the Board's Chief Executive, Executive Directors and appropriate senior management.

Chief Executive

*The Chief Executive provides leadership and direction in ways that guide and enable us to perform effectively across all services. This includes ensuring that there is an effective complaints handling procedure, with a robust investigation process that demonstrates how we learn from the complaints we receive. The Chief Executive may take a personal interest in all or some complaints, or may delegate responsibility for the complaint handling procedure to senior staff. Regular management reports assure the Chief Executive of the quality of complaints performance. **The Chief Executive has designated this to the members of his Corporate Management Teams.***

Site Directors

*On the Chief Executive's behalf, directors **of operations will** be responsible for:*

- *managing complaints and the way we learn from them;*
- *overseeing the implementation of actions required as a result of a complaint;*
- *investigating complaints **in their CMT / HSCP**; and ,or*
- *deputising for the Chief Executive on occasion.*

However, directors may decide to delegate some elements of complaints handling (such as investigations and the drafting of response letters) to other senior staff. Wherever possible it is important for the decision on a complaint to be taken by an independent senior member of staff. Directors should retain ownership and accountability for the management and reporting of complaints. They may also be responsible for preparing and signing decision letters, so they should be satisfied that the investigation is complete and their response addresses all aspects of the complaint.

Feedback and Complaints Manager:

Each relevant NHS body must appoint a Feedback and Complaints Manager, in accordance with the 2012 Regulations **and in NHS Lothian this role is called Team Leader,**

Complaints and Feedback. The Feedback and Complaints Manager is responsible for ensuring compliance with the requirements of this procedure. In particular they are responsible for ensuring that feedback, comments, concerns and complaints are monitored with a view to improving performance, and that action is taken as necessary following the outcome or any feedback, comment, concern or complaint. This function must be performed by the Chief Executive of the relevant NHS body or by an appropriately senior person authorised by the relevant NHS body to act on their behalf.

Feedback and Complaints Officer

According to the 2012 Regulations, each responsible body (including relevant NHS **Boards** and their service providers) must appoint a Feedback and Complaints Officer (**in NHS Lothian this would be Complaints and Feedback Officers [Triage or SPSO/Complex]**) to manage the arrangements. The Feedback and Complaints Officer is responsible for the management and handling of feedback, comments, concerns and complaints operationally. This post holder(s) should be of sufficient seniority to be able to deal with any feedback, comments, concerns and complaints quickly and effectively without needing to refer, in all but the most exceptional circumstances, to the feedback and complaints manager. Feedback and complaints officers should be readily accessible to patients, the public and staff. It is important that arrangements are made so that the role of the complaints officer is not interrupted by one individual's annual or sick leave.

The functions of the Feedback and Complaints Officer may be performed personally or delegated to an authorised person as defined by the Board. Although not intended to be prescriptive, the list below outlines the key duties of the Feedback and Complaints Officer:

- work across the Board to develop mechanisms for encouraging fast, effective and efficient patient feedback including the use of emerging technology as appropriate;
- operationally manage the administration of this guidance and supporting local policies and procedures ensuring that:
 - feedback and complaints recording systems are in place and records kept up to date; and
 - organisational learning from the operation of the feedback and complaints process is captured and reported.
- determine whether a complaint is one which should not be investigated under the procedure because of the likelihood that legal action will be raised in respect of the same issue.
- provide specialist advice and support to patients and staff and others on the management of this process, including delivery of local training and awareness raising; have access to advice and support on associated issues, for example patient consent, confidentiality, the operation of related legislation such as the Data Protection Act, access to medical records, Freedom of Information, etc; and

- have an understanding of partner organisations and how to work with them on managing feedback, comments, concerns and complaints.

All staff in the organisation

A complaint may be made to any member of staff in the Board. So all staff must be aware of the complaints handling procedure and how to handle and record complaints at the early resolution stage. They should also be aware of who to refer a complaint to, in case they are not able to personally handle the matter. We encourage all staff to try to resolve complaints early, as close to the point of service delivery as possible.

The SPSO liaison officer

Our SPSO liaison officer's role may include providing complaints information in an orderly, structured way within requested timescales, providing comments on factual accuracy on our behalf in response to SPSO reports, and confirming and verifying that recommendations have been implemented.

Patient Experience Team

The Patient Experience Team co-ordinate and support a single complaints function across the organisation. They can be contacted:

- Telephone: 0131 536 3370
- Email: feedback@nhslothian.scot.nhs.uk
- Post: 2-4 Waterloo Place, Edinburgh, EH1 3EG

The Patient Experience Team will also provide support to staff with the complaints procedure.

Complaints about senior staff

Complaints about senior staff can be difficult to handle, as there may be a conflict of interest for the staff investigating the complaint. When serious complaints are raised against senior staff, it is particularly important that the investigation is conducted by an individual who is independent of the situation. We must ensure we have strong governance arrangements in place that set out clear procedures for handling such complaints.

Recording, monitoring, reporting, learning from and publicising complaints

Complaints provide valuable feedback. One of the aims of the complaints handling procedure is to identify opportunities to improve services across **NHS Lothian**. We must record all complaints in a systematic way so that we can use the complaints data for analysis and management reporting. By recording and using complaints information in this way, we can identify and address the causes of complaints and, where appropriate, identify training opportunities and introduce service improvements.

Recording complaints

Certain information must be recorded by virtue of the 2012 Regulations and the Complaints Directions, and to comply with SPSO guidance on minimum requirements. Staff should ensure that all complaints are recorded even those resolved at the early resolution stage within five working days (although these do not require an acknowledgement or a written report of the investigation to be sent to the person making the complaint). To collect suitable data, it is essential to record all complaints information as follows:

- the person's name, address and email address, where that is their preferred method of communication
- the patient's name and Community Health Index number where relevant
- in the event that the complainant is making the complaint on behalf of another person, whether that other person has given consent for the complaint to be made on his or her behalf
- the date when the complaint was received
- the subject matter of the complaint and the date on which it occurred
- how the complaint was received
- the service the complaint refers to
- the date the complaint was closed at the early resolution stage (where appropriate)
- the date the complaint was escalated to the investigation stage (where appropriate)
- action taken at the investigation stage (where appropriate)
- the date the complaint was closed at the investigation stage (where appropriate)
- the outcome of the complaint at each stage
- the underlying cause of the complaint and any remedial action taken.

We have structured systems for recording complaints, their outcomes and any resulting action. These provide a detailed record of services that have failed to satisfy people, and the actions we have taken to improve services as a result.

If, subsequently, the complaint is referred to the SPSO, this may result in a request for all relevant papers and other information to be provided, in good time, to the Ombudsman's office. Complaints records should be kept separate from health records, due to the need to only record information which is strictly relevant to the patient's health in their health record. These documents should be managed with regard to the current Scottish Government Records Management Code of Practice.

Monitoring complaints

We have arrangements in place to monitor how we deal with the complaints we receive.

We recognise that an increase in the number of complaints should not in itself be a reason for thinking a service is deteriorating. It could mean that our arrangements for handling feedback, comments, concerns and complaints are becoming more responsive. The important point is to ensure that complaints (and feedback, comments and concerns) are handled sympathetically, effectively and quickly and that lessons are learned and result in service improvement.

Reporting complaints

In accordance with the Complaints Directions, relevant NHS **Boards** have a responsibility to gather and review information from their own services and their service providers on a ~~quarterly~~ **monthly** basis in relation to complaints. Service providers also have a duty to supply this information to their relevant NHS **Board** as soon as is reasonably practicable after the end of the three month period to which it relates. Data required for these quarterly reports is outlined in the NHS Complaints Performance Indicators; this includes:

- A statement outlining changes or improvements to services or procedures as a result of consideration of complaints.
- A statement to report the person making the complaint's experience in relation to the complaints service provided.
- A statement to report on levels of staff awareness and training.
- The total number of complaints received (other than complaints to which this procedure does not apply).
- Complaints closed at stage one and stage two of this procedure as a percentage of all complaints closed.
- Complaints upheld, partially upheld and not upheld at each stage of this procedure as a percentage of complaints closed in full at each stage
- The average time in working days for a full response to complaints at each stage of this procedure.
- The number and percentage of complaints at each stage which were closed in full within the set timescales of 5 and 20 working days.
- The number of complaints at stage 1 where an extension was authorised as a percentage of all complaints at stage 1.
- The number of complaints at stage 2 where an extension was authorised as a percentage of all complaints at stage 2.

Appendix 7 provides further information on these Complaints Performance Indicators.

Complaints details are analysed for trend information to ensure we identify service failures and take appropriate action. Regularly reporting the analysis of complaints information helps to inform management of where services need to improve.

Our regular reporting demonstrates the improvements resulting from complaints and shows that complaints can influence our services. It also helps ensure transparency in our complaints handling service and will help show people using our services that we value their complaints.

We should also

- report on a quarterly basis about the trends that are evident in complaints and the actions taken as a result; and
- use case studies and examples to demonstrate how complaints have helped improve services.

This information should be reported ~~regularly, and at least quarterly,~~ **monthly** to our senior management team, **and through our existing governance arrangements.**

Review by senior management

Senior management will review the information gathered from complaints regularly ~~(and at least quarterly)~~, and consider how our services could be improved or internal policies and procedures updated. The Feedback and Complaints Manager or someone senior acting on his or her behalf is involved in a review of each of the quarterly reports with a view to identifying areas of concern, agreeing remedial action and improving performance. Where appropriate, the review must also consider any recommendations made by the SPSO in relation to the investigation of NHS complaints. The outcomes of these reviews should be reported via the Board's governance structure to the Board of management or equivalent governing body.

Learning from complaints

At the earliest opportunity after the closure of the complaint, the complaint handler should always make sure that the person making the complaint and staff of the service involved are given feedback and, where applicable, understand the findings of the investigation and any recommendations made.

As a minimum, we must:

- use complaints data to identify the contributory factors to complaints;
- take action to reduce the risk of recurrence;
- record the details of corrective action in the complaints file; and
- systematically review complaints performance reports to improve service delivery.

Where we have identified the need for service improvement:

- an action plan should be developed where appropriate;
- the action needed to improve services must be prioritised for implementation;
- an officer (or team) should be designated the 'owner' of the issue, with responsibility for ensuring the action is taken;

- a target date must be set for the action to be taken;
- the designated individual must follow up to ensure that the action is taken within the agreed timescale;
- where appropriate, performance in the service area should be monitored to ensure that the issue has been resolved; and
- we must ensure that our staff learn from complaints.

The General Medical Council's education standards set out the requirements of NHS bodies and primary care providers, in terms of the Board and provision of medical education and training. It places a particular emphasis on the need for the learning environment and organisational culture to value and support education and training, so that learners are able to demonstrate the responsibilities, values, behaviours and learning outcomes required. Where appropriate we will ensure appraisers place emphasis on the role of learning from complaints in individual appraisals to identify where we can develop or change our approach to improve patient care.

Publishing complaints performance information

Each year we must publish a report setting out our performance in handling complaints, concerns, comments and feedback. This summarises and builds on the quarterly **monthly** reports we have produced about our own services and received from service providers in our area. It includes details of the numbers and types of complaints and information about the stage at which complaints were resolved, the time taken to do so, and about the actions that have been or will be taken to improve services as a result of complaints, concerns, comments and feedback.

These reports must be easily accessible to members of the public and available in alternative formats as requested.

The Complaints Directions require this publication to be sent to Scottish Ministers, the PASS, Healthcare Improvement Scotland, SPSO and where appropriate, the Scottish Prison Service.

National monitoring

In accordance with the Complaints Directions, complaints statistics gathered through the quarterly reporting of complaints must be submitted by relevant NHS **Boards** to the Information Services Division at National Services Scotland, within three months of the year end. This information should include the performance information of Primary Care providers which has been submitted to the Board. The information must be in an appropriate format to allow collation and publication of national complaints statistics.

Performance reporting by Primary Care service providers

The requirement to record and report on complaints applies equally to all Primary Care service providers. NHS Boards should ensure that arrangements are in place for all contractors to comply with this requirement so that they can include this information in their own reporting of complaints handling performance. This reporting should clearly differentiate between the Board and its contractors.

Maintaining confidentiality

Confidentiality is important in complaints handling. This includes maintaining the person's confidentiality and explaining to them the importance of confidentiality generally. We must always bear in mind legal requirements, for example, data protection legislation, as well as internal policies on confidentiality and the use of personal information.

Data Protection Act 1998

The NHS complaints procedure may be used for complaints arising from rights given by the Data Protection Act (1998). If this route is chosen, complaints staff should take the matter forward in conjunction with the Information Governance Manager/Caldicott Guardian (or other nominated person) who takes decisions on what information is stored and how it is processed by the NHS **Board** or health service provider. Where a person remains unhappy with the outcome of local resolution they should be advised to contact the UK Information Commissioner.

Dealing with problem behaviour

People may act out of character in times of trouble or distress. The circumstances leading to a complaint may result in the person acting in an unacceptable way. People who have a history of challenging or inappropriate behaviour, or have difficulty expressing themselves, may still have a legitimate complaint. Behaviour should not be viewed as unacceptable just because the person making the complaint is forceful or determined. In fact, being persistent can be a positive advantage when pursuing a complaint. However, the actions of people who are angry, demanding or persistent may result in unreasonable demands on time and resources or unacceptable behaviour towards staff.

NHS Scotland seeks to protect their staff and alongside the national Partnership Information Network (PIN) guidance on Preventing and Dealing with Bullying and Harassment in NHS Scotland, NHS bodies and health service providers should have policies and procedures in place for managing persistent or unreasonably demanding people.

We will apply our policies and procedures to protect staff from unacceptable behaviour such as unreasonable persistence, threats or offensive behaviour from people. Where we decide to restrict access to a person under the terms of an unacceptable actions policy, we have a procedure in place to communicate that decision, notify the person of a right of

appeal, and review any decision to restrict contact with us. This will allow the person to demonstrate a more reasonable approach later. **Further details can be found:** <http://intranet.lothian.scot.nhs.uk/NHSLothian/Corporate/A-Z/Complaints/Pages/ComplaintsDocuments.aspx>

Supporting the person making the complaint

All members of the community have the right to equal access to our complaints handling procedure. People who do not have English as a first language may need help with interpretation and translation services, and others may have specific needs that we will seek to address to ensure easy access to the complaints handling procedure.

We must always respect human rights and take into account our commitment and responsibilities to equality as defined within the Equality Act (2010). This includes making reasonable adjustments to our services where appropriate.

Several support and advocacy groups are available to support people to pursue a complaint and they should be signposted to these as appropriate.

Patient Advice and Support Service (PASS)

The Patient Rights Act provided for the establishment of the Patient Advice and Support Service (PASS). PASS operates independently of the NHS, and provides free, confidential information, advice and support to anyone who uses the NHS in Scotland. The service promotes an awareness and understanding of the rights and responsibilities of patients and can advise and support people who wish to give feedback, make comments, raise concerns or make complaints about treatment and care provided. Further information can be found on the PASS web site: www.patientadvicescotland.org.uk

More information on Edinburgh's Patient Advice and Support Service (PASS) can be found [here](#). You can visit your nearest Citizens Advice Bureau on the details below for more information:

- **Leith: 23 Dalmeny Street, EH6 8PG**
- **Dalry: Fountainbridge Library, 137 Dundee Street, EH11 1BG**
- **Portobello: 8 a&b, Bath Street, EH15 1EY**
- **Dundas Street: 58 Dundas Street, EH3 6QZ**
- **Pilton: 661 Ferry Road, EH4 2TX**

The number for the Citizens advice bureau in Edinburgh is: 0131 510 5510

Time limit for making complaints

It is recognised that it is not always possible to make a complaint immediately. In clinical complaints, for example, a complication or other issue may not become apparent for some

time after the procedure. Similarly the grief associated with the death of someone may make it difficult for their representatives or family members to deal with a complaint in the period immediately after the death.

Given the difficulties that the passage of time can make to the resolution of a complaint the timescale for accepting a complaint as set out in the regulations is within six months from the date on which the matter of the complaint comes to the person's notice, provided that this is also no later than 12 months after the date on which the matter of the complaint occurred.

The timescale for acceptance of a complaint may be extended if the Feedback and Complaints Officer considers it would be reasonable in the circumstances. Where a decision is taken not to extend the timescales a clear explanation of the basis for the decision should be provided to the person making the complaint, and the person should be advised that they may ask the Scottish Public Services Ombudsman to consider the decision.

Appendix 1: Complaints

The following tables give examples of complaints that may be considered at the early resolution stage, and suggest possible actions to achieve resolution.

Complaint	Possible actions to achieve resolution
<p>The complaint relates to clinical treatment. The person is unhappy that several attempts to draw blood were not successfully completed, and that there was a lack of pain management to address her discomfort.</p>	<p>Apologise for the pain and discomfort caused. Explain the appropriate procedure for taking blood and agree with the person making the complaint how this will be approached in the future. Perhaps ensure that an experienced person draws the blood, and ensure suitable pain management is available if needed.</p>
<p>The complaint relates to clinical treatment. The person disagrees with their care plan and wants it evaluated by an independent clinician.</p>	<p>Thank the person for bringing this matter to your attention. Confirm with them their reasons for disagreeing with the care plan. Explain the process for developing a care plan and the fact that you will check how this was applied in this case.</p> <p>Check with appropriate staff to ensure the care plan accurately reflects the agreed care needs, and addresses any issues raised by the person. Explain to the person the action you have taken, and the basis for the care plan.</p> <p>If the person continues to disagree with your response, advise them that the complaint will be escalated to stage 2 of the complaints procedure for further investigation.</p>
<p>The complaint relates to a lack of privacy during visiting hours. The person complained that visitors to the patient in the bed next to her could overhear medical staff discussing her condition and treatment. She felt humiliated by this.</p>	<p>Apologise for the distress felt by the person. Advise her of the normal procedure for discussing her medical condition with her. Explain the action you will take to ensure that this situation is not repeated, and any discussions in regard to diagnosis, care or treatment are conducted in private.</p>
<p>The complaint relates to clinical treatment.</p>	<p>The person complained to the nurse</p>

Complaint	Possible actions to achieve resolution
<p>A person was receiving anti-clotting medication injected into her stomach. Each treatment required two painful injections as the ward's drug trolley only had small doses in the pre-prepared syringes.</p>	<p>administering the injection, who then ordered a supply of larger doses from the hospital pharmacy. Next day the person (and others on the ward) received the correct dose with only one injection required.</p>
<p>The complaint relates to being in a mixed male/female ward. The person is unhappy at being in a mixed sex ward and wants moved to a single sex ward.</p>	<p>Thank the person for bringing this matter to your attention, acknowledge their discomfort and apologise for the impact this has had on them. Explain the basis for mixed sex wards and ask what you can do to resolve the issue satisfactorily. Where possible consider if the person can be located in a room, or be moved to a single sex ward.</p>
<p>The complaint relates to staff attitude. It is alleged that when asked to explain why surgery had been delayed, the nurse was rude, insensitive to the person's needs and did not explain the reason for the delay.</p>	<p>Thank the person for bringing the complaint to your attention. Apologise, recognising that they feel the nurse did not respond appropriately to the enquiry. Make sure that you provide a full response to the person's request for information about the surgery and any reasons for delay. Explain that you will record the complaint and ensure that staff are made aware of the need to respond fully and appropriately to all enquiries. Discuss the complaint with appropriate staff, to understand the issue from their perspective. If and where appropriate, provide support to staff to respond appropriately to enquiries.</p>
<p>The complaint relates to communication with the person. The letter sent by the Board to explain the next course of treatment used jargon that the person did not understand and said that details of the next appointment were</p>	<p>Thank the person for bringing the complaint to your attention. Advise that the use of jargon in letters is inappropriate and should not be used. Tell the person that you will bring this matter to the attention of the appropriate unit, who will contact her</p>

Complaint	Possible actions to achieve resolution
enclosed, when in fact they were not.	urgently to provide details of the next appointment. Tell them that you are sorry that this has happened, and that her complaint should help to ensure that this does not occur again.
The complaint relates to waiting times. Having waited for 12 weeks to be seen by a physiotherapist, the appointment was cancelled with only one day's notice.	Thank the person for bringing this to your attention, and apologise for the inconvenience that this cancellation has caused. Advise them of the process for making physiotherapy appointments and the associated timescales. Explain the reason that the appointment was cancelled at such short notice. Where possible arrange an alternative appointment at a date and time which is convenient for the person.
The complaint relates to a delay at the out patients clinic. The person complained that she had to wait too long in the reception area before being seen and she was not provided with a reason for the delay.	Thank the person for bringing the complaint to your attention. Explain the process for seeing people at an outpatient appointment, together with the reasons that something went wrong on this occasion. Apologise, and explain the actions you will take to ensure that this situation does not reoccur. This may be by reminding all staff on duty to ensure that people are kept updated where there is a delay in appointment times. It may also be by ensuring notices are placed in the reception areas advising people to approach reception if their appointment is delayed by more than 20 minutes.
The complaint relates to a lack of facilities within the hospital's waiting area. The person complained that she had no direct access to drinking water and when she asked at reception for a glass of water she was advised to purchase a bottle of water from the shop within the hospital complex.	Thank the person for bringing this matter to your attention. Apologise, recognising how the situation must have been for her. Explain the reason that drinking water may not have been immediately available, and what the options will be to access drinking water in the future. Where appropriate, signpost within the

Complaint	Possible actions to achieve resolution
	waiting areas, to explain how people may get access to drinking water.
<p>The complaint relates to car parking within the hospital grounds.</p> <p>The person is unhappy with the parking fees charged by the hospital.</p>	<p>Thank the person for bringing this matter to your attention. Explain the Board, or hospital policy on car parking, and where appropriate advise on alternative areas for parking or how people may use public transport in appropriate cases. Finally explain that the Board takes all complaints seriously and that information from complaints is analysed and used to inform policies and procedures moving forward.</p>
<p>The complaint relates to the catering services for patients.</p> <p>The person is unhappy that, despite notifying nurses that she is a vegetarian, no vegetarian meal was provided at dinner time. When she asked for a vegetarian meal she was advised that the kitchen was unable to provide one, and she was offered a salad sandwich as an alternative.</p>	<p>Thank the person for bringing the complaint to you. Apologise, acknowledging that there has been a failing and expressing empathy for the situation the person was in. Explain the normal protocol for ensuring all dietary requirements are met, and the action that you will now take to ensure that a vegetarian meal is always provided for her. Thereafter, follow up with her to ensure that the situation has been satisfactorily resolved and her dietary needs are being properly met.</p>
<p>The complaint relates to property.</p> <p>The person alleges that his dressing gown was removed from his bedside unit, and is now missing.</p>	<p>Thank the person for bringing the matter to your attention. Apologise, recognising the distress that the loss of the dressing gown will have caused. Offer to provide a hospital replacement gown in the meantime. Explain the action you will take to try and locate the dressing gown, and where appropriate, signpost him to the process for claiming for lost property.</p>

Appendix 2: Concerns

The following tables give examples of matters that may be considered as concerns.

Concerns	Suggested action
A person was worried about his forthcoming cataract surgery. He did not fully understand the procedure that would be followed and the implications in relation to his future eye care requirements.	Arrange an appointment for him to see the ophthalmologist to have a full explanation of the surgery, and long term eye care requirements provided.
The café uses plastic cups. An elderly person raised concerns that she and others have difficulty in holding these plastic cups.	Where mugs are available they should be used in the café. Alternatively, cardboard cup holders/sleeves with a handle may be considered.
A person raised a concern about when they would be seen in the clinic as the last clinic had overrun resulting in the her not being seen for her appointment.	The service should contact the person to apologise for the earlier missed appointment and to inform her that action has been taken to ensure the clinic is not overbooked. The person should be reassured that their concerns have been noted, and that arrangements are in place to ensure that they are seen at the stated appointment time next time.
A person said that his appointment letter was sent in an unsealed envelope, and he just wanted the board to be aware of this.	Apologise to the man, and explain that staff will now be reminded to ensure that all letters are properly sealed before postage.
A concern is raised about the provision of maternity (or other service) services and the impact that service re-provision would have in the future.	Provide information about the reasons for the re provision of services and explain the actions that will be taken to ensure no adverse effects on service delivery.
A person had had part of one of his fingers amputated. He wrote to the NHS asking for more information, as he felt the operation was unnecessary and that the complications were never fully explained to him. In his letter he states that he does not want to complain, but he is unhappy about his treatment.	The circumstances described here would normally be handled as a complaint. Where the person is adamant that they do not wish to complain, the matter should be recorded as being resolved at the early resolution stage. Provide a full detailed response advising why a decision to amputate was taken

Concerns	Suggested action
	<p>following what was considered to have been simple routine surgery.</p> <p>If the person comes back to say that they remain unhappy with this response, the matter should then be handled at stage 2 of the complaints procedure, with the person being signposted to SPSO if they remain dissatisfied with the subsequent response.</p>
<p>Prior to an operation eight months ago, the person had expressed fear to a number of staff that she would not have sufficient post-operative pain management. Despite these concerns being raised she experienced considerable pain after the operation. She now has concerns regarding a forthcoming operation. She wanted her pain to be managed more effectively than when she had underwent the same operation previously.</p>	<p>Explain to the person that the first operation was unsuccessful and therefore has to be performed a second time. Reassure her that her concerns about pain management have been noted and that medical staff will do all they possibly can to effectively manage any post-operative pain.</p>
<p>A patient suffers from a recurring problem with chest infections. This has been the case for several years. He is unhappy that his GP has refused to prescribe him another course of antibiotics.</p>	<p>The GP meets with the person to understand the reasons for his dissatisfaction, and to explain the basis for the decision not to continually prescribe antibiotics.</p> <p>The GP may arrange for further tests if appropriate.</p>

Appendix 3: Feedback, Comments, Concerns or Complaints Assessment Matrix

The person bringing the issue to your attention may be very clear from the outset that they do not want to complain. If however, the matter meets the definition of a complaint, the person should be offered an explanation that complaints provide valuable information that allow Boards to learn and improve services. Where it is not clear, after discussion with the person bringing the matter, whether it should be recorded as feedback, a comment, a complaint, or a concern, the matrix below may help you to arrive at the appropriate decision.

	Insignificant or None	Minor	Moderate	Significant or Certain
Your assessment of the rigour and extent of dissatisfaction expressed	Feedback or Comment	Concern	Concern	Complaint
The way in which the person raising the issue expresses their level of dissatisfaction	Feedback or Comment	Concern	Complaint	Complaint
Your assessment of the likely impact on patient care	Feedback or Comment	Concern or Complaint	Complaint	Complaint
Your assessment of the risks to the patient, patients or others	Feedback or Comment	Concern or Complaint	Complaint	Complaint
Your assessment of the risks to the NHS body	Feedback or Comment	Concern	Complaint	Complaint
The learning opportunities that may arise as a result of looking at the matter raised	Feedback or Comment	Concern	Complaint	Complaint

It is expected that you will use professional judgement in deciding whether an issue can be looked at as a 'Concern' or whether it is appropriate to handle the matter through the complaints handling procedure. Where an issue is looked at as a 'Concern' and the person raising the matter remains dissatisfied with your response, you must then investigate the matter as a complaint, at stage 2 of the complaints handling procedure.

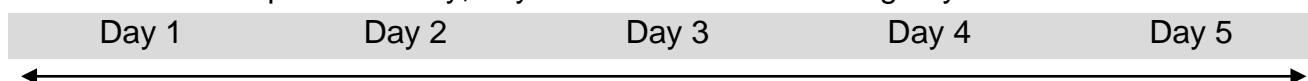
Appendix 4: Timelines

General

References to timelines throughout the complaints handling procedure relate to working days. When measuring performance against the required timelines, we do not count non-working days, for example weekends, public holidays and days of industrial action where our service has been interrupted.

Timelines at the early resolution stage

You must aim to achieve early resolution within five working days. The day you receive the complaint is day 1. Where you receive it on a non-working day, for example at the weekend or on a public holiday, day 1 will be the next working day.



Day 1:

Day complaint received by the Board, or next working day if day of receipt is a non-working day.

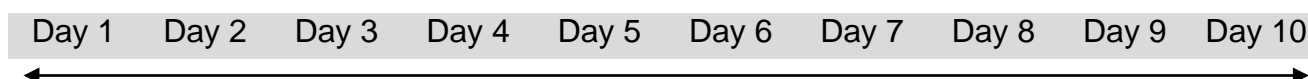
Day 5:

Early resolution achieved or complaint escalated to the investigation stage.

The date of receipt will be determined by the Board's usual arrangements for receiving and dating of mail and other correspondence.]

Extension to the five-day timeline

If you have extended the timeline at the early resolution stage in line with the procedure, the revised timetable for the response must take no longer than 10 working days from the date of receiving the complaint.



Day 1:

Day complaint received by the Board, or next working day if date of receipt is a non-working day.

In a few cases where it is clearly essential to achieve early resolution, you may authorise an extension within five working days from when the complaint was received. You must conclude the early resolution stage within 10 working days from the date of receipt, either by resolving the complaint or by escalating it to the investigation stage.

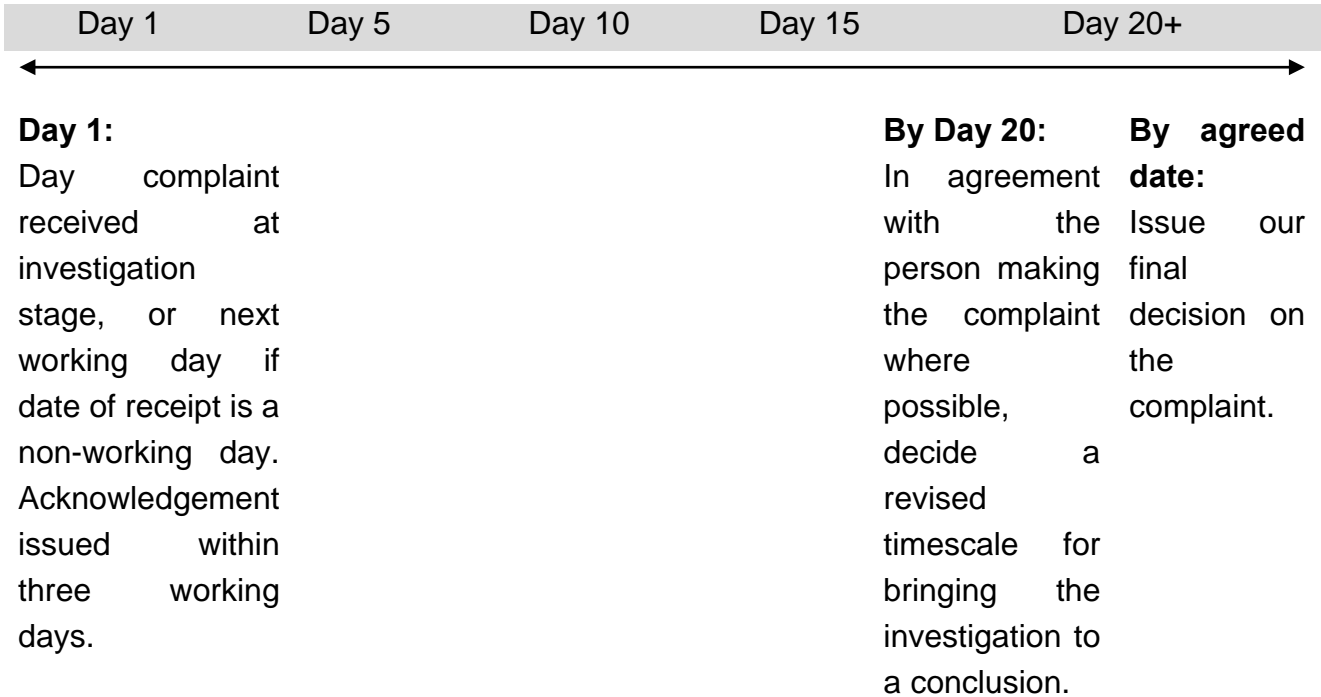
Day 10:

Early resolution achieved or complaint escalated to the investigation stage.

Acknowledgement issued within three working days.

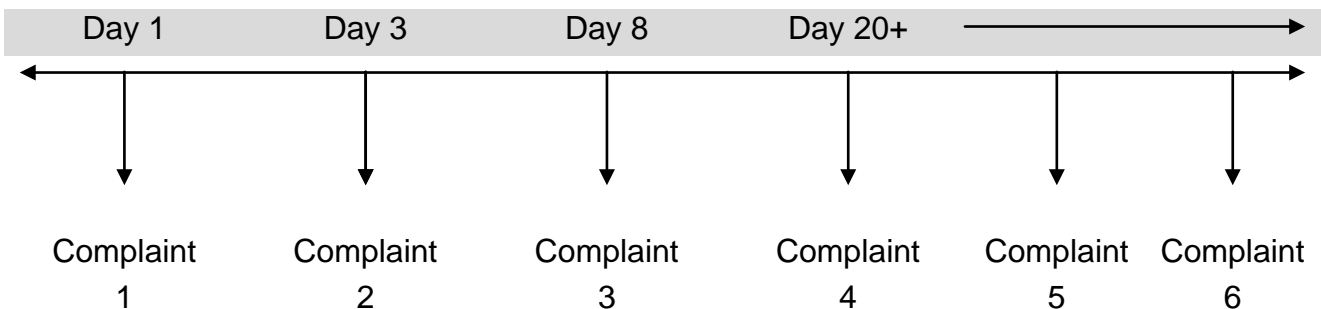
extend the deadline.

Exceptionally you may need longer than the 20-day limit for a full response. If so, you must explain the reasons to the person, and agree with them a revised timescale.



Timeline examples

The following illustration provides examples of the point at which we conclude our consideration of a complaint. It is intended to show the different stages and times at which a complaint may be resolved.



The circumstances of each complaint are explained below:

Complaint 1

Complaint 1 is a straightforward issue that may be resolved by an on-the-spot explanation and, where appropriate, an apology. Such a complaint can be resolved on day one.

Complaint 2

Complaint 2 is also a straightforward matter requiring little or no investigation. In this example, resolution is reached at day three of the early resolution stage.

Complaint 3

Complaint 3 refers to a complaint that we considered appropriate for early resolution. We did not resolve it in the required timeline of five working days. However, we authorised an extension on a clear and demonstrable expectation that the complaint would be satisfactorily resolved within a further five days. We resolved the complaint at the early resolution stage in a total of eight days.

Complaint 4

Complaint 4 was suitably complex or serious enough to pass to the investigation stage from the outset. We did not try early resolution; rather we investigated the case immediately. We issued a final decision to the person within the 20-day limit.

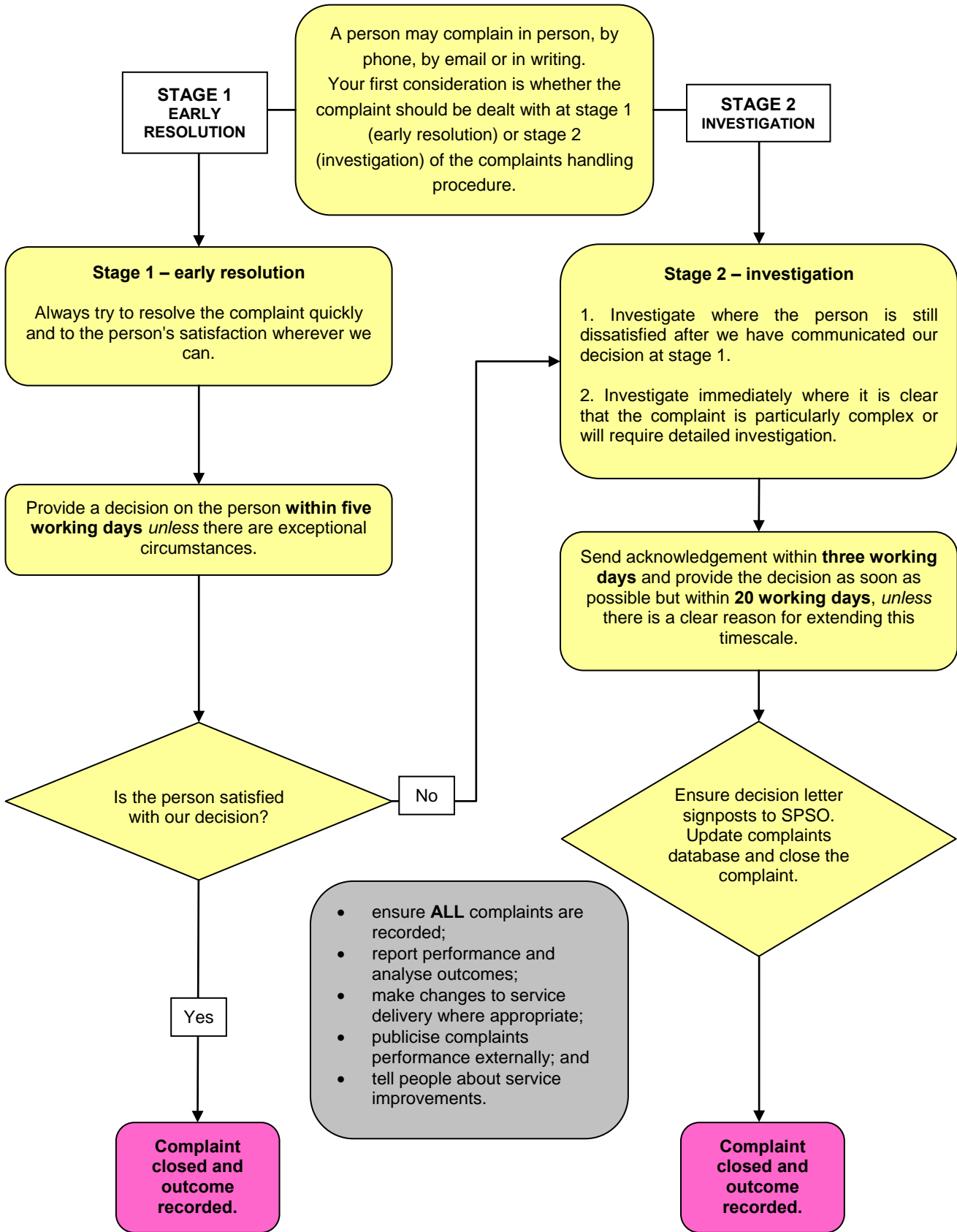
Complaint 5

We considered complaint 5 at the early resolution stage, where an extension of five days was authorised. At the end of the early resolution stage the person was still dissatisfied. At their request, we conducted an investigation and issued our final response within 20 working days. Although the end-to-end timeline was 30 working days we still met the time targets for investigation.

Complaint 6

Complaint 6 was considered at both the early resolution stage and the investigation stage. We did not complete the investigation within the 20-day limit, so we agreed a revised timescale with the person for concluding the investigation beyond the 20-day limit.

Appendix 5: The NHS complaints handling procedure



Appendix 6: Complaints Performance Indicators

Indicator One: Learning from complaints

A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:

- Trends and actions should be published externally quarterly together with a summary of information communicated to patients/customers/service users and signposting to Patient Opinion. Further to this, reporting can consider the complaints where an explanatory meeting was offered, and if this was accepted, the outcome of such meetings in terms of lessons learned, as well as the percentage of persons making the complaints who wished to have an explanatory meeting after the complaint was resolved.
- Qualitative data on complaints should be reported internally quarterly and externally annually. Trends should be highlighted and explained.
- Any services changed, improved or withdrawn should be highlighted with an explanation of any change.
- Actions taken to reduce the risk of reoccurrence should also be highlighted, as well as details of how this has been communicated across the Board.
- A section on feedback, concerns and comments (including compliments) should be included.

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided.

NHS **Boards** should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response. Information should be sought on:

- Ease of access to the process, including how easy it is to find on websites and via search engines.
- How the person making the complaint was treated by staff (for example were they professional, friendly, polite, courteous etc).
- Whether empathy was shown or an apology offered.
- Timescale in terms of responses being issued or updates as the case may be.
- Clarity of decision and clarity of reasoning.

Indicator Three: Staff Awareness and Training

A statement to report on levels of staff awareness and training. This may also cover those staff who have been trained in mediation (for example) and how many times mediation is used across the Board in any given year. Training on adverse events and duty of candour may also be included under this heading, as well as training on root cause analysis and human factors. Suggested headings for providing information under this indicator are:

- How often internal communications are issued on complaints and training and the take up of training after such communications.
- The number of staff, including managers, senior managers and Board members to complete mandatory or bespoke training.
- The number of staff who are undertaking or have completed a recognised professional qualification in this field.
- Details of the Senior Reporting Officer and Board Champion.
- NHS **Boards** should consider adding complaints and specifically, learning from complaints, into senior manager objectives.

Indicator Four: The total number of complaints received

The key point is to get a consistent benchmark and therefore it is suggested that a core measure is used which would measure complaints against the number of staff employed by the NHS **Boards**. For example:

- Acute Hospital Services – per episode of patient care
- Prisons – per average population
- GPs – percentage of patients registered with practice
- Pharmacy – per script dispensed per annum
- Dental – percentage patients registered with the practice
- Ophthalmic – per episode of care
- Mental Health – per episode of care
- NHS24 – per call demand in 000s

Indicator Five: Complaints closed at each stage

The term “closed” refers to a complaint that has had a response sent to the customer and at the time no further action is required (regardless at which stage it is processed and whether any further escalation takes place). This indicator will report:

- the number of complaints closed at stage one as % all complaints
- the number of complaints closed at stage two as % all complaints
- the number of complaints closed at stage two after escalation as % all complaints.

Indicator Six: Complaints upheld, partially upheld and not upheld

There is a requirement for a formal outcome (upheld, partially upheld or not upheld) to be recorded for each complaint. This indicator will report:

-
- the number of complaints upheld at stage one as % of all complaints closed at stage one
 - the number of complaints not upheld at stage one as % of all complaints closed at stage one
 - the number of complaints partially upheld at stage one as % of all complaints closed at stage one
 - the number of complaints upheld at stage two as % of all complaints closed at stage two
 - the number of complaints not upheld at stage two as % of all complaints closed at stage two
 - the number of complaints partially upheld at stage two as % of all complaints closed at stage two
 - the number of escalated complaints upheld at stage two as % of all escalated complaints closed at stage two
 - the number of escalated complaints not upheld at stage two as % of all escalated complaints closed at stage two
 - the number of escalated complaints partially upheld at stage two as % of all escalated complaints closed at stage two.

Indicator Seven: Average times

This indicator represents the average time in working days to close complaints at stage one and complaints stage two of the model CHP. This indicator will report:

- the average time in working days to respond to complaints at stage one
- the average time in working days to respond to complaints at stage two
- the average time in working days to respond to complaints after escalation

Indicator Eight: Complaints closed in full within the timescales

The model CHP requires complaints to be closed within 5 working days at stage one and 20 working days at stage two. This indicator will report:

- the number of complaints closed at stage one within 5 working days as % of total number of stage one complaints
- the number of complaints closed at stage two within 20 working days as % of total number of stage two complaints
- the number of escalated complaints closed within 20 working days as a % of total number of escalated stage two complaints

Indicator Nine: Number of cases where an extension is authorised

The model CHP requires allows for an extension to the timescales to be authorised in certain circumstances. This indicator will report:

- the number of complaints closed at stage one where extension was authorised, as % all complaints at stage one.
- number of complaints closed at stage two where extension was authorised, as % all

complaints at stage two.

Appendix 7: Who submitted the complaint?

The table below shows the definition of who may submit a complaint as developed by Information Services Division.

Code	Description
Patient	Patient or former patient
Kin	Next of Kin
Partner	Partner
Parent	Parent
Child	Child
Sibling	Sibling
Relative	Other relative
Carer	Carer
Friend	Friend
Neighbour	Neighbour
Minister	Minister
GP	General Practitioner (GP)
Media	Media
Councillor	Local Councillor
Parliament	MP / MSP
Solicitor	Solicitor
Cab	Member of CAB (PASS worker)
Advocate	Advocate
Visitor	Visitor to the NHS
Public	Member of the public
Veteran	Person who has worked in the Armed Forces
Other	Other

Appendix 8: Consent

Where someone other than the person to whom the complaint relates, or their authorised agent, (including MPs, MSPs and local Councillors), wishes to make a complaint on behalf of a person, we will ensure that any such complaint is handled in accordance with the common law duty of confidentiality and data protection legislation.

In such circumstances we will, for example, check whether consent has been received from the person for the complaint to be made on their behalf. In the event that consent has not been received, we will take this into account when handling and responding to the complaint. In such circumstances we are likely to be constrained as to what we can do in terms of investigating a complaint, or in terms of the information which can be included in the report of such an investigation.

In circumstances where the person does not have the capacity to consent to the complaint being made on their behalf, it is likely to be relevant (for example) to check that the person making the complaint on the person's behalf has a legitimate interest in the person's welfare and that there is no conflict of interest. It would also be good practice to keep the patient on whose behalf the complaint is being made, informed of the progress of any investigation into the complaint, in so far as that is possible and appropriate.

The Scottish Government's guidance *Handling Requests for Access to Personal Health Data* provides information to assist NHS Boards (Boards, GP practices, etc) through the process of handling data access requests to personal health data in accordance with the relevant law and subsequent considerations. It also details, for example, helpful guidance in relation to parental responsibilities and rights. It can be accessed here:

<http://www.ehealth.nhs.scot/wp-content/uploads/sites/7/documents/Access-to-Health-Data-Guidance-Note-November-2011.pdf>

Children and Young People

All NHS **Boards** and their health service providers should have and operate clear policies in relation to obtaining consent. These should include where the person who is the subject of a complaint is a child. These procedures should reflect any guidance or advice that may be issued by the Commissioner for Children and Young People in Scotland. The principles in that guidance will be equally relevant to the local operation of the NHS complaints procedure. A number of information leaflets for young people are available on NHS inform including *Confidentiality – Your Rights*.

Generally, a person with parental responsibility can pursue a complaint on behalf of a child where the NHS **Board** or health service provider judges that the child does not have sufficient understanding of what is involved. While in these circumstances, the child's consent is not required (nor is the consent of the other parent), it is considered good

practice to explain the process to the child and inform them that information from their health records may need to be disclosed to those investigating the complaint.

Where an NHS **Board** or health service provider judges that a child has sufficient maturity and understanding, the child can either pursue the complaint themselves or consent to it being pursued on their behalf by a parent or third party of their choice. It is also good practice to obtain the child's written consent to information from their health records being released.

Adults who cannot give consent

Where a person is unable to give consent the NHS **Board** or health service provider can agree to investigate a complaint made on their behalf by a third party. However, before doing so they should satisfy themselves that the third party has:

- no conflict of interest; and
- a legitimate interest in the person's welfare, for example if they are a welfare attorney acting on behalf of an individual covered by the Adults with Incapacity Act (2000).

Appendix 9: Consent form

[insert name and address of NHS Board]

Suggest we delete this form and add in our own as has been approved by AMcC.

Consent to release patient information to a third party

I hereby authorise [Name of NHS Board] to disclose personal information relating to my healthcare to the person named below for the purposes of replying to a complaint.

Name and address of person to whom disclosure is to be made:

Name	
Address	

Patient's details:

Name	
Address	
Date of Birth	

I understand that to ensure a comprehensive response to my complaint, staff who are bound by a code of confidentiality, may have to refer to my medical record, and I have no objection to this.

Signature	
Date	



NHS Lothian Complaints Handling Procedure

Quick guide to the NHS Lothian complaints procedure

Complaints procedure

You can make your complaint in person, by phone, by e-mail or in writing.

We have a **two-stage complaints procedure**. We will always try to deal with your complaint quickly. But if it is clear that the matter will need a detailed investigation, we will tell you and keep you updated on our progress.

Stage one: early, local resolution

We will always try to resolve your complaint quickly, within **five working days** if we can.

If you are dissatisfied with our response, you can ask us to consider your complaint at Stage two.

Stage two: investigation

We will look at your complaint at this stage if you are dissatisfied with our response at Stage one. We also look at some complaints immediately at this stage, if it is clear that they are complex or need detailed investigation.

We will acknowledge your complaint within **three working days**. We will give you our decision as soon as possible. This will be after no more than **20 working days** *unless* there is clearly a good reason for needing more time.

The Scottish Public Services Ombudsman

If, after receiving our final decision on your complaint, you remain dissatisfied with our decision or the way we have handled your complaint, you can ask the SPSO to consider it.

We will tell you how to do this when we send you our final decision.

NHS Lothian complaints procedure

NHS Lothian is committed to providing high quality care and treatment to people in our communities through the delivery of safe, effective and person-centred care. We understand, however, that sometimes things go wrong. If you are dissatisfied with something we have done, or have not done, please tell us and we will do our best to put things right. If we cannot resolve matters in the way you want, we will explain why it's not possible to do as you suggest.

This leaflet tells you about our complaints procedure and how to make a complaint. It includes information about what you can expect from us when we are dealing with your complaint.

What is a complaint?

We regard a complaint as:

Any expression of dissatisfaction about our action or lack of action, or about the standard of service provided by us or on our behalf.

If you need to complain about something, we encourage you to do so. We also understand that your complaint may involve more than one NHS body or service, or relate to both health and social care services, or it may be about someone working on our behalf. Our complaints procedure covers all of these possibilities.

Who can complain?

Anyone can make a complaint to us. You can complain directly to us, or if you would rather have someone make the complaint on your behalf, we can deal with your representative. This could be a relative, a carer, a friend or any other person that you choose. We can also give you information about advocacy services, and about the Patient Advice and Support Service, which can help you to make your complaint. If you agree to someone making the complaint on your behalf, it is important for you to know that we will need to ask for your permission for us to deal with that person.

What can I complain about?

You can complain about things like:

- Your care and/or treatment;
- delays;
- a failure to provide a service;
- an inadequate standard of service;
- a lack of information and clarity about appointments;
- difficulty in making contact with us for appointments or queries;
- treatment by or attitude of a member of our staff;
- scheduled or unscheduled ambulance care;
- transport concerns, either to, from or within the healthcare environment;
- environmental or domestic issues;
- operational and procedural issues;
- our failure to follow the appropriate process; and
- your dissatisfaction with our policy.

We realise that it is not possible to list everything that you can complain about. If you want to complain about something that we have not listed above, we encourage you to do so.

What can't I complain about?

There are some things we cannot deal with through our complaints handling procedure. These include:

- a routine first-time request for a service, for example a request for an appointment or a request for a specific course of treatment;
- a request for a second opinion in respect of care or treatment;
- matters relating to private healthcare or treatment;
- matters relating to services not provided by or funded by the NHS;
- a previously concluded complaint or a request to have a complaint reconsidered where we have already given our final decision;
- a complaint made by an employee of the NHS Board or health service provider or other person in relation to their employment contract;
- a complaint that is being or has been investigated by the Scottish Public Services Ombudsman (SPSO);
- a complaint arising from a suggested failure to comply with a request for information under the Freedom of Information Act; and
- a complaint about which you have commenced legal proceedings, or have clearly stated that you intend to do so, rather than pursue the matter using the NHS complaints procedure.

We also realise that it is not possible to list everything that you cannot complain about. If other procedures can help you resolve your concerns, we will give information and advice to help you.

How do I complain?

You can complain in person at the place where you have received care, treatment or advice, or where the incident that you want to complain about happened. You can also complain by phone, in writing, by email or by using our online complaints form.

Wherever possible we encourage you to speak with a member of staff. It's easier for us to resolve complaints if you make them quickly and directly to the service concerned. So please talk to a member of our staff at the service you are complaining about. They will always try to resolve any problems on the spot if it is possible to do so.

When complaining, please tell us:

- your full name and address, and your email address if this is your preferred method of contact;
- the full name, address and date of birth of the person affected if you are complaining on behalf of somebody else;
- as much as you can about the complaint;
- what has gone wrong;

- when did this happen;
- where did this happen; and
- how you want us to resolve the matter.

Giving us this information will help us to clearly identify the problem and what we need to do to resolve matters.

How long do I have to make a complaint?

Normally, you must make your complaint within six months of:

- the event you want to complain about; or
- finding out that you have a reason to complain, but no longer than 12 months after the event itself.

In exceptional circumstances, we may be able to accept a complaint after the time limit. If you feel that the time limit should not apply to your complaint, please tell us why. If we decide that, because of the time that has passed since the incident occurred, we cannot consider your complaint, you can ask the Scottish Public Services Ombudsman (SPSO) to review our decision.

What happens when I have complained?

We will always tell you who is dealing with your complaint. Our complaints procedure has two stages:

Stage one – early, local resolution

We aim to resolve complaints quickly and close to where we provided the service. Where appropriate, this could mean an on-the-spot apology and explanation if something has clearly gone wrong and immediate action to resolve the problem.

Sometimes we will have to make some enquiries before we can respond to your complaint. We will give you our decision at Stage one in five working days or less, unless there are exceptional circumstances.

If we cannot resolve your complaint at this stage, we will explain why and tell you what you can do next. We might suggest that you take your complaint to Stage two. You may choose to do this immediately or sometime after you get our initial decision.

Stage two – investigation

Stage two deals with two types of complaint: those that have not been resolved at Stage one and those that are complex and require detailed investigation.

When using Stage two we will:

- acknowledge receipt of your complaint within three working days;

- where appropriate, discuss your complaint with you to understand why you remain dissatisfied and what outcome you are looking for; and
- give you a full response to the complaint as soon as possible and within 20 working days.

If our investigation will take longer than 20 working days, we will tell you. We will agree revised time limits with you and keep you updated on progress.

What if I'm still dissatisfied?

If you are still dissatisfied with our decision or the way in which we have dealt with your complaint when we have sent you our full response, you can ask the SPSO to look at it.

The SPSO **cannot** normally look at:

- a complaint that has not completed our complaints procedure, so please make sure it has done so before contacting the SPSO;
- events that happened, or that you became aware of, more than a year ago; or
- a matter that has been or is being considered in court.

You can contact the SPSO:

In Person:

SPSO

4 Melville Street

Edinburgh

EH3 7NS

By Post

SPSO

Freepost EH641

Edinburgh

EH3 0BR

Freephone: 0800 377 7330

Online contact www.spsso.org.uk/contact-us

Website: www.spsso.org.uk

Mobile site: <http://m.spsso.org.uk>

Getting help to make your complaint

We understand that you may be unable, or reluctant, to make a complaint yourself. We accept complaints from the representative of a person who is dissatisfied with our service as long as the person has given their permission for us to deal with that person. We can take complaints from a friend, relative, or an advocate, if you have given them your consent to complain for you.

The Patient Advice and Support Service (PASS) is an organisation that provides free and confidential advice and support to patients and other members of the public in relation to NHS Scotland. The service promotes an awareness and understanding of the rights and responsibilities of patients and can advise and support people who wish to make a complaint to the NHS. Further information and contact details can be found on the PASS web site:

www.patientadvicescotland.org.uk

We are committed to making NHS services easy to use for all members of the community. In line with our statutory equalities duties, we will always ensure that reasonable adjustments are made to help you to access and use our services. If you have trouble putting your complaint in writing, or want this information in another language or format, tell us in person, contact us on 0131 536 3370 or email us at feedback@nhslothian.scot.nhs.uk.

Our contact details

Please contact us by the following means:

NHS Lothian Patient Experience Team
Freepost RSTR-RLJH-YLTR
2-4 Waterloo Place
EDINBURGH
EH1 3EG
Phone 0131 536 3370
E-mail feedback@nhslothian.scot.nhs.uk
Website www.nhslothian.scot.nhs.uk/YourRights

We can also give you this leaflet in other languages and formats (such as large print, audio and Braille).

Scottish Public Services Ombudsman – Action Plan

	Action	10 March Update	Timescales	Who
1	SPSO Improvement Framework	<p>SPSO Improvement Framework circulated to all ANDs / CNs and completed for their area of responsibility. The framework includes 6 standards [1) organisational culture, 2) procedure and processes, 3) accessibility, 4) quality, 5) learning & 6) complaints handling performance]. This information has been collated and further discussion has taken place with the ANDs. Two clinical areas have agreed to participate in the supportive work with the SPSO – Maternity and RHSC.</p> <p>There were 2 staff sessions with the RHSC and Maternity that took place in February that were supported by the Learning & Improvement Unit (LIU). Feedback from the staff has been very positive.</p> <p>An investigation template has been developed and forms part of the new complaints operational procedure.</p> <p>We are working with the LIU to develop a quality assurance framework. In addition to this the LIU shared with us other templates that we are incorporating into our new operational procedure for complaints investigation and management.</p> <p>There is a further staff training event with the LIU and PET to identify “Heads of Complaints” and to support staff with telephone skills.</p>	<p>Completed</p> <p>Completed</p> <p>24 March</p>	ANDs / CNs
2	Review the SPSO reports on NHS Lothian	<p>The Parliamentary Reports have been reviewed and the clinical teams were asked to provide an update on these. This information has been discussed and presented at a number of fora across the organisation including the REAS management team, UHSS CMG, NHS Lothian Healthcare Governance Committee and NHS Lothian Board. This is now a regular report for the Patient Safety & Experience Action Group.</p> <p>It has been agreed with the Complaints Champion and HCG that this will be considered as part of the review of the existing HCG paper ahead of the implementation of the new national complaints handling procedure.</p> <p>Following a telephone between SPSO and NHS Lothian on 9 March a further review of the SPSO Parliamentary Report (RIE) has taken place and a case note audit is being undertaken. NHS Lothian will report back to SPSO by 31 March.</p>	<p>Completed</p> <p>April 2017</p> <p>31 March</p>	UHS / IJBs
3	SPSO/NES Educational materials	<p>Early discussion with Mary Parkhouse regarding the opportunity to include these as part of the NHS Lothian corporate Induction. Further conversations are required to address this. The uptake of these modules is very low. The modules are currently being updated by NES ahead of the new national guidance.</p> <p>Early conversations with Martin McKelvie to discuss ways that these modules can be</p>	<p>December 2016</p> <p>Ongoing</p>	All

		<p>incorporated into the dashboard function.</p> <p>Discussions have taken place between the Nurse Director, Medical Director and the Interim HR Director to consider how we can work use the learning and tools from “Being Open” in a complaints setting. Further discussions will take place at the Nurse Director’s Leadership Forum – Daring to be Great in May 2017.</p>	May 2017	
4	Working with the SPSO office re process, timescales and quality of information	<p>Two meeting between NHS Lothian and the SPSO have already taken place regarding issues of consent. This will be an ongoing element of the SPSO action plan.</p> <p>This forms part of the complaints improvement project and we are being supported by LIU to develop our complaints operational procedure and toolkit. The toolkit will provide the staff with a range of information and templates to support them.</p>	Completed	JM / PET
5	Chairman to meet the Ombudsman	<p>Two meetings have taken place. In addition Dr Simon Watson has met with Mr Martin.</p>	Completed	
6	Quality of Investigations and corrective action	<p>See action 4</p> <p>Working with the LIU and this will be one of the outputs. See item 1.</p>	By March 2017	UHS / IJBs / PET
7	Prison healthcare complaints	<p>JM and LMCM are meeting regularly with REAS management team to discuss the ongoing concerns with the quality of the response letters. Additional support for stage 2 complaints is being provided by PET. The work to address this remains ongoing.</p> <p>Test of change commenced at the end of Jan to test new acknowledgement process.</p>	December 2016	REAS / PET
8	New complaints process/Implementation plan for April 17	<p>An action plan has been developed to prepare for the implementation of the new guidance and includes liaising with Comms Team – banner on the intranet, information in Team Brief. A PPP has been prepared and is being delivered in a number of fora including practice managers and other staff groups.</p> <p>The NHS Lothian Complaints Policy and operational procedure will need to be updated.</p> <p>Separate overview summary has been shared with the Complaints & Improvement Quality Assurance Working Group at their Jan meeting. Additional support is being provided by E&P. This work remains ongoing and 4 sub-projects have been identified 1) NHS Lothian Complaints Handling Policy and Procedure, 2) SPSO Complaints Process, 3) Support to NHS Lothian from the SPSO’s Learning & Improvement Unit & 4) Learning from Complaints, Compliments and Feedback</p>	By April 2017	PET
9	Visits to other organisations i.e. GG&C Health Board and Glasgow Housing Association	<p>Completed during Nov and Dec</p> <p>Visit to Police Scotland with a follow up meeting of the Triage Team in January to look at their Frontline Local Resolution Team has taken place.</p> <p>Separate summary paper has been shared with the Complaints & Improvement Working Group at their Jan meeting as this has highlighted the different ways organisations support their complaints function, including the resource required to do this.</p>	Completed	AMcM / JM

10	Develop a letter to GP's re increase in waiting times. Review the increase in the number of complaints re waiting time increases	GPs now have access to up to date waiting times for each of the different outpatient areas. For GPs, the waiting times information is now being published on RefHelp and updated monthly. http://www.refhelp.scot.nhs.uk/index.php?option=com_content&view=article&id=1089:waiting-times-dashboard&catid=60:latest&Itemid=1429	Completed	
11	Develop a template for responding to complaints-person centred	Work has been taking place on the RIE and WGH sites. This will form part of the ongoing work with the SPSO and the LIU and additional resources have been included in the new model CHP policy and operational procedure. As per item 1 & 6	December 2016 Ongoing	ANDs / CNS / PET
12	Focus on some test of change areas i.e. orthopaedics; cardiology and prisons	As per item 1 & 6	By December 2016	UHS / PET
13	Review the number of complaints that translate into legal cases	This was done for a 6 month period as it was a manual task and took 25 man-hours to do as each one must be looked at individually. Out of the 1940 formal complaints received 01/04/2016-30/09/2016 we have identified 41 which directly related to adverse events reported. These have been linked. Moving forward, in order to have this information available routinely, complaints need to be linked to the adverse event, if relevant at the time of recording.	Completed	PET / QIST
14	We need to show evidence of being a learning organisation and how we follow up and use complaints as part of our continuous quality improvement	This forms the 4 th work-stream in the Project Brief. Work is underway to develop a short life working group.	By March 2017	Comms / UHS / IJBs / PET
15	Look at our capacity for administering complaints at a local level - and the authority held by those who do	Additional support has been provided from a Management Trainee and from a Project Manager from the Efficiency and Productivity Team. This is an ongoing discussion between JM and AMcM. We have collated the operational resource across the organisation that supports complaints and feedback. Early indication demonstrates that the majority of this work is undertaken by Admin / PA staff as part of their substantive duties in addition to the investigation element that is undertaken by clinical staff as part of their substantive duties. 10.3.17 – Complaints & Feedback - The Triage Team and we are now fully established with the most recent appointment taking place in Feb 2017 (5 staff / 4.85WTE). - There is a band 4 vacancy in the team and a new appointment is due to start in April 2017. During the last few months we have been using staff bank to cover the vacant hours There is a meeting scheduled with the Nurse and Medical Director to discuss the resource required to support the complaints function and to consider options for a new approach.	By March 2017	UHS / IJBs / PET
16	Examine complaint issues relating to our own administration and	As part of the preparation for the new model complaints procedure we will review the reporting data for the Healthcare Governance and NHS Lothian Board meetings.	By March 2017	UHS / IJBs / PET

	internal/external communication processes and approaches - and consider what action is needed here - to include both training and support	The Complaints Champion has assisted in the development of a new reporting template to be used in line with the new complaints model.																										
17	Consider whether we need a person/persons to have responsibility for co-ordinating the learning and improvement actions relating to Ombudsman and internal complaint recommendations (and from other sorts of adverse events/feedback - and not forgetting the importance of compliments in order to reinforce good practice).	This will form part of the second and fourth work-streams of the complaints improvement project. Currently the SPSO / Complex posts (3.38WTE) support this workload as it relates to the SPSO complaints activity.	By March 2017	UHS / IJBs / PET																								
18	Budget in relation to complaints - what we are spending on what - including staff costs and training.	<p>March 2017</p> <table border="1"> <thead> <tr> <th>Complaints Posts</th> <th>Grade</th> <th>WTE</th> </tr> </thead> <tbody> <tr> <td>Team Manager – Complaints & Feedback</td> <td>Band 7</td> <td>1</td> </tr> <tr> <td>Complaints Officers - Triage</td> <td>Band 5</td> <td>4.85</td> </tr> <tr> <td>Complaints Officers - SPSO</td> <td>Band 5</td> <td>3.38</td> </tr> <tr> <td>Admin Support</td> <td>Band 4</td> <td>2.4 + 1 vacant post</td> </tr> <tr> <td>Total</td> <td></td> <td>12.63</td> </tr> <tr> <td>Vacancy</td> <td>Band 1</td> <td>1</td> </tr> <tr> <td>Total after sickness - March</td> <td></td> <td>11.63</td> </tr> </tbody> </table> <p>A PET Development Plan has been established and is being implemented. There has been additional staff training on Information Governance and Patient Opinion. We are also being supported by OD, Partnership and Occupational Health and LIU. Please see action 15. The resource for complaints training sits with and beyond PET and will involve all UHS / IJBs.</p>	Complaints Posts	Grade	WTE	Team Manager – Complaints & Feedback	Band 7	1	Complaints Officers - Triage	Band 5	4.85	Complaints Officers - SPSO	Band 5	3.38	Admin Support	Band 4	2.4 + 1 vacant post	Total		12.63	Vacancy	Band 1	1	Total after sickness - March		11.63	Ongoing	AMcM / JM
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Key

Red text indicates work that has been completed

Black text indicates work that remains ongoing

DRUG AND ALCOHOL FUNDING 2017/2018

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

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

Substance Misuse Services are delegated to IJBs. Community services are managed directly within Health and Social Care Partnerships. Pan Lothian services are managed by REAS under the direction of and on behalf of IJBs.	2.1
7 th January 2016, confirmation was received that the total Alcohol and Drug funding to Boards would reduce from circa £70m to circa £55m across Scotland. In prior years, NHS Lothian has received a total of £11.47m of the £70m national figure. NHS Lothian had based its financial plan on an NRAC share of the reduction to Boards of the £15m, equating to circa £2.1m.	3.1/3.2
In HMP Addiewell the West Lothian ADP has proposed removing its share of the funding required to provide a different service to West Lothian residents only. 68K. NHS Lothian is in the process of identifying funding to continue the service	4.1
Ritson in patient Detox pan Lothian is being redesigned	4.2
Lothian and Edinburgh Abstinence Programme (LEAP) is being redesigned	4.3
Harm Reduction Team is being redesigned to better serve local need	4.4
Primary Care Facilitation Team (PCFT) supports the local enhanced service for substance misuse	4.5
ABIs (Alcohol Brief Interventions – Heat Standard) NHS Lothian has a locally enhanced service that contracts with GPs to pay them for each ABI delivered. This will continue meantime	4.6
Regional Infectious Disease Unit, GUM Clinic and Hep C Treatment & Prevention Services. The funding over the years has become part of these services baseline budgets and is now placed within the NHS Lothian financial planning assumptions for 17/18.	4.7
Toxicology. ADPs propose a service review and a reduction of 23% from the £34,000 NHS Lothian will consider this as part of financial this year’s planning assumptions.	4.9

Psychology support. Currently £137,000 is funded from single system psychological services with an additional £200,000 from drug & alcohol monies. Needs review before decisions made on future funding model	4.10
Alcohol Related Brain Damage Unit (ARBD). Previously funded from Unscheduled Care Money. Edinburgh IJB have agreed to consider 75% funding so the pressure to NHS Lothian is to identify £157,	4.12

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DRUG AND ALCOHOL FUNDING 2017/2018

1 Purpose of the Report

- 1.1 The purpose of this report is to provide a progress report to the Board on the work to date on the review of drug and alcohol services funded by NHS Lothian and the three Lothian Alcohol & Drug Partnerships (ADP's). This work has been undertaken through each Alcohol and Drug Partnership and bi-monthly meetings of the Lothian Substance Misuse Collaborative. This builds on work to develop recovery oriented systems of care, enhance the community capacity and infrastructure to support patients more effectively at a locality level.

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

2 Recommendations

- 2.1 To note that Substance Misuse Services are delegated to IJBs. Community services are managed directly within Health and Social Care Partnerships. Pan Lothian services are managed by REAS under the direction of and on behalf of IJBs.
- 2.2 To note that since 2009 there has been a national strategy to create recovery oriented systems of care. This requires an increased focus and investment in community based recovery services, to sit alongside existing approaches to treatment and harm reduction. This shift is reflected in ADP strategies and IJB Strategic Plans.
- 2.3 To note that a process has been underway during 2016/2017 financial year to review pan Lothian services and consider the options around retaining, changing or re-commissioning those services in conjunction with the three Alcohol and Drug Partnerships in Lothian (ADP's) in Lothian.
- 2.4 To Note that the Edinburgh IJB discussed the proposals described in this paper on 24th March and requested that they be subject to review, detailed risk assessment and revised for further discussion on 28th April 2017. The Edinburgh Professional Advisory Committee have to be consulted on proposals in advance of the meeting on 28th April.
- 2.5 To note the impact of the proposed ADPs changes and how this will affect NHS Lothian services and potential impact on performance against HEAT standard.
- 2.6 To note that we are working with the ADPs to fully understand the impact on services and service users and a fuller equality impact assessment will require to be completed.
- 2.7 To note the Governance structures in place to confirm final proposals and any changes before final sign off require proposed service changes to go through each IJB and NHS Lothian during the month of March and April.
- 2.8 That we are required to submit our Local Delivery Plan to the Scottish Government once discussed at the 5th April Board meeting.

3 Discussion of Key Issues

- 3.1 In the letter to Health Boards from the Cabinet Secretary dated 7th January 2016, confirmation was received that the total Alcohol and Drug funding to Boards would reduce from circa £70m to circa £55m across Scotland.
- 3.2 In prior years, NHS Lothian has received a total of £11.47m of the £70m national figure. NHS Lothian had based its financial plan on an NRAC share of the reduction to Boards of the £15m, equating to circa £2.1m.
- 3.3 In July 2016 the allocation letter from Scottish Government confirmed the 2016/17 funding allocation for ADPs in the NHS Lothian Board area as £8,887,133. The letter referred back to the January correspondence stating that “**there is a clear expectation that existing services, resources and outcomes are maintained at 2015/16 levels.**” The challenge that was set for NHS Lothian and the three ADP’s was how, if possible, could we deliver services and maintain performance within a reduced budget if it was not possible to re-instate the funding.
- 3.4 ADP chairs have been informed that for 17-18 the Scottish Government funding for drug & alcohol services £53.8M will be transferred to NHS Boards as part of the baseline budget for delegation to Integration Authorities specifically earmarked for Alcohol and Drug Partnership activities.
- 3.5 Following a meeting of the Lothian Wide Substance Misuse Collaborative on 30th January 17, a number of proposed decisions were made by ADPs which may, if supported, directly impact on a number of NHS Lothian services.
- 3.6 Following a presentation of the key risks at the NHS Lothian Strategic Planning Committee on 9th February, the Corporate Management Team also received an update paper at its meeting on 13th February and the Healthcare Governance Committee also discussed this at its meeting on the 14th March.

4 Key Risks

- 4.1 **Prisons.** An allocation of £144,000 was provided by Scottish Government from 2011 for providing alcohol awareness, ABIs and delivering counselling support to prisoners. Prison treatment remains a health responsibility and in IJB terms is a non delegated function whereas drugs and alcohol services are delegated. An existing contract to deliver counselling support in HMP Edinburgh remains in place at present and the service is available to all prisoners regardless of their normal residence. This is funded by East, Mid and Edinburgh ADPs. In HMP Addiewell the West Lothian ADP has proposed removing its share of the funding required to provide a different service to West Lothian residents only. NHS Lothian is therefore in the process of identifying funding to ensure that all prisoners, regardless of their original health board of residence receive access to appropriate counselling and psychological therapies. This leaves the anomaly that local ADP funding for counselling for all prisoners in HMP Edinburgh is still funded by East, Mid and Edinburgh ADPs. This will be reviewed in line with the IJB strategic Plans for these areas over the course of the financial year.
- 4.2 **The Ritson Inpatient Clinic** which is the NHS in patient detoxification facility in the Royal Edinburgh is to be redesigned for 6 beds from the current 12, incorporating a day programme for Edinburgh patients with East, Mid and West developing local day

programmes for their residents. A saving has been assumed but is as yet not clear. A business case is being developed. Providing a Ritson Clinic with fewer beds may have an impact on the waiting times HEAT standard. This will be further developed before any final decisions are made including a risk assessment of the HEAT standards.

- 4.3 **Lothian and Edinburgh Abstinence Programme (LEAP).** West Lothian is seeking a reduction in their share of the funding to this Lothian service, whilst Edinburgh wants to invest and East and Midlothian want to retain funding at existing levels. The proposal is to review the LEAP model. Edinburgh wants to attract additional funding from out of area placement costs by changing the referral criteria and making better use of accommodation options. The aim is to provide an additional 10 places for Edinburgh residents. A reduction in funding share could impact on West Lothian's waiting times to use this service. West Lothian has accepted this may be an outcome and will put in place models locally to manage the client group safely.
- 4.4 **Harm Reduction Team.** This team provides needle exchange and other harm reduction advice across Lothian. East and Midlothian wish to reduce their funding contribution to this service. They believe they will have services locally to manage this. Edinburgh & West Lothian are willing to maintain existing funding but to review service provision and availability going forward. Again this will be impact assessed.
- 4.5 **Primary Care Facilitation Team (PCFT).** The PCFT works with healthcare staff in primary care and community in relation to drugs, alcohol and blood borne viruses to promote good practice in providing care to drug users, alcohol users and people affected by blood borne viruses. This is achieved via policy development, service improvement and strategic planning; developing, publishing and disseminating good practice guidance; training, education and workforce development; supporting the Lothian Enhanced Services for drug misuse, alcohol brief interventions and blood borne viruses and audit, evaluation and research.

This team has reduced significantly in size and is now primarily the work of an analyst and session GP time. Lothian has a nationally enhanced service with Lothian GPs who for approximately £400 per patient per year support 4,000 drug using clients in primary care. The analyst provides all data associated with the local contract and the GP provides advice and support to GPs re the management of drug users, leads on the monitoring and management of the contracts/software between PCCO and SMD and overall provides educational support to GP practices. The ADPs were proposing retaining the analyst role but stopping the GP support session time. ADPs will mitigate this risk by ensuring that support for GPs is localised with Health and Social care Partnerships.

- 4.6 **ABIs (Alcohol Brief Interventions – Heat Standard)** NHS Lothian has a locally enhanced service that contracts with GPs to pay them for each ABI delivered. In the last 8 years, NHS Lothian has continued to exceed its heat target, now a standard, by a minimum of 127% and latterly in 15/16 by 294%. The yearly target is 9,738 ABIs delivered with a focus on priority settings A&E, Maternity and Primary Care. Last year 42% were delivered in these settings with 58% in the wider community settings with the latest developed areas being police custody suites, dentists and alongside stop smoking awareness.

Currently spending £100,000 on payments to GPs but ADPs felt that this should be embedded in GP services and wanted to cease the payment for ABI work. The GP Sub Committee and Local Medical Committee were not supportive. The Chief Officers have

agreed that, given the national GMS agreement between the Scottish Government and the BMA that there should be no reduction in enhanced services whilst the GMS contract is under negotiation, the LES will continue in the meantime.

- 4.7 **Regional Infectious Disease Unit, GUM Clinic and Hep C Treatment & Prevention Services.** Historically in the 1980's when Scottish Government first provided HIV/AIDs funding the Regional Infectious Diseases Unit, GUM Service and HEP C Services received funding from ADP allocations. There appears to be no evidence to show that these funds directly support people with drug and alcohol problems. The ADPs view is that 100% (£198,000) of the funding should be returned to the ADPs. However, a risk assessment is required prior to a final decision being reached. The impact for IJBs on removing this funding stream requires to fully understood. The funding over the years has become part of these services baseline budgets and is now placed within the NHS Lothian financial planning assumptions for 17/18.
- 4.8 **Paediatrics.** NHS Lothian will cover the £2,000 which is part of baseline provision supporting Consultant time with HIV babies and/or drug costs associated with this group.
- 4.9 **Toxicology.** ADPs propose a service review and a reduction of 23% from the £34,000 which contributes to part funding of the Alcohol Nurse Liaison Service at the RIE. This service developed the protocol to support patients in an inpatient setting who detox, the nurses provide support to ward staff as well as to patients on detox and relapse prevention, they further provide Outpatient Services to any patients seen by them in the RIE. At times they will work in A&E with detox patients. Last year the service supported 1,200 patients and links them with the range of community based support provided by NHS, ADPs and 3rd sector. NHS Lothian will consider this as part of financial this year's planning assumptions.
- 4.10 **Psychology support.** Currently £137,000 is funded from single system psychological services with an additional £200,000 from drug & alcohol monies. Midlothian want to reduce a full time post to 0.5wte and West are seeking a 23% reduction in their share. This reduction in service provision will possibly impact on psychological waiting times and disturb the balance of psychology provision across Lothian. Therefore this needs to be more fully understood before any final decisions are reached.
- 4.11 **Drug Related Death Post** – Allocated funding of £40,000, ADPs have agreed to reduce to £24,000 p.a. and employ a band 5 (0.6wte) post. The post will continue in Public Health providing data base entry, full case history on all drug related deaths so that locality groups can conduct reviews, prepare annual report, ad hoc support for individual case reviews and support to Drug Related Death Lothian Steering Group and communications. This reduced option will have minimum impact.
- 4.12 **Alcohol Related Brain Damage Unit (ARBD).** The 10 bedded unit providing a service to 48 patients per year was initially funded from Unscheduled Care monies. In the last 9 months it has been funded from two non recurring funding streams. For 17/18 the budget has been reviewed and reduced by 4% to £630,000. Edinburgh IJB are willing to consider 75% funding as they use 75% of the beds. East, Mid and West Lothian are unable to offer recurring funding but East and Midlothian would consider a spot purchasing model as required - initial costs are around £16,000 for a 12 week stay. This service mainly used by Edinburgh and the RIE site is saving/offers improved bed management of 3,408 acute bed days (9 – 10 beds) per year. There may be opportunities to consider this service alongside the other residential services and out of area placements. The pressure to NHS Lothian is to identify £157,500 or 25% (based

on bed usage) of the costs which it would recoup through partnerships paying for the spot purchasing of beds.

5 Risk Register

- 5.1 A reduction in services may impact on :
- Longer waits for new patients and less throughput in core SMD services. Inability to achieve and maintain HEAT Standard A11.
 - Impact on service delivery which will provide a risk to drug and alcohol clients within Addiewell Prison for non West Lothian prisoners who would be unable to access services currently provided.
 - Potential risk to achieving HEAT Standard to deliver 9,738 ABIs.

6 Impact on Inequality, Including Health Inequalities

- 6.1 To date an impact assessment has been carried out by Midlothian & East Lothian Alcohol & Drug Partnership (MELDAP). Further EQIs will be undertaken as the proposed detail of change is confirmed. Following IJB approval in Edinburgh EQIs are expected in April/May on residential rehab/Leap, Ritson Ward reduction in beds and a shift towards pharmacy prescribing.

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

- 7.1 The ADPs of Midlothian, East Lothian and West Lothian have had formal engagement with service users and providers about proposed changes to local services. Edinburgh ADP has also undertaken engagement via its internal Collaborative Group.
- 7.2 At the Lothian Wide Substance Misuse Collaborative meeting on 30th Jan it was noted that some staff/services have been made aware of possible reductions in budgets via a communication from ADPs. However, all proposals are at this stage “directions of travel” until they are signed off through the governance procedure highlighted in appendix 1. There were further plans for a generic Q&A communication that could be shared by all partners to convey changes to staff and service users providing a consistent response to local and pan Lothian questions.

8 Resource Implications

- 8.1 The resource implications are as detailed in this paper. If the proposals detailed above are implemented there is a potential shortfall of almost £300,000 for those services affected. There is an additional £157,000 for the NHSL share of ARBD unit.
- 8.2

Area	Potential Reduction
Prisons HMP Addiewell	£68K
Regional Infectious Disease Unit (RIDU)	£149K
GUM Clinic	£34K
Hep C Treatment & Prevention Services	£15K
Paediatrics	£2K
Toxicology	£8K
Drug Related Death Post	£16K

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22.03.17

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List of Appendices

Appendix 1: Governance Process

Appendix 1

Governance Process

- Strategic Planning Committee
- IJB Chief Officers – Feb – assess impact
- CMT – Feb and March – assess impact
- Substance Misuse Collaborative – March - review
- IJB Boards March – possible directions
- NHS Lothian Board – April - consider impact on service users and services and risk