BOARD MEETING

DATE: **WEDNESDAY 21 JUNE 2017**

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

VENUE: **WATERLOO SUITE, APEX WATERLOO PLACE HOTEL, WATERLOO PLACE, EDINBURGH, EH1 3BH**

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

AGENDA

Item		Lead	
	Welcome to Members of the Public and the Press		
	Apologies for Absence		
1.	**Items for Approval**		
1.1.	Minutes of the Previous Board Meeting held on 5 April 2017	**BH**	*
1.2.	Running Action Note	**BH**	*
1.3.	Corporate Risk Register	**TG**	*
1.4.	Proposed Amendments to Section 4 of the Standing Financial Instructions – External Audit	**SG**	*
1.5.	Final Report on 2016 Measles Outbreak in Lothian	**AKM**	*
1.6.	Vaccination Transformation Programme (VTP)	**AKM**	*
1.7.	Committee Memberships and Midlothian Integration Joint Board Appointments	**BH**	*
1.8.	Finance & Resources Committee - Minutes of 15 March & 10 May 2017	**MH**	*
1.9.	NHS Lothian Patients' Private Funds - Annual Accounts 2016/17	**SG**	*
1.10.	Healthcare Governance Committee - Minutes of 14 March & 09 May 2017	**RW**	*
1.11.	Acute Hospitals Committee – Minutes of 30 May 2017	**KB**	*
1.12.	Staff Governance Committee – Minutes of 29 March 2017	**AM**	*
1.13.	Strategic Planning Committee – Minutes of 13 April 2017	**BH**	*
1.14.	Audit & Risk Committee – Minutes of 24 April 2017	**MA**	*
1.15.	West Lothian Integration Joint Board - Minutes 14 March & 20 April 2017	**SG**	*
1.16.	East Lothian Integration Joint Board - Minutes 23 February & 30 March 2017	**PM**	*
1.17.	Edinburgh Integration Joint Board - Minutes 24 March & 28 April 2017	**SA**	*
1.18.	Midlothian Integration Joint Board - Minutes 9 February & 16 March 2017	**JO**	*
2.	**Items for Discussion** (subject to review of the items for approval)		
2.1.	Regional Delivery Plan	**TD**	**v**
2.2.	2017-18 Local Delivery Plan (LDP) Feedback and Arrangements for NHS Lothian 2017 Annual Review	**AMcM**	*
2.3.	Quality and Performance Improvement	**SW**	*
2.4.	2017/18 Financial Performance – 31 May 2017	**SG**	*

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

2.5.	Scheduled Care Access Performance, 2017/18 Trajectories and Allocation of Funding	**JC**	*
2.6.	Equality & Human Rights Update	**AKM**	*
2.7.	Primary Care Update	**TG**	*

3. Annual Accounts for the Year Ended 31 March 2017 **SG** ®

The Draft Annual Accounts are the subject of separate a confidential circulation with the Board papers, as they cannot be presented formally in the public domain until laid before Parliament in the Autumn.

4. Next Development Session:
Wednesday 19 July 2017 at 9:30 a.m. at the Scottish Health Service Centre, Crewe Road South, Edinburgh EH4 2LF

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

6.	Resolution to take items in closed session	**BH**	**v**
7.	Minutes of the Previous Private Meeting held on 1 February & 5 April 2017	**BH**	®
8.	Paediatric Programme Board Update – Workforce and Sustainability	**JC**	®
9.	Lothian GP Correspondence Update	**TG**	**v**

10. Matters Arising

11. Any Other Competent Business

Board Meetings in 2017

2 August 2017	Scottish Health Service Centre
4 October 2017	Scottish Health Service Centre
6 December 2017	Scottish Health Service Centre

Development Sessions in 2017

19 July 2017	Scottish Health Service Centre
6 September 2017	Scottish Health Service Centre
1 November 2017	Scottish Health Service Centre

DRAFT **1.1**

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 5 April 2017 in the Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Councillor D Grant; Councillor R Henderson; Mr M Hill (from 10am); Ms C Hirst; Ms F Ireland; Mr A Joyce; Mrs J McDowell; Mrs A Mitchell; Mr P Murray; Mr J Oates and Professor M Whyte.

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

In Attendance: Mrs R Kelly (Associate Director of Human Resources – representing Mrs J Butler) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mrs K Blair, Mrs J Butler, Councillor H Cartmill, Mr P Johnston, Councillor C Johnstone, Mrs L Williams and Dr R Williams.

Welcome and Introduction

The Chairman thanked colleagues for their good wishes during the early stages of his recent illness.

The Chairman welcomed members of the public and press to the Board meeting

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.

Valedictory Comments

The Chairman commented that this would be the last Public Board meeting for Councillor Grant, Mr Johnston and Mrs McDowell and that a suitable leaving event would be organised. It was noted that attempts had been made to organise an informal lunch but the eventual numbers had made this unviable. The Chairman on behalf of the Board recorded his appreciation for the contributions made by members and wished them good fortune in the future.

1. Items for Approval

1.1 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.

1.2 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:-

1.3 Minutes of the previous Board meeting held on 1 February 2017 - Approved.

1.4 Running Action Note – Approved.

1.5 Corporate Risk Register – The Board accepted the paper as assurance that the corporate risk register contained all appropriate risks which were contained in section 3.2 and set out in detail in appendix 1, and to inform assurance requirements. The Board also acknowledged that as a system of control, the Governance Committees of the Board had been asked to assess the level of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

1.6 Finance and Resources – Minutes of 18 January 2017 – Endorsed.

1.7 Healthcare Governance Committee – Minutes of 17 January 2017 – Endorsed.

1.8 Acute Hospitals Committee – Minutes of 6 December 2016 and 22 February 2017 – Endorsed.

1.9 Staff Governance Committee – Minutes of 26 October 2016 and 25 January 2017 – Endorsed.

1.10 Strategic Planning Committee – Minutes of 8 December 2016 and 9 February 2017 – Endorsed.

1.11 Audit and Risk Committee – Minutes of 5 December 2016 and 27 February 2017 – Endorsed.

1.12 West Lothian Integration Joint Board – Minutes of 31 January 2017 - Endorsed.

1.13 East Lothian Integration Joint Board – Minutes of 21 December 2016 and 26 January 2017 - Endorsed.

1.14 Edinburgh Integration Joint Board – Minutes of 20 January and 17 February 2017 - Endorsed.

1.15 Midlothian Integration Joint Board – Minutes of 1 December 2016 - Endorsed.

Items for Discussion

2. Scottish Government Health and Social Care Delivery Plan and the Development of an East of Scotland Regional Health and Social Care Delivery Plan

2.1 The Chairman commented that he anticipated that this item along with the next item on the '2017/18 draft Local Delivery Plan including the 2017/18 financial plan' would represent the main items of discussion at the current meeting. He commented that an additional dimension over previous years was the introduction of a regional delivery plan.

2.2 It had been felt to be important that Board members had sight of the Scottish Government Health and Social Care Delivery Plan and the East of Scotland Regional Health and Social Care Delivery Plan with it being noted that the standards and timelines of these were reflected in the Local Delivery Plan (LDP) and corporate objectives both of which would be discussed later on the agenda. The key challenges were around the reduction of beds, the development of a primary care structure, outpatients and treatment centres.

2.3 The Board noted that the Scottish Government had asked that regional plans be submitted by September 2017. The Chief Executive of NHS Lothian had been appointed to lead the delivery of the regional Health and Social Care Development Plan for the East Region. It was reported that the Chief Executive as the Chair of the South East and Tayside Regional Planning Group had established a discussion forum to bring key stakeholders together to discuss issues within the context of improvement plans, finance, workforce and regional planning for the acute services. A Programme Board would meet at the end of December with progress being reported to future Board meetings. The Board received details of the other Boards involved within the East Regional Planning process with it being noted that communications on an ongoing basis would be important. It was anticipated that the Health and Social Care Delivery Plans would be developed and delivered through the transformation process.

2.4 The Board noted that anticipated changes to Health Board structures had not occurred although the Scottish Government had recognised the advantages of regional working for planning purposes as well as for the management of resources. It was noted that under the East of Scotland arrangements that 9 Boards of governance were involved in the regional planning process and that all of these organisations would be developing financial plans and commissioning services. It was noted that this represented a sophisticated landscape and that governance arrangements would develop on an iterative basis. The Board noted that the East Region represented around 25% of Scotland and in that regard there were significant planning aspects to be addressed. The Board noted that a regional financial plan was also being developed with the key issue being around how to develop financial sustainability.

2.5 The point was made that the Board paper stated that at this point it was not known how performance would be monitored. The question was raised about whether NHS Lothian would have an opportunity to set its own standards with it also being questioned what steps would be taken to influence the process moving forward. The

Board were advised that the National Delivery Plan set clear expectations and was clear about how priorities and timescales would be evaluated. It was pointed out however that through the 6 Integration Joint Boards (IJBs) of governance that there were real opportunities to enhance local as well as regional services. A National Programme Board had been established to drive a national plan and the 3 Lead Regional Chief Executives would serve as part of the National Board and would have a part to play in shaping the agenda and how this would be approached in each region.

2.6 The Board noted that the Chief Executive had met with the Chief Executive's and Chief Officers of the 6 IJBs to discuss the regional planning process and that whilst there was no real flexibility around the national direction there was flexibility around how achievement could be delivered.

2.7 A question was raised in respect of the expectation that IJBs would deliver a 10% reduction in unscheduled care bed days in Lothian with clarification being sought around whether this meant a reduction in bed days or a reduction in bed numbers. The Board were advised that the direction was around reducing bed numbers although it would be important that that a sensible approach was adopted.

2.8 The Board were reminded at the recent Board Development Session it has been reported that unscheduled care acute beds were running at 95% capacity and that this led to inappropriate boarding and further delays. It was noted that an 85% occupancy rate was the aspiration and if 60,000 bed days could be reduced this would move the system to the 85% level. This would allow the system to operate safer with a more sustainable acute sector providing better quality and safety of care for patients with it being stressed however that this would not release costs. The point was made that if cost was to be taken out of the system then beds would need to be reduced, which might lead to an increase in occupancy rates.

2.9 The Board were referred to a recent Nuffield report on 'Shifting the Balance of Care: Great Expectations' which suggested that whilst alternatives to hospital care improved the quality of care and patient experience that it did not result in a reduction in cost. The Chief Executive commented that he still felt that it was the correct course of action to drive the Shifting the Balance of Care policy although concurrently there was also a need to drive efficiency savings out of the system.

2.10 The Board were advised that elements of the national plan would be consulted upon nationally with discussions also having been held about regional aspects. The focus moving forward would be to deliver the national plan on a regional basis with the Scottish Government looking for specific priorities to be in place to cover a 2 – 3 year timeframe leading up to a 10 – 15 year approach although this represented challenges in respect of Macro / micromanagement. The longer term view would be that national planning would drive creativity to deliver large set piece infrastructure solutions and that consultation would need to reflect engagement requirements.

2.11 The point was made by a Board member that at the Cabinet Secretary launch the expectation had been that there would be a movement of resources as a result of reduced bed days although the point was made that this did not necessarily represent a one to one relationship.

2.12 The Chief Executive commented that he was clear about the need for bed closures which were required to release resource. Reference was made to the impending closure of Liberton Hospital, community care beds and longer term beds at the Royal Edinburgh Hospital which were already closing.

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

3. 2017/18 Draft Local Delivery Plan Including 2017/18 Financial Plan

3.1 The Chairman drew the recommendations contained in the circulated paper to the attention of the Board.

3.2 The Board were advised that the Director of Finance was conscious that only a one year plan was being presented and that this was problematic in terms of future planning. One aspect was the conversation around the relationship between IJB beds and the configuration of services which was absent from the financial plan with there being a need to consider the development of a longer term financial plan. It had not been possible at this juncture to bring forward a 3 year plan to the Board as this would not have been balanced. An iterative process was currently underway to attempt to reach a balanced position. The current year financial plan did not reflect Directions from IJBs although the specificity of this would emerge with there being a need for reflection in future financial plans. The Board were advised that within finance there was a need to get away from the focus on balancing the books each year and the need to move to the development of longer term financial strategies.

3.3 The Board were advised that when the financial plan had been presented in February 2017 that it had reported a potential £51m deficit and this position had been improved. It was reported that Directors of Finance were working together to identify further non-recurring sources of funding. In addition to this a more Regional approach to financial planning was underway locally with business units and individual Executive Directors were examining every option to reduce the cost base.

3.4 A Development Session has been held on the 1 March to respond to the Boards earlier concerns around the prescribing position and an additional allocation of £3m had been made to reflect this and bring spend up to the 2016/17 position. This would be reflected in IJB allocation letters. In addition a quality improvement approach was being taken to primary care prescribing to mitigate the financial pressure with a focus on cost and variation. This work was being taken forward by the effective prescribing forum.

3.5 The Board were advised that it had been reported at the most recent meeting of the Finance and Resources Committee that all residual recurrent reserves had been allocated to the bottom line. The current financial gap was £22.4m and this excluded any provision for the use of the independent sector to reduce waiting times which would impact on performance as discussed within the LDP. It was noted that further discussions around this position would be held with the Scottish Government later in the day.

3.6 The Board received a summary of the cost pressures facing the system as well as sources of funding and their allocation to move to a balanced financial position. The

National Resource Allocation Committee (NRAC) position was also discussed. It was noted that the efficiency savings proposal of 2% was consistent with previous years delivery with it being unlikely that an increased level could be achieved without impacting on services. It was noted that a sustainability and value approach was being driven nationally and that this moved away from the efficiency and productivity focus in previous years and reflected the need to do more with less. In that respect non cash and productivity opportunities were important and the Scottish Government allocation letter was clear about expectations for inclusion in improvement plans.

3.7 The Board noted that work was continuing on all fronts in respect of reducing the financial gap with focus in particular around prescribing, junior doctor pressures and nursing. It was too early to predict a breakeven financial position particularly within the context of all reserves having been applied to the financial bottom line.

3.8 The point was made in respect of the LDP and the performance areas why the Board was not putting resource into high risk areas and whether the Board was satisfied that it had enough influence in this respect. The Director of Finance commented that she did not think that resources were being allocated to where they should be and that each year there was a need to respond to pressures. In that respect in the current year there had been an attempt to skew investment towards IJBs and primary care to reduce pressure in acute services by giving IJBs less of an efficiency gap. The point was made that the solution was about more than financial dialogue and needed to include quality improvement etc.

3.9 The point was made that there was a need to be clear about the outcomes that needed to be achieved and the need for appropriate challenge and that if these were clear then there were opportunities to make more nuanced decisions. The point was made it was not always easy for Board members to understand the means against which performance had been risk assessed.

3.10 The Board were advised that between 60-80% of cancer cases were preventable by looking at risk factors and that small interventions particularly in areas like alcohol intervention could have significant impact and that there was a need to focus investment on where evidence was available. The Director of Public Health and Health Policy commented that Scotland had a below average spend on prevention and she would be concerned if this were to be reduced further. It was noted that this and related debate moved into the realistic medicine agenda and was further complicated when debate moved into expected outcomes from a patient perspective.

3.11 The Chairman commented that the question around the influence of the Board was a fundamentally important point although he felt that currently the system was not properly equipped to answer the question posed although there was a need for assurance that decisions were properly made. He commented that historically and correctly that the Board had been driven down an imposed target setting route and that performance targets had been discussed in the past in respect of the validity of targeting of resources. The Chairman thought that there was a need for more scrutiny around this area.

3.12 The Board were reminded that thought the development process of ‘Our Health Our Care Our Future’ that criteria for investment and resourcing had been established

and it might be worth revisiting this in respect of the points made at the current meeting.

3.13 The Board were advised in terms of the generalality of the LDP that this was a long document and was still in draft form and was therefore an iterative live document which would be able to respond to Government policy as it was published. The point was made in response to a comment about the importance of realistic medicine that this was reflected in the LDP although more detail might be required. It was noted that the inaugural meeting of the Primary Care Programme Board would be held later in the day where the availability of funds to tackle prescribing and workforce as well as other issues would be discussed. It was noted that the LDP majored on workforce as one of its key priorities and that the regional approach allowed a different view on this to be taken. The Board noted that in the current LDP that this was the first time that research and development had a strong emphasis with the intention being that this should be used to drive future business. Other key aspects of the LDP were explained and discussed by the Board.

3.14 The Board noted that scheduled care and unscheduled care continued to need to be considered given the intention that there would be no investment in the private sector and there would be a need to consider how to manage the current capacity. The Board received an update on the Scotland wide position in respect of waiting times, outpatients and day case activity. It was noted that NHS Lothian would continue to invest in in-house waiting time activity but not the independent sector. It was noted that an Outpatient Programme Board had been established and was Chaired by the Medical Director which would look at areas of significant redesign. Proactive communication with the service and patients would continue. The Board were advised that an exercise was underway looking at how to risk assess patients on waiting lists and how to target resource to the highest risk areas. A clinically driven framework was being developed and would be discussed further at the meeting with the Scottish Government later in the day.

3.15 The point was made that the continued annual focus on finances and performance was a misnomer within the context of developing a more strategic approach. It was felt that the current LDP did not make clear what was being achieved in the current year and would benefit from the inclusion of a matrix about what the plan hoped to achieve and what the measure of success would be. As currently framed it was suggested that the LDP represented a general description of activity. The Board were advised that the format of the report was designed to meet Scottish Government requirements. The LDP linked to the corporate objectives in terms of measureability around performance. The suggestion was made that at the end of each section of the LDP it should be made clear what the specific targets were.

3.16 An update was provided on the Boards ability to deliver the 73 recommendations contained in the maternity neonatal plan with a key challenge for the Board being around the availability of midwifes.

3.17 The Chairman agreed that currently the LDP was suffering from extensive narrative with there being a need to quantify actions and outcomes. The Board noted that the LDP in final format would be submitted to the Scottish Government in September and could therefore be amended to reflect debate and be brought back to the next Board meeting. It was agreed that key performance indicators would be developed

to reflect the complexities of interdependency and to inform the project plans. Any updated information available since the production of the existing plan would be incorporated in future iterations.

3.18 The Board discussed in detail the paragraphs in the covering paper relating to key risks and the risk register. It was noted that at the moment no risk schedule was being presented to the Board as it was under development. The risk schedule would come forward to the next Board meeting at part of the general update on the LDP.

3.19 The Board discussed the complex global perspective of workforce development and questioned the understanding of the composition of skills within the NHS and the availability of appropriately skilled staff moving forward into the future. In response it was suggested that there was a need to look at examples of where workforce planning was done well and use this in other areas. It was suggested that some of the work would be informed by research and development and the creation of multi professional teams. Specific work was being undertaken looking at modernising the outpatient model. The Board noted that in workforce terms the default position was often to move to a nurse led solution without recognising that nursing staff were not always available. In that respect workforce planning needed to reflect services. The Board noted that a Workforce Development Board had been established. Individual IJBs would also need to produce workforce plans.

3.20 The Chief Executive commented in respect of the global workforce that a view of a lot of younger generation medical staff was that they were generally looking for a work-life balance as an aspiration in their career planning. In addition some medical staff took significant career breaks with there also being a reduction in the level of fulltime working with this being reflected across a number of specialties including general practice. The Board were advised that there was a need to recruit an increasing number of Scottish domiciled staff who wanted to work and stay in Scotland and that this position was referenced in the National Workforce Plan. The point was made that with the further development of artificial intelligence that medical staffing would be a significant area of impact. A significant workforce challenge was to create care capacity in social care to support people to live in their own homes. The Chief Executive commented that whilst a lot was happening that there was not yet a global view of the workforce and this was one of the challenges that the National Workforce Plan would be trying to respond to.

3.21 The Board agreed the recommendations contained in the circulated paper and agreed that an updated LDP would be brought forward to the next meeting.

4. Corporate Objectives 2017/18

4.1 The Board noted that the content of the previously discussed 2 papers had informed the production of the corporate objectives for 2017/18. It was noted that in the previous year no corporate objectives had been produced with the intention being to utilise the LDP although this approach had not been as successful as intended. In the current year there had been an attempt to distil the LDP into the corporate objectives and thereafter personal objectives for Executive Directors. It was noted that in a departure from previous years that complaints and patient feedback now featured as a specific objective for each individual Executive Director given the

impact on the whole system agenda. It was felt that the six objectives detailed in the circulated paper covered the issues discussed earlier in the meeting.

4.2 The Chief Executive commented that at one level there was a level of greater granularity around the LDP although it had been felt to be important to distil this into a smaller number of objectives. He pointed out that the Boards vision statement in itself covered at least 3 of the corporate objectives and he felt this was a correct balance. The remaining 3 corporate objectives covered other significant issues including engagement with staff and the development of a new culture. The Chief Executive commented that if agreement could be achieved around the corporate objectives then he would see these being used as a key communication tool for use in internal and external presentations. It was agreed there was a need to articulate the risk of the regionalisation agenda.

4.3 The Board discussed the prioritisation of e-Health with it being noted that this was a key constraint within primary care. The Medical Director undertook to progress this offline. The Board felt that there was also a need to include within the objectives a requirement for individual performance objectives with staff and this issue would be picked up with the Interim Director of Human Resources and Organisational Development.

4.4 The point was made that there was a need to be cognisant of the presentation of the corporate objectives and their intended audience. In that respect it was agreed to reorder the objectives putting objective 3 and 5 at the forefront.

4.5 The Board agreed that reference to IJBs should be made more specific within the objectives. It was noted that IJB Chief Officers through the Corporate Management Team had inputted in to the production of the corporate objectives and understood the interfaces with the IJB position.

4.6 The point was made that there remained a misconception that shifting the balance of care would make savings and the previous reference to the Nuffield report was referenced. The point was made that there was a need to invest in the community to create capacity to reduce hospital activity. In respect of investing in the community it would be important to make an effort not to reinforce a wrong assumption around future cost releases.

4.7 The Board noted the need to reflect on shifting the balance of care to let hospitals operate at 85% occupancy. Reference was made back to previous debate about the need to reduce beds to release financial savings and the fact that this position was reflected in the corporate objectives. The point was made that within the objectives there should be an attempt to be less specific around percentages and to reflect the objective by providing examples of desired outcomes.

4.8 A further amendment to the corporate objectives was agreed in respect of the need to have more focus around participation and engagement with people in order to encourage them to take responsibility for their own health. This would need work with the wider population. The corporate objectives would be amended accordingly.

4.9 The Board agreed the recommendations contained within the circulated paper subject to the corporate objectives reflecting the amendments suggested at the meeting.

5. Quality and Performance Improvement

5.1 The Board were advised that informed decisions needed information and analytical support. Information needed to be relevant to key partners and that in future iterations of the paper attempts would be made to link information in graphical format.

5.2 The Board received a detailed report on performance and mitigating action in respect of the cardiac arrest rate; children and adolescent mental health services; outpatient waiting times; surveillance endoscopy and the complaints 20 day response which was subject to a separate Board paper.

5.3 The Board noted the Chief Quality Officer's aspirations around the future use of information and his desire to internally enhance quality improvement programmes around data capture, analysis and presentation into services. This would ensure that information presented to the Board was relevant and reflected key initiatives like primary care and realistic medicine. There was a need to move to a position of having local ownership of data.

5.4 In terms of recommendation 2.1.2 it was suggested that this could be amended to more accurately reflect the reality of the position around the Board Committee assurance process and in particular the fact that on at least one occasion the Healthcare Governance Committee had reached a 'no assurance' provided position in respect of the complaints handling process.

5.5 The Board noted that the science of applied probabilities against indicator required two separate issues the first of which was sustainability and the other was a reflection of the magnitude of improvement both of which could be graphically presented. The Chief Quality Officer advised that he was cautious about extending the period of performance reporting as it often took a long time to recognise improvement and that this approach might slow down the tempo of change.

5.6 The point was made that future iterations of the paper should include introductory comment to set the context as there would be clear reasons why some targets had not been met. The outcomes of the national work undertaken by Sir Harry Burns would where appropriate feature in future reports.

5.7 The Chief Executive in response to a question commented that previously the Board had increased the parameters of what was regarded as a waiting times acceptable offer to 97 miles and in that regard this meant that the Golden Jubilee Hospital in Clydebank was routinely used for appointments. In general people were happy to travel to the Golden Jubilee Hospital which had a low DNA (did not attend) rate. The legislation and national guidance around waiting times was clear around the need to source and look at capacity elsewhere including in extremis in Europe although this option had not been used in Lothian although patients had been treated in other

Boards and in England. The point was made that in some specialties like cancer patients were best managed by a single team.

5.8 The Board agreed that the content and structure of the performance report had improved. The confidence in governance terms remained around the consistency in the way that information was presented which did not allow the Board to get to the nub of the problem. The information was still not felt to be robust enough in terms of providing assurance that issues were being managed on an ongoing basis. The point was made that up to date information was needed when funding decisions were being taken. A question was raised about whether the available data was sophisticated enough to allow horizon scanning. It was noted that the development of such data was part of the ongoing work around demand and capacity. The Chief Quality Officer confirmed that such data could be produced.

5.9 The Board agreed the recommendations contained in the circulated paper subject to the caveats made around recommendation 2.2.

6. Complaints and Feedback

6.1 The Board noted that following previous concerns raised by the Healthcare Governance Committee that a project plan had now been produced that aligned to the Short Life Working Group Chaired by Mrs Hirst reporting into the Healthcare Governance and Risk Management Committee. It was noted that additional capacity had been brought in to support the in-house team where the largest piece of ongoing work was around what the model would look like to support the implementation of the new legislation.

6.2 The Board noted that significant performance improvement had been made around the 3 day acknowledgement requirement and also the Royal Infirmary of Edinburgh overall process. It was noted that the new process around the complaints procedure had been live since 1 April 2017 and that NHS Lothian was in the process of implementing the requirement and had been required to submit a progress checklist to the Scottish Government. The Board received a tabled paper which updated on the current position.

6.3 The Board received an update report on continuing work with the Scottish Public Services Ombudsman and were advised that a recent workshop on maternity and woman and children services had been productive. The Board noted the progress being made around prison services where work around improving the early intervention requirement had been put in place.

6.4 The Board noted that discussions had been held around organisational development and links with the value statement in respect of the need for ownership of the complaints process to be embedded in culture and behaviours as part of routine daily business.

6.5 The Board noted that a full report on the implementation of the new legislation would be brought back as currently a hybrid model was in operation. The Board noted that having a Non Executive Board member chairing the working group was useful in

terms of objectivity and suggesting the best way to communicate with staff and other partners.

6.6 The Board noted that the following key workstreams required to be progressed. The first was the need to implement the new procedures as detailed in the legislation. Thereafter there was a need to engage staff and patients around the public facing document. The checklist back to the Scottish Government required to be completed to recognise compliance with the new legislation although primary care still remained an area of challenge. GPs and dentists and others were required to provide information which was not supported by internal infrastructure. Finally there was a need to consider and agree the proper infrastructure to support the complaints team.

6.7 Mrs Hirst commented as Chair of the working group that she was interested to hear the views of the Board about the format of the report which had moved to a more high level overview with the Healthcare Governance Committee receiving a more detailed report. She commented that the two key issues facing the service at the moment were to satisfy the SPSO that the complaints procedure within NHS Lothian was fit for purpose to include evidence of a learning culture. There was also a requirement to satisfy him around the investigative process being applied to complaints. As part of the new legislative process there would be a need to work with Council colleagues and IJBs and work had commenced in this area.

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

7. Drug and Alcohol Funding 2017/2018

7.1 The Board noted that drug and alcohol funding had represented the first large challenge of integration. The Scottish Government had reduced the funding available by 23% although its guidance had stated that Health Boards and others were required to maintain 2015/16 funding levels. In order to progress this requirement a substance misuse collaborative process had been adopted to look at the current spend profile for services. This had led to robust discussions which had usefully concluded the areas where further provision was needed. It was noted that NHS Lothian had a responsibility for the prison population within its area in totality in order to avoid postcode inequalities.

7.2 The Board noted that the process had considered inpatient facilities at the Ritson Clinic where beds had reduced from 12 to 6 through the provision of safe community detoxification facilities for patients. An update report was provided around the funding position in respect of the alcohol brain damage unit and the requirement for community alternatives to be identified if IJBs did not want to contribute to the overall funding of the service. The Edinburgh IJB had agreed to consider 75% funding.

7.3 The Board noted that this was a complex landscape and further work was required. The position paper had been brought to the Board for discussion around the process for funding and risk tolerance.

7.4 The point was made that the reduction in funding had forced a focus on ensuring that drug and alcohol services were provided efficiently. A concern was raised that each year the LDP looked at pressures and despite the Scottish Government expectations

around this service alcohol and drug funding had never featured as an issue in the LDP. Reference was made to previous Board debate around the prevention agenda. The point was made that the Board had not received this level of detail because of the governance process which meant that these issues should be discussed at IJB level. The Board were reminded that in the previous year funding had been sustained by NHS Lothian and that in the current year partnerships would need to discuss through IJBs their position which if justified could result in a reflection in the current LDP.

7.5 The Board noted that assessment work needed to be completed looking at needs in respect of harm reduction which would allow a focus on what the forward position should be for IJBs.

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

8. Date and Time of Next Meeting

8.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 21 June 2017 in the Scottish Health Services Centre, Crewe Road, Edinburgh.

9. Invoking of Standing Order 4.8

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

LOTHIAN NHS BOARD MEETING

RUNNING ACTION NOTE

1.2

Action Required	Lead	Due Date	Action Taken / Outcome	Outcome
Delayed Discharges				
• Provide more detail on the lack of availability of care packages, particularly identifying if the problem was a recruitment or a budget issue	**AMcM**	Ongoing	*For IJB Chief Officers to address*	
Quality and Performance Improvement				
• 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**	*June 2017*		
Person Centred Culture				
• The Nurse Director would arrange for the Internal Audit department to bring focus to complaints as part of the improvement process, this to be included in the work programme for the Internal Audit department in the forthcoming year.	**AMcM**	2018/19 Plans	*Action Plan being progressed*	
2017/18 Draft Local Delivery Plan				
• The Board agreed the recommendations contained in the circulated paper and agreed that an updated LDP would be brought forward to the next meeting.	**AMcM**	21 June 2017	2017-18 Local Delivery Plan (LDP) Feedback and Arrangements for NHS Lothian 2017 Annual Review	

NHS LOTHIAN

1.3

Board Meeting
21 June 2017

Medical Director

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.

• There has been a review of Delayed Discharges and GP Sustainability, in the light of integration and proposed changes to these risks.	3.2.1 / 3.2.2
• There has been a review of the current Achievement of National Waiting Times risk and proposed changes including an increase in grading from High 16 to Very High 20 are set out in the paper.	3.2.3
• A new patient focussed risk relating to access is proposed for inclusion on the risk register.	3.2.4
• 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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19 May 2017
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NHS LOTHIAN

Board
21 June 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 the new Access to Treatment patient risk on the Corporate Risk Register.

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

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

3 Discussion of Key Issues

3.1 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 4 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. Table 1 has a new additional column to set out the assurance the governance committees of the Board have received with respect to timely plans being in place to mitigate the risk to the Board.

3.2.1 The February 2017 Audit & Risk Committee recommended a number of actions to enhance the Risk Register processes which 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 confirmed the above. An assurance column has been added to the risk register report (see Table 1) to illustrate the governance committees' consideration of risks on the corporate risk register. The assurance column would suggest that this process is being implemented.

- The Committee asked that risks such as Delayed Discharges and GP Sustainability be reviewed in light of Integration Joint Boards (see below).

A review of Delayed Discharges identified that IJBs considered Delayed Discharges and associated risks through a variety of mechanisms and actions are taken to mitigate the risk. These include performance management arrangements, specific programme Boards such as Edinburgh Flow Board and/or Strategic Plan Programme Board (East Lothian), Audit & Risk Committee and at IJB meetings as illustrated by IJB minutes.

In addition for 2017/18, 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.

NHS Lothian and the H&SCPs all have delayed discharges as risks associated to service delivery. A review of the H&SCP risk register highlighted a range of risks related to delayed discharges and controls are in place to mitigate the risk. These include:-

- Home Care Provision
- Nursing Home Capacity
- Workforce Sustainability, and/or
- A delayed discharge risk.

The current delayed discharge performance is used to assess the adequacy of controls in place to mitigate this risk. These risks are articulated in a similar manner, however, the controls reflect the level and context of the risk. For example, the controls for the management of a risk at IJB level focus on delivery of the Strategic Plan whereas at an H&SCP level the focus is on delivery of the service.

In response to the review, the NHS Lothian Delayed Discharge risk (3726) has been updated. This includes:-

- A change in title from Unscheduled Care: Delayed Discharge, to Timely Discharge of Inpatients, as this title is more illustrative of the risk
- The IJB controls in place to manage the risk including mechanisms enhanced partnership arrangements to manage this risk are stated on the NHS Lothian risk register.

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 Officers were asked to bring back plans 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 there were plans in place to mitigate the risk to the Board and asked the Chief Officers to come back in July 2017 with plans to HCG.

3.2.2 As with Delayed Discharges, GP Sustainability is clearly set out as a risk to delivery of IJBs strategic plans and service delivery on H&SCP risk registers.

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. The committee considered each Partnership's funded plans to address GP Sustainability which were positively received and developmental in nature. The committee concluded that currently there is limited assurance that plans in place would lead to improvement and as a result the Joint Officers will come back to present a progress report in July 2017.

3.2.3 The Risk Management Steering Group reviewed the Achievement of National Waiting Times risk and has updated the existing risk. This includes:-

- A change of name from Achievement of National Waiting Times to Access to Treatment (organisational risk), as it is more illustrative of the risk
- Strengthening of controls within the context of current performance
- The increase of this risk from High 16 to Very High 20 is given the current performance.

3.2.4 The RMSG is recommending that an additional risk is added to the Corporate Risk Register which is a patient-focussed risk with respect to access to treatment rather than the organisational risk set out above. This risk is described as:-

Description
There is a risk that patients will wait longer than described in the relevant national standard due to demand exceeding capacity for in-patient/day case and outpatient services within specific specialties.

Clinical risk is identified in two dimensions:
1) the probability that due to length of wait the patient's condition deteriorates;
2) the probability that due to the length of wait significant diagnosis is delayed.

Controls in place

- Service developed trajectories that are used to monitor performance, early indications of pressures, and opportunities to improve efficiencies/productivity.
- A re-invigorated Delivering for Patients (DfP) programme provides a framework for learning and sharing good practice through a programme of quarterly reviews.
- New referrals are clinically triaged, a process which categorises patients as Urgent Suspicion of Cancer (USOC), Urgent or Routine. Within each of these categories, patients are triaged into the most appropriate sub-specialty queue, each of which is associated with a different level of clinical risk.
- A revised communications strategy has been established to ensure that both patients and referrers are appropriately informed of the length of waits.
- If the patient's condition changes, referrals can be escalated by the GP by re-referring under a higher category of urgency. There is an expectation that the GP would communicate this to the patient at the time of re-referral.
- Specific controls are in place for patients referred with a suspicion of cancer. Trackers are employed to follow patients through their cancer pathways, with reporting tools and processes in place which trigger action to investigate / escalate if patients are highlighted as potentially breaching their 31-day and / or 62-day targets. Trackers undergo ongoing training, and have access to clear escalation guidance on how to deal with (potential) breachers.

Rational for adequacy of controls

Some controls are in place and additional controls currently being designed and as such, overall control is inadequate. Controls and actions are being reviewed quarterly at Acute Clinical Management Group to ensure any areas of concern are highlighted and actioned. The risk is very high while demand continues to exceed available capacity and as such graded as Very High 20.

Updates & Actions

<u>Ongoing Actions</u>

- DfP quarterly reviews are supported by more regular meetings with service management teams and clinicians to develop and implement improvement ideas, and to facilitate links to the Outpatients and Theatre improvement programmes. Running action notes are kept at each service meeting, and regularly reviewed by service management teams and the DfP core group.
- Significant redesign and improvement work is being undertaken through the Outpatient Programme Board and through the Theatre Improvement Programme Board, to help mitigate some of the increasing waiting time pressures and clinical risks.
- Revised communications strategy includes an "added to outpatient waiting list" letter, which informs patients that their referral has been received, and that some service waits are above the 12-week standard. Current waiting times are also published on *RefHelp*, making them available to GPs at the time of referral. It has been agreed (March 2017) that a link to *RefHelp* waiting time information will be included in letters to patients, allowing them to check service waiting times regularly.

- Information on the projected length of wait throughout a patient's pathway is communicated clearly to patients at clinical appointments throughout their cancer journey.

Additional Actions

- There are some ongoing issues with resilience with regard to cross-cover among trackers during periods of absence and / or annual leave and these are being addressed robustly with, in the first instance, an in-depth review of current cancer tracking arrangements. Executive Medical Director and Interim Chief Officer have developed risk matrix for specialties under waiting time pressures, and will work with NHS Grampian to develop a clinician led framework for risk analysis to help prioritise resources.

3.2.5 There are currently 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 6 risks at Very High 20 are set out below.

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

* Outwith risk appetite as illustrated in Table 2.

3.2.6 The Board and Governance committees of the Board need to assure themselves that adequate improvement plans are in place to attend to the corporate risks pertinent to the committee. These plans are set out in the Quality & Performance paper presented to the Board and papers that are considered at the relevant governance committees.

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 – is overseen by the Acute Hospitals Committee. In February 2017 the committee received moderate assurance and asked for more detail in the next paper on the impact of measures taken to manage this risk. The present data has not shown sustained improvement and as such the risk remains Very High.

3.2.9 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.

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

Table 1

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Apr-Jun 2016	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. **(Finance & Resources Committee)**	March 2017 No assurance with respect to financial balance 2017/18.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
3203	Unscheduled Care: 4 hour Performance **(Acute Services Committee)** (Set out in Quality & Performance Improvement Report)	February 2017 Moderate Assurance; Members approved the recommendations laid out in the paper and accepted moderate assurance, but asked for more detail in the next paper on the greater impact of the measures taken to manage unscheduled care.	High 10	Very High 20	Very High 20	Very High 20	Very High 20
3726	Timely Discharge of Inpatients **(New areas for HCG Committee)** (Set out in Quality & Performance Improvement Report)	January 2017 Limited assurance. No clear improvement plans in place to mitigate the risk. A plan to be presented at the next HCG meeting in July to inform assurance.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	GP Workforce Sustainability (new risk – October 2015) **(HCG Committee)**	March 2017. Limited assurance. No clear improvement plans in place at March 2017. Plans presented in May 2017. Due to limited assurance, Chief Officers asked to come back with an update to July HCG.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3454	Management of Complaints and Feedback **(HCG Committee)** (Set out in Quality & Performance Improvement Report)	March 2017. Moderate assurance with respect to a plan being in place, but need assurance that the plan will lead to an improvement and asked for an update every 2nd meeting. Next considered July 2017.	High 12	High 16	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Apr-Jun 2016	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017
1076	Healthcare Associated Infection **(HCG Committee)** (Set out in Quality & Performance Improvement Report)	March 2017. Overall moderate assurance due to SAB infections, but significant with respect to CDI HEAT target achievement. Considered in May 2017 – moderate assurance.	High 12	High 16	High 16	High 16	High 16
3211	Access to Treatment - Organisation **(Acute Services Committee)** (Set out in Quality & Performance Improvement Report)	February 2017 Limited Assurance. The Committee was impressed with the work in progress but also disappointed that performance remained of concern with the volume of patients waiting over 12 weeks. Recognition that systems of control were in place was accepted.	High 12	High 16	High 16	High 16	⇧Very High 20
3480	Delivery of SPSP Work Programme **(HCG Committee & Acute Services Committee)** (Set out in Quality & Performance Improvement Report)	January 2017 Significant assurance received with the exception of the management of deteriorating patients. Committee in March approved a plan for a review of this issue with a paper coming back in July 2017 with recommendations for areas of improvement based on the review. Agreed scope of review of deteriorating patients in March – to be presented in July 2017.	High 16	High 16	High 16	High 16	High 16
3527	Medical Workforce Sustainability **(Workforce assessment reported to Board) (Staff Governance Committee)**	March 2017 Moderate Assurance that all reasonable steps are being taken to address the risks	High 16	High 16	High 16	High 16	High 16
3189	Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015) **(Finance & Resources Committee)**	To be assessed June 2017	High 15	High 16	High 16	High 16	High 16
3455	Management of Violence & Aggression. (Reported at H&S Committee, **via Staff Governance Committee**)	March 2017 Limited Assurance. Pending the review of the management of violence and aggression commissioned by Medical Director. Findings of review to be considered by Staff Governance in July 2017 and inform the management of this risk.	Medium 9	High 15	High 15	High 15	High 15
3828	Nursing Workforce – Safe Staffing Levels **(Staff Governance**	March 2017 Moderate assurance that systems are in place to	High 12	High 12	Medium 9	Medium 9	Medium 9

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Apr-Jun 2016	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017
	Committee)	manage this risk as and this risk will be regularly reviewed particularly with respect to District nursing.					
3328	Roadways/ Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee, **via Staff Governance Committee**)	March 2017 Moderate Assurance that issues are regularly reviewed, managed and improvements developed as supported by recent audits.	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**			
• Scotland target to reduce acute hospital mortality ratios by 10% with a tolerance of 15-20% by Dec 2018 [1] All sites within HS limits & <=1	Green	0.87	Quality & Performance Improvement Report (HCG Committee)
• Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015	Green	99.9%	Patient Safety Programme Annual Report (Jan 2017) (HCG Committee)
• Achieve 184 or fewer SAB by March 2018 with a tolerance of 95% against target. n=193 to 184	Green	23	Quality & Performance Improvement Report (HCG Committee)
• Achieve 262 or fewer C.Diff by March 2018 with a tolerance of 95% against target. n=275 to 262	Green	17	Quality & Performance Improvement Report (HCG Committee)
• Reduce falls with harm by 20% with a tolerance of 15-20% by March 2017	Green	53%	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
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.1 Deliver Person-centred Care) **Low Risk Appetite**			
• Patients would rate out of 10 their care experience as 9, with a tolerance of 8.5	Green	8.80	Quality & Performance Improvement Report (HCG Committee)
• 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%	Red	74%	iMatters first report. Frequency of reporting to be confirmed. Staff Governance Committee)
• Staff absence below 4% with a 5% tolerance (4.2%)	Red	5.10%	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**			
• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Red	78.8%	Quality & Performance Improvement Report (Acute Hospitals Committee)
• 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%	Red	84.7%	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**			
• 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%	Amber	95.2%	Quality & Performance Improvement Report (Acute Hospitals Committee)
• 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	204	Quality & Performance Improvement Report (HCG Committee)
• No of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle, with an appetite of 80% and a tolerance of 75%.	Amber	79.1%	Quality & Performance Improvement Report for management actions (Acute Hospitals Committee)
Corporate Objective 1 – Protect & Improve the Health of the Population. **Medium Risk Appetite**			
• Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas, with a 10% tolerance (36-40%). (Target = 293 minimum per quarter).	Red	203	Quality & Performance Improvement Report (HCG Committee)
• At least 80% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation, with a 10% tolerance (69.3-77%) •	Green	Lowest SIMD is SIMD 4 – 88.8%	Quality & Performance Improvement Report (HCG Committee)

	Current Status	Current Position	Data Report
Corporate Objective 3 – Secure Value & Financial Sustainability (LDP 2015-16 – 3.1 Financial Planning) **Medium Risk Appetite**			
• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Red	£1,756k underspend at period 12 equating to 1.0%	Period 12 Finance Report (Finance & Resources Committee)
• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%	Green	£332k underspend for the year-to-date, equating to 0.0%	Period 12 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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19 May 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/actions	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.	NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target. On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years. If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.	The Board has already established a financial governance framework and systems of financial control. 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. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.	Risk reviewed for period Jan-Mar 2017: The medium term financial plan will have a renewed focus on the national opportunities identified via the national Value and Sustainability work streams. The positive impact on finance from the Quality Initiatives work on reducing unwarranted variation and waste will also be reflected in the plan. In the short term it is not anticipated that this work will impact on the risk grading/rating which remains at Very High/20.	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Craig Marriott	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	There is a risk that patients are not seen in a timely manner that require emergency care as required by the Emergency Care standard of 95% resulting in sub optimal care experience and outcome.	A range of governance controls are in place for Unscheduled Care notably: - Bi monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. -The bi-monthly Acute Hospitals Committee as well as formal SMT meetings. Both are chaired by Chief Officer; NHSL University Hospitals & Support Services.. - The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis. - Monthly SMG and SMT meetings in place for acute services in Lothian - Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, SJ H NHS Lothian's Winter Planning Project Board is now established as NHS Lothian Unscheduled Care Committee in collaboration with the Integrated Joint Boards to promote sustainability of good performance all year round A number of performance metrics are considered and reviewed, including: - 4 hour Emergency Care Standard and performance against trajectory - 8 and 12 hour breaches - Attendance and admissions - Delayed Discharge (see Corporate Risk ID 3726) - Boarding of Patients - Winter Planning - Length of Stay (LOS) - Cancellation of Elective Procedures - Finance Adherence to national guidance/ recommendations Plethora of work now focussed around the Scottish Government's *6 Essential Actions* initiative to support achievement of 95% target (stretch target of 98%) for 4 hour performance.	**Risk Reviewed for period Jan-Mar 2017** Updates highlighted below Risk Grade/Rating remains Very High/20 Work continues in line with the Scottish Governments 6 Essential Actions initiative. Boards now involved in taking forward set of actions (per site) to support a step change in performance. Priority interventions will focus on: • Clinical Leadership • Escalation procedures • Site safety and flow huddles • Workforce capacity • Basic Building blocks models • Proactive discharge • Flow through ED/ Acute Receiving • Smooth admission/ discharge profiling • Effective capacity and Demand models being developed re in /out , BBB methodology • Patients not beds principle • Daily Dynamic Discharge/check, chase, challenge methodology rolled out across the acute sites • Plan to roll out across the whole system and partnerships campus's The above has been absorbed as part of approach to winter planning, led by NHSL UCC Committee. The approved Winter Plan outlined the approach to supporting performance over the winter period and beyond. This reflected a number of actions namely: • Winter Readiness plans established for each site • Plans focused on discharge capacity as well as bed capacity • Clear measures in terms of escalation procedures • Measures to counter any demand unmatched to support winter and patient flow • A focus on DD and POC to ensuring sustainable performance throughout the winter period liaising closely with IJB partner organisations. • Weekly teleconference with IJBs • Each partnership has trajectories in place to support reduction in DD • Agreed data set to assist with developing a wider capacity plan across all health & social care areas Winter Planning Board has been changed to NHSL UCC Committee and will meet monthly throughout the calendar year. Winter Preparedness will be on the Agenda seasonally, however notable improvements through planning will be embedded as systems to promote sustainable access performance and mitigate risk. This year's process was developed following a 2015/16 winter planning de-brief which is the platform for the next iteration of winter planning during 2016-17 and debrief from winter is planned for May 2017. NHS Lothian achieved 94% performance against the standard for the quarter January-March 2017. The Winter Planning Board was established 2016/17 as NHS Lothian Unscheduled Care Committee to enhance performance as a collaborative response all year round.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jacquie Campbell	To be confirmed	Acute Services Committee

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3726	2: Improve the quality and safety of health care	Timely Discharge of Inpatients	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	A range of governance controls are in place for Unscheduled Care notably: NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a fortnightly basis The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings. Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON NHS Lothian's Winter Planning Project Board is now established as the NHSL Unscheduled Care Committee in collaboration with the Integrated Joint Boards 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.	Risk Reviewed for period Jan – Mar 2017 <u>No changes/updates since last review.</u> Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include: • Criteria led discharge pilots • Downstream hospitals to have admission and discharge quotas similar to main acute sites. • A capacity and demand exercise is being implemented re hours of care at home required across the City of Edinburgh and other councils • Locality based Services (hubs) being developed to support pulling patients out of hospital and promoting prevention of admission and reducing delayed discharges • Evidence Based Daily Dynamic Discharge is rolled out across the whole system in collaboration with Scottish Government Improvement Team • Extending Hospital to Home and HAH capacity • Additional capacity to support weekend discharge (diagnostic, pharmacy, AHPs, transport etc) • Twice daily Teleconference to plan and match transfer of care to right place for patients • Weekly teleconference with the IJB, 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 The Winter Planning Board/ NHS Lothian Unscheduled Care Committee are overseeing the necessary actions in support of sustained performance during the winter period and beyond. Lothian's approved Winter Plan sets out the key requirements in supporting service delivery and access performance during winter and beyond. Actions include: • Development of robust site winter readiness plans • Focus on Capacity and Demand in relation to beds and hours or care requirements • Clear measures in terms of escalation procedures • Counter any demand as a result of the extended 4 day break during the festive period. • Focus on DD and POC liaising with IJB Partner organisations to support patient flow and sustainable performance throughout the winter period. • Agreed Trajectories in place for each partnership and being monitored to support capacity to meet demand • Agreed data set to assist with developing a wider capacity plan that covers all health and social care areas • Further planning capabilities have been enhanced following the 2015/16 winter de-brief process • Health and social Care Partnerships are embracing the Integration agenda and working collaboratively to mitigate risk to patients due to poor performance and have put joint plans in place to support	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jacquie Campbell	To be confirmed	Acute Services Committee in partnership with IJBs

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

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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.	• 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.	Risk Reviewed for period Jan-March 2017 (updates highlighted) • A new complaints procedure is in place from 1 April 2017 and submission Scot Gov. • This forms part of a wider improvement project that has 4 sub-projects and will be overseen by a Project Board, chaired by the Executive Nurse Director and a programme of improvement work to supported by the LIU / SPSO in Maternity and RHSC. • Feedback & Improvement Quality Assurance Working Group meet monthly chaired by Non Executive and has overseen the implementation of SPSO action plan. Letter sent to SPSO to update on progress. • A revised approach to reporting to the Healthcare Governance Committee has been developed that separates complaints performance and patient experience reports and was given a moderate assurance by the committee. Complaints and patient experience are part of the monthly Q&P reporting arrangements. Improved performance in 11 of the last 12 months. • Devolved complaints process now in place: WGH, DATCC, Women's services, RIE, REAS, East Lothian HSCP, Midlothian HSCP & Edinburgh HSCP. • Ongoing conversations with independent contractors re new model. • Meetings with the clinical teams have taken place to discuss local arrangements and performance • Weekly performance reports shared with clinical teams • Agreement to have the PE Team contact details on all correspondence • Work ongoing to support the complaints and feedback systems within the 2 prisons encouraging early resolution and the devolved complaints function. • Meeting with RIE team and Patient Opinion scheduled. • Complaints improvement work commissioned directly by the RIE & WGH sites. • Contributing to the Daring to be Great May programme. Risk Grade/Rating remains Very High/20	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Alex McMahon	Jeannette Morrison	Healthcare Governance Committee

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

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1076	2: Improve the quality and safety of health care	Healthcare Associated Infection	Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital, increased mortality and morbidity and further treatment requirements. Support to the clinical teams and service deliverables is currently being impacted due to staffing within the service.	The NHSL 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 NHSL care of patients with, or at risk of, infection whilst ensuring cost-effectiveness of service by 'delivering more for less'. The integration of services supports the Scottish Governments' 'Vision 2020' that aims to improve the nation's health whilst providing integrated health and social care. The integrated service project board consists of key professional team representatives and these are: Head of Infection Prevention and Control Service, Lead Infection Prevention and Control Nurse, Infection Control Doctor, Senior Consultant Microbiologist and Virologist, Chair Antimicrobial Management Team, Senior Consultant Infectious Diseases. The NHS Lothian Infection Committee reports to the Board through Healthcare Governance Committee. Lothian Infection Control Advisory Committee receives the reports from the committee along with reports from the public health and environmental aspects. The review of It LICAC's role has been postponed to allow the work to be undertaken in the IJB s and HSCP. In addition to LICAC and local committees, Infection Prevention and Control routinely report at a senior management level to CMG and bi-monthly board papers. • A review of CHP Committee has commenced with Edinburgh HSCP and Integrated Joint Board. The aim is to share the work developed there with the other Lothian IJBs and HSCB to develop structured governance and reporting mechanisms for IPC aspects across the Lothian services. • The current 4 geographical regions (Edinburgh North, Edinburgh South, Mid & East and West Lothian) within the Infection Prevention & Control team have responsibility for both acute and community settings within their remits. Work has commenced to review the structure with the move of RHSC which is the major component of South Region to RIE site. • A review of the current workload across the regions is ongoing as the service cannot sustain existing work streams and integrate the new work programmes into business as usual within the current workforce establishment. • The HAI Strategy summarises the roles and responsibilities for the various levels across the organisation. This document was approved by the Board and disseminated to the Site Directors and Associate Nurse Directors to inform their Infection Control Committee's work plans. This strategy will be reviewed and updated in 2017/18 Education: • The HAI Education Strategy (Aug 2015) defines the training and education requirements for staff of all disciplines across the organisation. It will next be due for review in August 2017.	Risk Reviewed for period Jan-Mar 2017: The progress against the plans to expand of the IPCT Geographical Structure to include medical representatives has made limited progress due to lack of appropriately qualified medical personnel. Support is currently still sourced through the current ICD any local projects and developments are on hold until the teams are more reliably established. The single point of contact whilst it is to be tested at WGH the default will be to forward any calls for medical teams to the relevant services duty rooms NHS Lothian Infection. Concerns have been escalated to the HAI Executive Lead regards the Local Committees implementation and reliability as a means to deliver the intended clinical ownership The Lothian Acute services and LICAC will be kept appraised of the situation but this also requires to be managed through the Acute Services management team. This is a combination of, the ratio of trainees to trained IPCNs, sickness and absence including 2 staff on Maternity leave. Due to the level of trainees within the service and a reduction in available IPCN numbers there is an increased frequency in weekend working for the remaining staff. This has an impact on their availability for other duties throughout the week.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 4	Tracey Gillies	Fiona Cameron	Healthcare Governance Committee

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					There are new streams of Mandatory work from SGHD and HPS. These are additional SSI surveillance for Colorectal and Vascular Surgery, increased surveillance time frames and data requirements within existing programmes for CSection and Hip Arthroplasty. In addition there has been introduction of ECB surveillance and this is now to be extended to all Gram Negative Bacteraemia. None of these additional workstreams are resourced. There is a risk that there will be significant gaps in information and data collated as there are challenges within clinical resources who are essential in contributing to the surveillance protocol. The increased ownership and clinical engagement that was anticipated with the introduction of Local ICC has not been delivered. Local Management teams have chosen to integrate the ICC into other managerial meetings. This has resulted in limited opportunity for management to review performance on HAI related matters or develop any meaningful dialogue for improvement and/or prevention.						

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					The implementation of the NHS Lothian Infection Services structure remains a work in progress. Currently medical resources have not permitted allocation of an appropriately experienced or qualified ICD per region. There are suggestions this role can be allocated to Registers rather than Consultants. This could potentially post a clinical risk and could impact on the pressures on the nursing team and the current ICD post holder. In addition it is proposed the single point of contact be implemented but at present there is no clear resource of how this will be manned by the other speciality fields of the service such as AMT, In addition it is proposed the single point of contact be implemented but at present there is no clear resource of how this will be manned by the other speciality fields of the service such as AMT, Microbiology and Virology. The plan is to establish the single point of contact and test at WGH. However this has its limitations and could cause confusion with clinical team.						

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					The risk has been reviewed the description/controls have been updated and the Risk Grade/Rating remains the same. The impact of the additional work streams and staffing levels will have an impact on existing service delivery and will be assessed and reported in QI. The action for the upgrade of server to HL7 has been updated: An agreement with ICNET on the contract cost has been reached. However NHS Lothian IT have advised that the server preparation is unlikely to take place before late April early May. Risk Grade/Rating remains at High 16						

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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	• 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.	Risk Reviewed for Period Jan – Mar 2017 • 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 MCQIC 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, deteriorating patients, MCQIC and Paeds etc and as such there remains a patient safety risk to NHS Lothian. • HCG requested a review of Management of Deteriorating Patients (Safety Priority). The plan for the review is set out in the Quality Improvement and Performance report. The outcome of the review will go to the July HCG Committee. Risk grade/rating remains High/16 based on unmet actions for key safety priorities	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Tracey Gillies	Jo Bennett	Healthcare Governance Committee

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3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.	A Lothian Workforce Planning & Development Board has been established and will meet for the first time in May. This board will coordinate work within all professional groups including the medical workforce. 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 the Staff Governance Committee when required, providing an update on areas of risk and providing an update of the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. A Medical Workforce Group has being established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model.	Risk Reviewed for period Jan-Mar 2017 A recent review of trained doctor establishments show significant improvements in recruitment from 2 years ago with an overall establishment gap of 4.3%. There remain challenges in particular at the St John's site within General Medicine(7.6wte), there also remain gaps. There has however been recruitment to 2wte Ophthalmology posts with successful candidates taking up posts in June/July. Recruitment to 8wte posts to provide additional capacity at both RHSC and St John's sites in line with the recommendations of RCPCH review has been partially successful with 6wte successfully appointed, there remains however 2wte vacancies. Recruitment to GP posts within independent practices continues to be very challenging, recruitment to permanent salaried Board employed GP posts has had some limited success however recruitment to fixed term posts has thus far been unsuccessful. There remain GP posts under recruitment. Whilst the position remains challenging NHS Lothian has the lowest percentage utilisation of supplementary staffing of any board in Scotland and SE Region continues to have high fill rates as part of annual recruitment. A recent update paper was taken to the Staff Governance Committee providing a detailed up date and the current risk rating was supported. Risk Grade/Rating remains High/16	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 / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3189	3. Secure Value of Financial Sustainability	Facilities Fit for Purpose	Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk.	•The reported backlog maintenance as at 1st May 2015 and reported in the Property Asset Management Strategy (PAMS) 2015 is now £67.4m which includes a 13% uplift for inflation which has been applied nationally. The PAMS describes the action which will be taken to reduce the figure, which includes estate rationalisation, capital investment and Re-provision projects.. •The financial plan for 2015/16 has allowed for a further £3m BLM allocation for 2015/16, thereafter the allocation has been reduced to £2.5m. Programmes of works are being confirmed for the next three financial years. •The capital plan for 2015/16 has a number of capital projects which will improve the physical condition of the estate and reduce backlog maintenance. •The programme of works will continue to address high and significant risks. The programme continues into the financial year 2015/116. The allocation for this financial £3m has been committed. •A procurement and implementation strategy was approved in early November 2012, which described how this funding would safely expended. •An update of the PAMS each year will log the affect upon the backlog maintenance and compliance figure. - Regular updates are provided to the Capital Steering Group and Capital Investment Group •A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance. •A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years.	Risk Reviewed for period Jan-Mar 2017 The 2016/17 Programme of works has now been completed and a number of projects completed. The allocation for 2016/17 of £2.5m. The programme of works concentrated on high and significant risk areas including fire precaution works at all sites, mechanical and electrical plant replacement, legionella, HEI, building fabric. The Backlog Maintenance items is currently being reviewed in the Estates Asset Management System (EAMS) which will be used to establish a programme of works for 2017/18 and future years. A review of the current risks and re-categorisation of the risks dependent on use of property, life expectancy of the property is reviewed and updated as required. Scottish Government has now agreed that BLM should not be reported on vacant properties which have been declared surplus. As a result the BLM items highlighted in a number of vacant properties will now be archived. Further surveys have been undertaken at the Western General Hospital, St Michael's and Health Clinics. This information is currently being reviewed by Hard FM and will be uploaded on to EAMS. Further Surveys are currently being undertaken on Edinburgh Community Properties The disposal programme, capital investment projects will contribute in reducing the overall backlog maintenance liability for the Board. The disposal disposal of 15 Craiglea Place, 162 & 163 Craiglea Drive, 151 Morningside Drive and 63 Morningside Drive, were concluded at the end of March 2017 which reduced the BLM exposure. Risk Grade/Rating remains High 16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 4	Jim Crombie	George Curley	Finance & Resources Committee

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

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3828	2.2 Deliver Safe Care	Nurse Workforce – Safe Staffing Levels	There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and / or inability to recruit. 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. Particularly where there is a reliance on agency staff to make up the shortfall. Service sustainability risks are high within theatres and anaesthetics, critical care and district nursing owing to lower levels of workforce supply. Risks arise from the high use of supplementary staffing to counteract shortfalls. 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	Two Nursing and Midwifery Workforce meetings are being held (one for in patient areas and one for community nursing) alternate months. These provide a governance committee to monitor progress against agreed actions The agency embargo remains with every use of agency subject to scrutiny by a senior nurse. Recruitment meetings to oversee the recruitment plan are being held monthly 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. 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.	Risk Reviewed for period Jan-Mar 17: UPDATE The controls have been updated and are producing sustained results. The risk, with the exception of District Nursing, is showing a sustained improvement in the establishment gap for 3 successive months. This supports the previous amendment of the likelihood reducing to possible from likely although the impact would remain moderate (until the improvements can be shown to be sustained in the longer term) Risk Grade/Rating remains: Medium/9 ACTIONS A new agency supplier is being engaged to supply into the exempt areas of critical care / theatres and PICU where 3/12 block booking is in place pending the national arrangements for bank for critical care and theatres. The infrastructure for the Theatres and Anaesthetics, Critical Care national bank is in place. Increased number of trainee District Nurses being engaged (up from 7 to 15) for the specialist practitioner qualification and an alternate modular approach being implemented with 22 candidates on the first cohort Work is underway to improve the efficiency of the complex care service for adults, working with the home ventilation team. Draft risk assessment and guidelines for the use of 1:1 specialling are being tested in 4 pilot wards (evidence of reduced reliance on 1:1 in early phase of testing) A calendar to ensure the annual use of the nationally accredited workforce tools has been developed. iPad minis have been procured to enable RIE site to use full functionality of SafeCare live as a test of change	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 / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3328	2:Improving the Quality and Safety of Healthcare	Roadways / Traffic Management	There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites	• Traffic surveys have been conducted across all hospital sites, and action plans have been prepared. Higher risks have been prioritised and actions taken where funding has permitted. • Actions include: o segregation of vehicle and pedestrian traffic where possible; o risk assessing and controlling reversing manoeuvres for drivers and vehicles under NHSL control o creation of protected walk ways where possible; o development and use of one way systems where possible o use of barriers and entry systems to control traffic where possible o drop-off areas and disabled spaces; o additional parking attendants. • Interim measures have been put in place to prevent illegal and inappropriate parking including temporary barriers and bollards. • RIE Site Campus Group has been put in place to co-ordinate the re-provision of DCN & RHSC, including impact on activity on traffic management. Action plans have been revisited on a number of hospital sites and has resulted in additional high risk works being undertaken • Banks man arrangements in place on high volume high risk delivery areas, • Risk assessments and procedures are being developed and reviewed all areas where risk has been identified – a more robust risk assessment process has been developed • NHSL fleet vehicles fitted with reversing cameras and audible alarms. • Traffic Management training in place along with regular refreshers. • Work Place Transport policy available and reviewed within agreed time scales. • Escalation process in place should congestion become an issue • Site traffic management groups to review all sites established. • Action plans developed from the above groups and implemented monitored and reviewed by Traffic Management Review Groups • Capital proposals to introduce engineered solutions for in-patient sites. • High Risk Capital proposals funded. • Reviews regularly carried out as to effectiveness of plans and operational procedures • Site walk rounds in place conducted by site stakeholders • Improved monitoring systems in place – formally recorded • Known areas of people v vehicle conflict segregation measures put in place to avoid risk of injury due to contact where reasonable and practicable to do so Rationale for Adequacy of Controls: There are ongoing issues with traffic management and potential for pedestrians to stray into Facilities type areas. Proposals have been prepared and costed for each site. These will have to be approved before works can commence. The plans have been provided to capital to incorporate into master plans and this is reflected in the Adequacy of Controls Local TM Groups will continue to apply simple and low cost actions and repairs/improvements where approvals and budgets allow.	Risk Reviewed for period Jan-Mar 2017 The Pan Lothian TM Plan is being updated monthly and tabled quarterly at each Heads of Service Meeting. This details the risks, controls and further actions required at each site. Applications have been submitted to extend the TRO at the REH and introduce a TRO at the AAH. Works now completed on both sites. Awaiting confirmation of the date for the TRO to be introduced The resurfacing of car park P at St John's Hospital (main visitors car park) is now complete and operational and has assisted with the implementation of traffic management controls. Additional works being considered for 2017/18. Works completed at the WGH to address the high risk items identified by the Traffic Management Group. – that is the alterations of the road network at Turner House. Cycle paths now completed on site. Traffic Management works are underway at Whitburn Health Centre. Works also completed at Liberton Hospital, PAEP and Midlothian Community Hospital. Additional works at St John's and WGH are being considered for funding in 2017/18. It has been agreed that Consort will undertake a traffic managment audit on the RIE site. Risk grade/rating remains unchanged - High/12	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 8	Jim Crombie	George Curley	Staff Governance Committee

NHS LOTHIAN

Board Meeting
21 June 2017

1.4

Director of Finance

SUMMARY PAPER – PROPOSED AMENDMENTS TO SECTION 4 OF THE STANDING FINANCIAL INSTRUCTIONS – EXTERNAL AUDIT

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

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

• The Audit & Risk Committee has reviewed the section of the Standing Financial Instructions relating to external audit, to ensure that it properly reflects the Committee's role and activities. The current section states that if required, the Committee shall recommend to the Board a policy on the provision of non-audit services by the external auditor. The Committee has developed a policy and incorporated it into its suggested amendments to the section. The amendments also include a revised provision relating to the performance appraisal of the external auditor.	1.1
• The effect of the proposed amendments to the Standing Financial Instructions is for the Board's policy to be that providing Audit Scotland has approved the engagement, the Board's external auditors may be engaged to provide additional services to the Board.	3.5
• The Committee agreed on 25 April 2017 to recommend these amendments to the Board.	1.2

Alan Payne
Corporate Governance Manager
25 April 2017
alan.payne@luht.scot.nhs.uk

NHS LOTHIAN

Board Meeting
21 June 2017

Director of Finance

PROPOSED AMENDMENTS TO SECTION 4 OF THE STANDING FINANCIAL INSTRUCTIONS – EXTERNAL AUDIT

1 Purpose of the Report

1.1 The Audit & Risk Committee has reviewed the section of the Standing Financial Instructions relating to external audit, to ensure that it properly reflects the Committee's role and activities. The current section states that if required, the Committee shall recommend to the Board a policy on the provision of non-audit services by the external auditor. The Committee has developed a policy and incorporated it into its suggested amendments to the section. The amendments also include a revised provision relating to the performance appraisal of the external auditor.

1.2 The Committee agreed on 25 April 2017 to recommend these amendments to the Board.

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

2 Recommendations

The Board is asked to:

2.1 Review and approve the proposed amendments to the Standing Financial Instructions at Appendix 1, as recommended by the Audit & Risk Committee.

3 Discussion of Key Issues

3.1 The Auditor General appoints the Board's external auditor, not the Board. All external audit work is carried out in line with the Code of Audit Practice and auditing standards. The Code gives the external auditors of NHS Boards a wide remit as to the nature and extent of work they may carry out under their engagement. Audit Scotland published Audit Planning Guidance for 2016/17 audits in October 2016. Appendix 1 of that guidance sets out the Policy statement on non-audit work by appointed auditors, which requires that Audit Scotland must formally approve any proposal for an appointed auditor to undertake any additional services for public bodies which they audit. When making the request the audit firm must provide express assurance that the designated Ethics Partner has reviewed the proposed work and does not consider that it presents a conflict with the firm's role as the external auditor. Audit Scotland will consider the request with regard to the current Ethical Standard such as The Ethical Standard (Financial Reporting Council, June 2016).

3.2 At the moment Scott-Moncrieff are the appointed external auditors to the Board, its patients' private funds, and the endowment fund. Given that Audit Scotland's policy relates to "any additional services", this will capture the appointment of the external auditor for the Board's patients' private funds' accounts. Audit Scotland was made aware of the firm's appointment as the external auditor for the patients' private funds as part of the tender process for the 2016/17-2020/21 audits of NHS Board accounts.

3.3 It is important to note that the Edinburgh & Lothian's Health Foundation's trustees, in line with the Foundation's own charter and Standing Orders, approve the appointment of the external auditor of the endowment accounts. Consequently the external audit of the endowments is not regarded to be additional services relating to the activities of the Board's external auditor.

3.4 The Corporate Governance Manager has reviewed the Standing Financial Instructions of a sample of Scottish NHS Boards however none of them address this issue. The Scottish Public Finance Manual does not offer any assistance either as it still refers to the Scottish Government Audit Committee Handbook which was last updated in 2008.

3.5 The effect of the proposed amendments to the Standing Financial Instructions (at Appendix 1) is for the Board's policy to be that providing Audit Scotland has approved the engagement, the Board's external auditors may be engaged to provide additional services to the Board.

3.6 Given the measures that are already in place with regard to the Auditor General's relationship with the appointed firm, the firm's own internal ethical procedures for segregating different audit engagements, and the risk that a market testing exercise for any engagement may not generate interest from a variety of firms, this proposed policy is a pragmatic one. Additionally the fees for additional services are likely to be insignificant compared to any firm's total income, and consequently it is unlikely that the engagements will threaten the independence, integrity and objectivity of the auditor.

3.7 There are further provisions requiring the Director of Finance to notify the committee of all engagements, and for the committee itself to set out in its annual report when the external auditor has provided additional services.

Performance Appraisal of the External Auditor

3.8 Scott-Moncrieff has advised that Audit Scotland is in the process of developing its quality appraisal system. However Audit Scotland also confirmed that it was content for audited bodies to determine a local process for assessing the performance of their external auditors. In light of this there is an amended bullet at 4.7 of Appendix 1 which now reads:

4.7 "The Audit & Risk Committee shall: ……..

- Determine the process to monitor the performance of the external auditor, and reflect any such results from that process in the Committee's annual report. "

4 Key Risks

4.1 The risk is that the Board's external auditor engages in the provision in inappropriate non-audit services which leads to a loss of confidence in their independence and integrity.

5 Risk Register

5.1 There is no residual risk which would require to be captured on a risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 An integrated impact assessment is not required for this subject. This report is providing assurance on an administrative process, and has no obvious or direct link to decision-making with specific and significant implications for any particular group of people.

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

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

8 Resource Implications

8.1 There are no resource implications arising from this paper.

Alan Payne
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25 April 2017
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Appendix 1: Proposed Revised Version of Section 4 of the SFIs

APPENDIX 1: PROPOSED REVISED VERSION OF SECTION 4 OF THE STANDING FINANCIAL INSTRUCTIONS

4 EXTERNAL AUDIT

4.1 The Auditor General for Scotland appoints the external auditor to the Board.

4.2 The appointed external auditor shall conduct their duties in line with what is required by law and Audit Scotland's Code of Audit Practice.

4.3 All employees and Local Authority Employees are to provide the external auditor:

- Access at all reasonable times to any documents or information that the Board holds; and
- Any assistance, explanation, or information as the external auditor considers necessary

4.4 The Director of Finance shall prepare accounts and make arrangements to provide any information that the external auditor may require, so as to support the efficient conduct of the external audit.

4.5 It is important that the Board's external auditors are independent and seen to be independent in the work that they undertake. It is therefore not appropriate for them to undertake any non-audit work that might be perceived to create a conflict of interest with their role as external auditors.

4.6 The Board's external auditors may be engaged to undertake additional services only if Audit Scotland has previously confirmed that it would be appropriate for them to do so. These additional services include the external audit of patients' funds accounts. The Foundation trustees appoint the external auditor of the endowment fund accounts, and consequently that appointment is not regarded as additional services by the Board's external auditor. The Director of Finance shall notify the Audit & Risk Committee of any such engagement at its next available meeting.

4.7 The Audit & Risk Committee shall:

- Approve the remuneration of the external auditors within the range that Audit Scotland has set
- Examine any reason for the resignation or dismissal of the external auditor
- Review and confirm the external auditor's strategy and plans
- Receive and review the outputs from the work of the external auditor.
- Ensure that the external auditor has direct access to the Board Chairman and the Chair of the Audit & Risk Committee.
- Meet the external auditor once a year without the presence of management
- ~~Annually appraise the performance of the external auditor and provide the results to Audit Scotland~~Determine the process to monitor the performance of the external auditor, and reflect any such results from that process in the Committee's annual report.
- Receive assurance that the external auditor has arrangements in place to maintain their independence and objectivity. This should include consideration as to whether

any of the audit staff have any business interest with Lothian Health Board, or personal relationships with any of the Board employees or Local Authority Employees, which could compromise independence and objectivity.

- ~~If required, develop and recommend to the Board a policy on the provision of non-audit services by the external auditor. The Committee will also s~~Set out in its annual report whether the external auditor has provided any additional~~such~~ services ~~have been provided~~ during the year.

4.8 In the event that there is a problematic working relationship between the external auditor and the Board, the Chair of the Audit & Risk Committee shall advise the Board of the circumstances.

NHS LOTHIAN

Board Meeting 21st June 2017

1.5

Director of Public Health and Health Policy

FINAL REPORT ON 2016 MEASLES OUTBREAK IN LOTHIAN

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the recommendations and actions being taken following the outbreak of measles in Edinburgh that occurred from September to December 2016 and to provide the Board with an overview of the epidemiological and virological investigations undertaken.

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

2 Recommendations

2.1 Prevention of future measles outbreaks: This was an avoidable outbreak as measles infection is a vaccine preventable.. NHS Lothian is recommended to continue efforts to ensure all target groups are fully vaccinated with two doses of measles, mumps and rubella vaccine (MMR), especially with those who may have missed MMR vaccine in childhood and are now in secondary school or university. Lead: Lothian Immunisation Coordinating Group

2.2 NHS Lothian should have a clear set of practical recommendations for the use of personal protective equipment in primary care and secondary care for measles and other emerging infections. Lead: NHS Lothian Health Protection Team, Infection Prevention Control Team, Lothian Infection Control Advisory Committee.

2.3 NHS Lothian Health Protection Team to clarify the arrangements for flight contact tracing with Health Protection Scotland. Lead: NHS Lothian Health Protection Team

2.4 NHS Lothian should clearly recognise that the department of Occupational Health has a crucial role in protecting staff from vaccine preventable diseases before staff exposure occurs. Occupational health, together with management, need to ensure frontline staff are protected against measles and other vaccine preventable infections. Lead: Occupational Health, Lothian Infection Control Advisory Committee.

2.5 NHS Lothian to review and test the NHS Lothian mass vaccination plan to ensure it covers a range of scenarios and practical issues e.g. potential venues, staffing, how to set up a vaccination clinic, ordering supplies, waste disposal. Lead: NHS Lothian Health Protection Team

2.6 NHS Lothian Communications department to set up intranet site for similar situations so that the clinical guidance is accessible during an outbreak. Lead: NHS Lothian Communications

2.7 Joint working with Universities: NHS Lothian to develop outbreak plans (including information cascades) with universities in advance of an outbreak. Lead: NHS Lothian Health Protection

2.8 Scottish Ambulance Service to review their measles protection and infection prevention and control in non-Special Operations Response Team (SORT) ambulances. Lead: Scottish Ambulance Service

3 Discussion of Key Issues

3.1 The on-call Health Protection Team at NHS Lothian was informed of a confirmed case of imported measles on Monday 26 September 2016. From October to November 2016, a further 17 confirmed cases of measles were reported. The majority of these cases were students and staff linked directly to the University of Edinburgh. The Health Protection response involved extensive contact tracing and follow up of over 1500 individuals.

3.2 Twelve multidisciplinary Incident Management Team meetings, led by NHS Lothian Health Protection consultants, were convened to manage the outbreak throughout this period.

3.3 Drop-In MMR vaccination clinics were set up on University of Edinburgh campuses and elsewhere in Edinburgh. Over the duration of the outbreak 22 vaccination clinics were held, administering over 1200 doses of MMR vaccine. These vaccination clinics took place over a number of venues including University of Edinburgh, Queen Margaret University and Lothian Unscheduled Care Service (LUCS).

3.4 Healthcare staff had contact with measles cases in busy areas such as Royal Infirmary Edinburgh, LUCS and GP practices, both in and out of hours. They required follow up with vaccination and three healthcare workers required formal exclusion from work under the Public Health (Scotland) Act 2008. Due to the highly infectious nature of the measles virus, the identification of healthcare workers considered immune to measles, and consequently safe for deployment to clinical areas, became time critical.

3.5 The NHS Lothian Community Vaccination Team has organised an MMR catch up letter for school age children with MMR clinics being held in June 2017.

4 Key Risks

4.1 There is a risk of further measles outbreaks affecting a larger number of individuals if vaccination rates with MMR are not maintained.

4.2 There are financial risks associated with avoidable outbreaks of vaccine preventable disease. The additional direct costs of this outbreak (virological testing and vaccination clinics) amounted to an estimated £53,000. Larger outbreaks would be more costly.

5 Impact on Inequality, Including Health Inequalities

6.1 This outbreak had an impact on a secondary school setting in Edinburgh that had previously had low MMR uptake identified. It also affected a large number of the student and staff population at the University of Edinburgh.

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

6.1 During the outbreak, a statement was sent out to all university students advising about the increase in measles cases, that full protection required two doses of MMR and informing them of drop-in MMR vaccination clinics. Information on the increase in measles and MMR vaccination clinics was offered via multiple media channels throughout the University.

6.2 The NHS Lothian communications department co-ordinated wider communications to the public throughout the outbreak. A press release was issued to the media and was taken up by a several news outlets. The number of cases was updated daily on the NHS Lothian website.

7 Resource Implications

7.1 Additional resources are required by the NHS Lothian Occupational Health Service to protect frontline staff against vaccine preventable infections.

7.2 Ongoing resource is needed by the NHS Lothian MMR vaccination programme to maintain the current high levels of MMR 1 and 2 uptake in NHS Lothian plus targeted MMR clinics for older age groups.

7.3 Resources are required to fund practical recommendations for the use of personal protective equipment in primary care and secondary care for measles outbreaks and other infectious disease outbreaks including emerging infections.

7.4 Appropriate resources need to be put in place to facilitate a mass vaccination plan for NHS Lothian which covers a range of possible scenarios.

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14/06/2017
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List of Appendices

Appendix 1: 2016 Measles Outbreak in Lothian: Outbreak report from the Incident Management Team [Final Report]

Measles Outbreak in Lothian 2016
Outbreak report from the NHS Lothian Incident Management Team

Produced by Amir Kirolos (Public Health Speciality Registrar), Catriona Waugh (Surveillance Officer) and Janet Stevenson (Consultant in Public Health Medicine) on behalf of the NHS Lothian Incident Management Team

Contents

Abbreviations & Glossary

Comms – Communications
GP – General Practitioner
HNIG – Human Normal Immunoglobulin
HPS – Health Protection Scotland
HPT-Health Protection Team
IgG – Measles IgG Antibody
IMT – Incident Management Team
IPCT – Infection Prevention & Control Team
LUCS – Lothian Unscheduled Care Service
MMR – Measles, Mumps & Rubella Vaccine
OHS – Occupational Health Service
PAG – Problem Assessment Group
PCR – Polymerase Chain Reaction
PHE – Public Health England
PPE-Personal protective equipment
RHSC – Royal Hospital for Sick Children
RIE – Royal Infirmary of Edinburgh
SSPE – Subacute Sclerosing Panencephalitis
WGH – Western General Hospital
WHO – World Health Organisation

1. Executive Summary

This report of the Incident Management Team details an outbreak of measles in Lothian from September to December 2016. A total of 18 confirmed cases were reported to the Health Protection Team (HPT) of the Directorate of Public Health and Health Policy during the outbreak. The majority of these cases were students and staff linked directly to the University of Edinburgh.

Twelve Incident Management Team (IMT) meetings were convened to manage the outbreak throughout this period. The Health Protection response involved extensive contact tracing and follow up of over 1500 individuals. Drop-in Measles, Mumps and Rubella (MMR) vaccination clinics were set up on University of Edinburgh campuses and elsewhere in Edinburgh. Over the duration of the outbreak 22 vaccination clinics were held, administering over 1200 doses of MMR vaccine.

The last confirmed case was infectious until the 20th November 2016 and the outbreak was declared over on 31st December 2016, 42 days (2 incubation periods) after this.

2. Introduction

The on-call Health Protection Team (HPT) at NHS Lothian was informed of a suspected case of imported measles on 26th September 2016. A total of 18 confirmed cases were reported to the HPT of the Directorate of Public Health and Health Policy during the outbreak. The majority of these cases were students and staff linked directly to the University of Edinburgh.

Twelve Incident Management Team (IMT) meetings were convened to manage the outbreak throughout this period. The Health Protection response involved extensive contact tracing and follow up of over 1500 individuals. Drop in Measles, Mumps and Rubella (MMR) vaccination clinics were set up on University of Edinburgh campuses and elsewhere in Edinburgh. Over the duration of the outbreak 22 vaccination clinics were held, administering over 1200 doses of MMR vaccine. These vaccination clinics took place over a number of venues including University of Edinburgh, Queen Margaret University and Lothian Unscheduled Care Service (LUCS).

The last confirmed case was infectious until the 20th November 2016 and the outbreak was declared over on 31st December 2016, 42 days (two incubation periods) after this.

Measles virus

Measles is a highly infectious viral disease which is easily spread via droplet transmission. It is a vaccine preventable infection using MMR and there is a World Health Organisation (WHO) target for elimination of measles in Europe. There is a highly effective vaccine for the prevention of measles with one dose resulting in 95% of individuals being protected and two doses resulting in up to 99% of individuals being protected if the second dose is given at or over 12 months of age.

The transmission rate is particularly high in populations with sub-optimal MMR vaccination uptake. In an unvaccinated population, one measles case can lead to 12 to 18 further cases. It has an incubation period of 10 days before fever onset and 14 days before rash onset but the incubation period can be up to 21 days. It is infectious from 5 days before rash onset to 4 days after the emergence of rash.

Clinical Presentation, Diagnosis and Treatment

Measles causes a number of symptoms including rash, coryza (runny nose), conjunctivitis, cough and pyrexia. It can be associated with serious complications such as pneumonia, encephalitis and death (1 in 5000 cases). More rarely (1 in 25000 cases), it can cause sub-acute sclerosing panencephalitis, a severe and progressive neurological complication that occurs years after infection.

Diagnosis in NHS Lothian is carried out in the Virology laboratory typically via PCR using a throat swab, salivary or urine sample. The results can be influenced by co-infection with other viruses and recent MMR vaccination.

There is no specific treatment for measles. Treatment consists mostly of supportive measures and treatment of any associated bacterial infection.

Measles Epidemiology and Vaccination Rates

Measles is now a relatively uncommon and preventable childhood disease in the UK, with an average of 23 confirmed cases in Scotland annually (3). There have been several major outbreaks in recent years, primarily affecting school age children e.g. in Wales, North West England and London.

The annual number of confirmed cases of measles by year in NHS Lothian is shown in **table 1**.

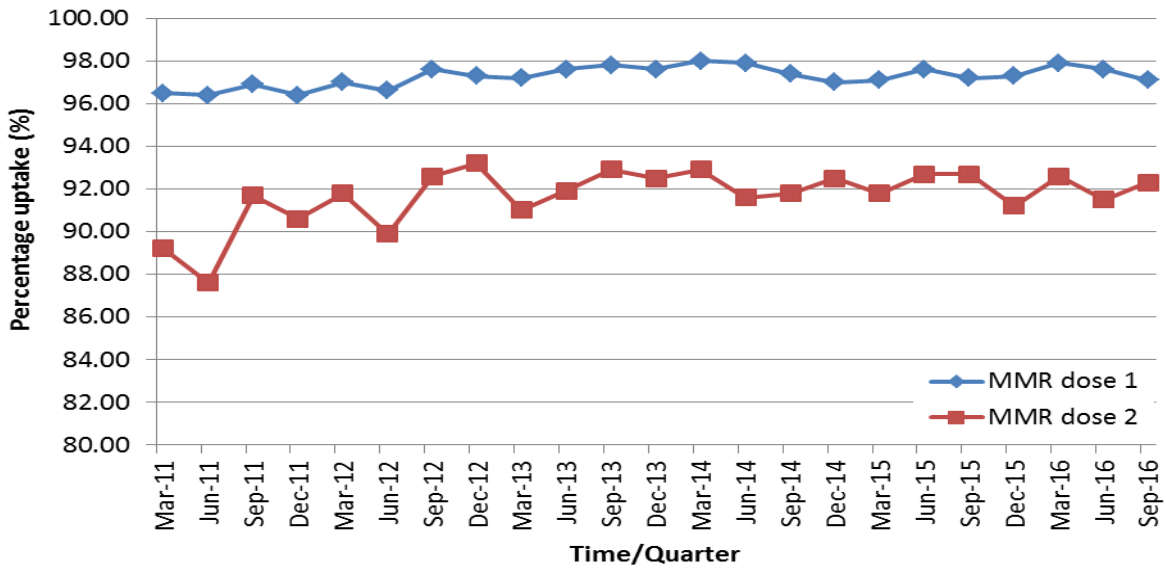
Table 1. Number of laboratory confirmed measles cases by year in NHS Lothian between 2002 and 2016.
Source: Health Protection Scotland

Year	Number of cases seen in NHS Lothian	Description
2002	1	
2003	0	
2004	0	
2005	0	
2006	5	
2007	0	
2008	25	Lothian outbreak in travellers
2009	2	
2010	2	
2011	15	Lothian outbreak
2012	4	
2013	7	Sporadic increase
2014	1	
2015	0	
2016*	19	Current outbreak

*Includes cases from this outbreak

Children in NHS Lothian currently have a high uptake of MMR. Up to September 2016 the uptake of the first dose of MMR at 5 years of age was 97% (above the national target of 95%) with the uptake of the second dose of MMR 92.3% at 5 years and 93.5% at 6 years (**Figure 1**).

Figure 1. Percentage uptake of MMR by 5 years of age in NHS Lothian



3. Investigation

3.1 Epidemiological investigation and results

Index Case

An initial report of a clinically suspected imported case of measles in a student at the University of Edinburgh was reported to the Health Protection Team in the afternoon of Monday 26th September 2016 and was subsequently confirmed on a throat swab that evening. The case had developed a rash on the 25th September 2016 and was seen at the out-of-hours GP service at the Western General Hospital, Edinburgh. They were seen in the Medical Receiving Unit and then transferred to a side room on a medical ward before being transferred to a negative pressure room in the Infectious Diseases unit.

During the case investigation it emerged that this index case had travelled to Edinburgh from abroad two weeks prior to the onset of symptoms and had attended a number of University of Edinburgh events and lectures in the previous week. The HPT contacted members of the index case's household and followed up other community and healthcare contacts of the index case, this involved following up over 300 individuals. HPT also followed up the case's GP practice to provide advice and enable action to reduce the risk of secondary infection.

A Problem Assessment Group (PAG) was held on 27th September 2016 to co-ordinate this response. An initial rapid MMR vaccination clinic was set up at the University of Edinburgh on 30th September 2016 to which contacts of the case from events and lectures were invited.

Out-of-hours GP services were sent information to be vigilant for further cases.

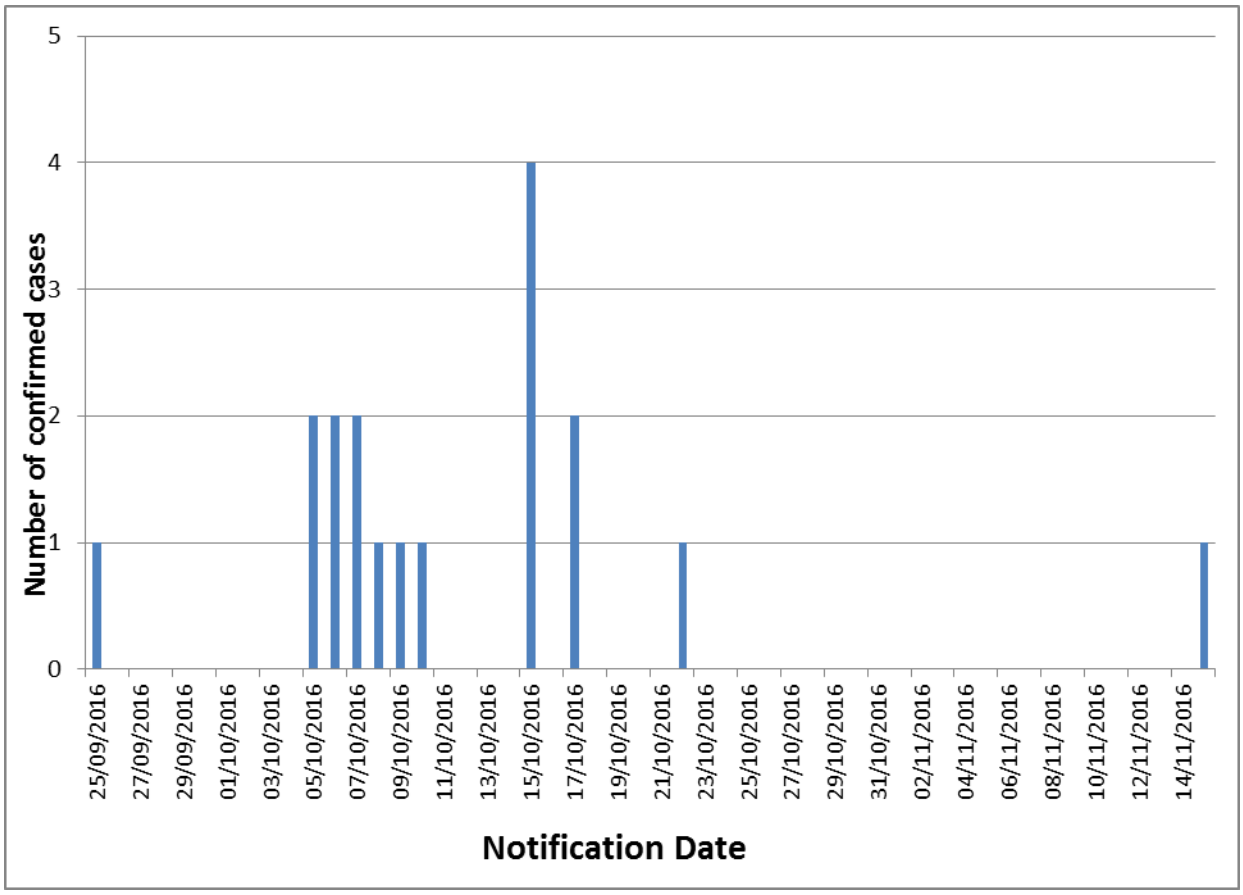
Case Definitions
The following cases definitions were agreed and are shown in **table 2**.

Table 2. The case definition used throughout Edinburgh outbreak, October 2016

Case definitions	
Possible cases	Those who present with symptoms consistent with measles having visited or been resident in Edinburgh after 20th September 2016 but who have not had contact with a confirmed case of measles
Probable cases	Those who present with symptoms consistent with measles having visited or been resident in Edinburgh after 20th September 2016 and who had contact with a confirmed case of measles
Confirmed cases	Those with laboratory confirmed measles having visited or been resident in Edinburgh after 20th September 2016

Linked cases
From October to November 2016, a further 17 confirmed cases of measles were reported to the HPT at NHS Lothian. An initial peak in secondary cases began on 5th October 2016. A further increase in cases occurred on 15th October 2016. The last confirmed case had a rash onset on 15th November 2016 and was infectious until 20th November 2016. The outbreak was declared over two incubation periods (42 days) after this date on the 31st December 2016. Figure 2 shows the epidemic curve.

Figure 2. Epidemiological curve of laboratory-confirmed measles cases by notification date



The University of Edinburgh has a population of 36,491 students. Of these 14,915 students are from outside of the UK with 4,625 coming from the EU and 10,290 coming from elsewhere in the world (4). This means that there will be a variety in the level of vaccination coverage due to different vaccine schedules and availability across the globe. The University advises all students to have had MMR vaccinations before matriculating with the University.

Table 3 shows the breakdown of confirmed cases by educational establishment including the cases linked to the University of Edinburgh (student or staff member) and a local secondary school.

Table 3. Relationship of confirmed and probable cases of measles to educational settings

Confirmed cases-Educational setting	Number of cases
University of Edinburgh student –Kings buildings	7
University of Edinburgh staff member –Kings buildings	2
University of Edinburgh student– College of Art campus	2
University of Edinburgh student – George square campus	1
Edinburgh secondary school pupil	2
Not in an educational setting	4
Total cases	18

Figure 3 shows that ten of the confirmed cases were aged between 15-24 years old and ten were female and eight were male. However, whilst the outbreak was ongoing the majority of clinical notifications of rash-like illness received by HPT from clinicians were in children aged less than 5 years.

Figure 3. Age ranges of confirmed cases and measles notifications

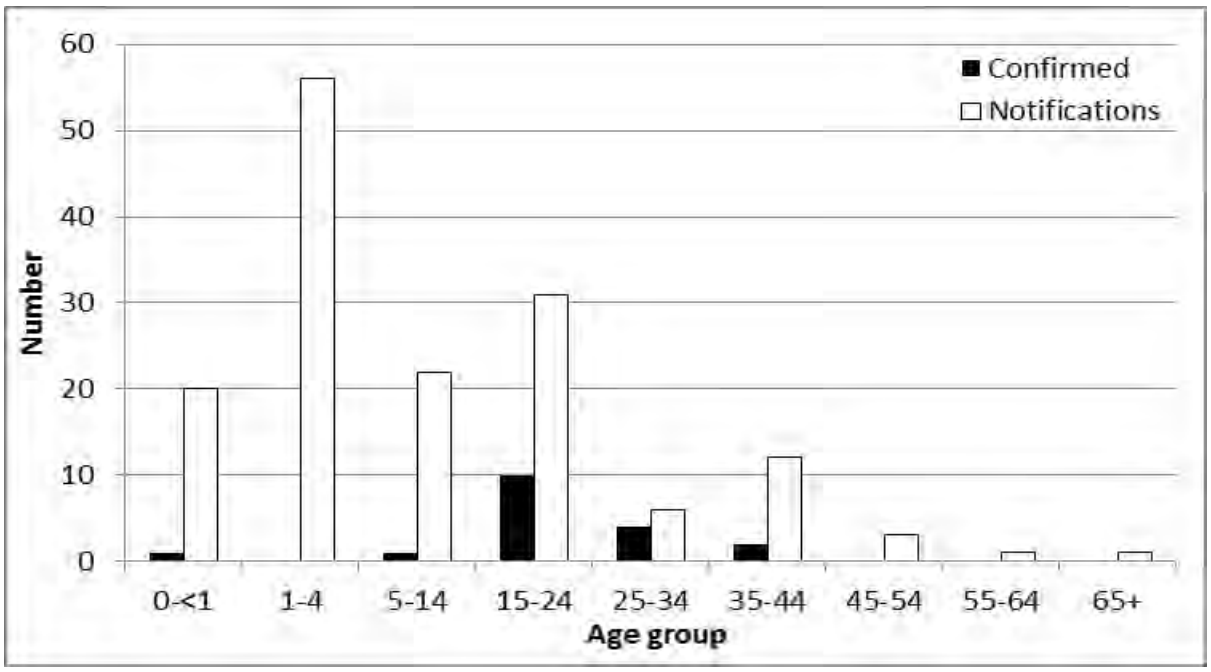


Table 4 shows the vaccination status of confirmed cases. Eleven of the confirmed cases were known to be unvaccinated and only one had received two doses of MMR.

Table 4. MMR Vaccination status of cases

Vaccination Status	Number of Cases
2x MMR vaccine	1
1x MMR vaccine	1
Too young to receive vaccine	1
Unvaccinated	10
Unable to be confirmed	5
Total	**18**

Hospital admissions

Five of the eighteen confirmed cases had a short stay in an NHS Lothian hospital due to measles related symptoms or complications.

Secondary school age confirmed case

One confirmed measles case was admitted to hospital via the out-of-hours GP service on 7th October 2016. They were an unvaccinated school pupil who attended a south Edinburgh secondary school. They had no clear contact with any confirmed cases or contact with the University of Edinburgh in general.

Unvaccinated household contacts of this case were identified and excluded from school, college and work as a precautionary measure. Four unvaccinated household contacts went on to develop symptoms and were all later confirmed to have developed measles. One of these household contacts also attended the same south Edinburgh secondary school.

Measles information was sent out to pupils, parents and staff at the secondary school. No further cases emerged at the secondary school during the outbreak despite this secondary school having a relatively lower uptake of MMR vaccination than in other areas of NHS Lothian. MMR catch up clinics were subsequently arranged within the secondary school.

Infant Case

One of the initial secondary cases was an infant who had not yet been vaccinated with any doses of MMR vaccine due to their age. They presented after having had contact with the index case at a social event. They were managed at the Royal Hospital for Sick Children in Edinburgh.

Case Resulting in Significant Exposure on a flight to Edinburgh Airport

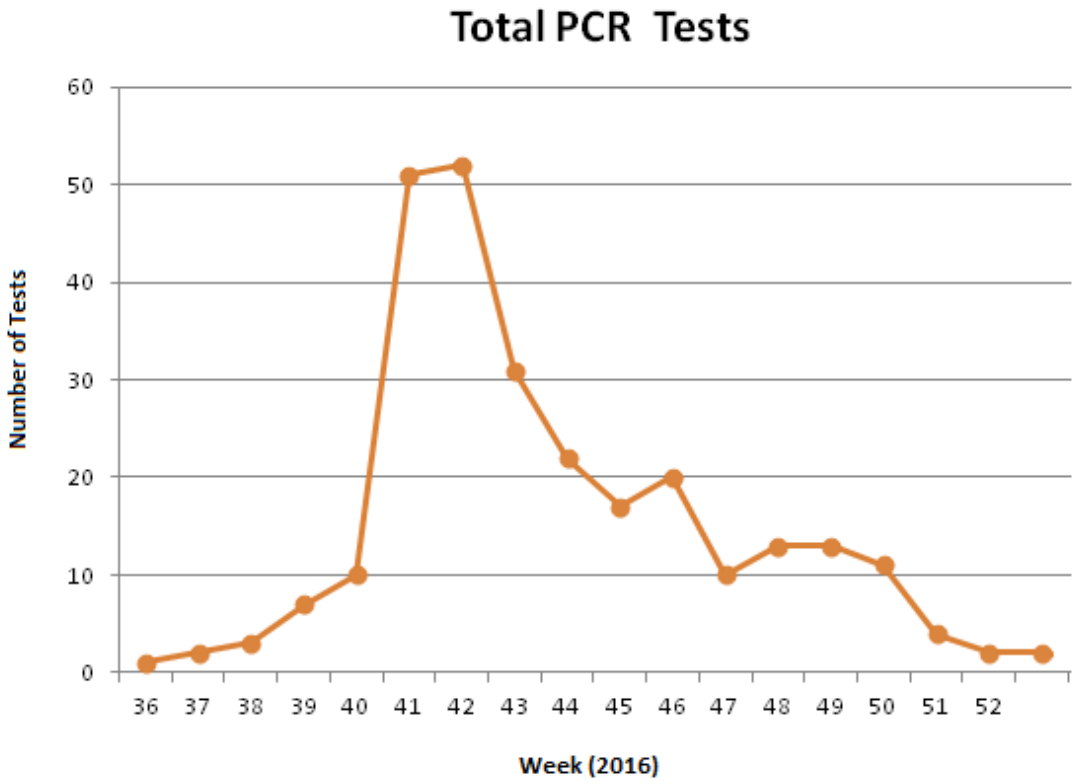
One of the adult contacts of the index case developed a rash on 17th October 2016 and was subsequently reported to the NHS Lothian HPT after being seen by their GP. They had travelled abroad by plane during their infectious period and on the day of their return to Edinburgh had become symptomatic and developed a rash. Extensive follow up of other passengers on the aircraft was undertaken. Health Protection Scotland (HPS) liaised with the airline to obtain the flight manifest and made initial contact with exposed passengers, who were followed up by NHS Lothian HPT and other health boards.

3.2 Virological investigation and results

Measles Polymerase Chain Reaction (PCR) testing undertaken

The index case was diagnosed in week 39 of 2016. The normal level of activity for measles PCR testing in Lothian is one to three tests per week. The total number of PCR tests performed from week 39 until week 52 of 2016 was 263. There were two weeks of peak activity during weeks 41 and 42. In this two week period, 101 measles PCR tests were performed.

Figure 4. Number of measles PCR tests undertaken at NHS Lothian Virology by week of 2016



There were 20 samples that initially tested positive by measles PCR in Lothian. All positive samples were then sent to Public Health England (Colindale) for further typing. MMR history and contact with other cases were noted for all samples tested in order to interpret the results.

In total seventeen samples were confirmed via local PCR testing. Sixteen of these were typed as measles strain D8 with one unable to be typed. Three other samples tested weakly positive in children with a recent MMR history with one being confirmed as an MMR strain, with the other having a Ct value of >32 meaning they were unable to be detected or typed by the reference laboratory at PHE Colindale. There was one other confirmed case identified

by oral swab in PHE Colindale and not by local PCR testing**.** The total number of virologically confirmed measles cases in the outbreak was 18.

Figure 5. Number of positive measles PCR results by week of 2016

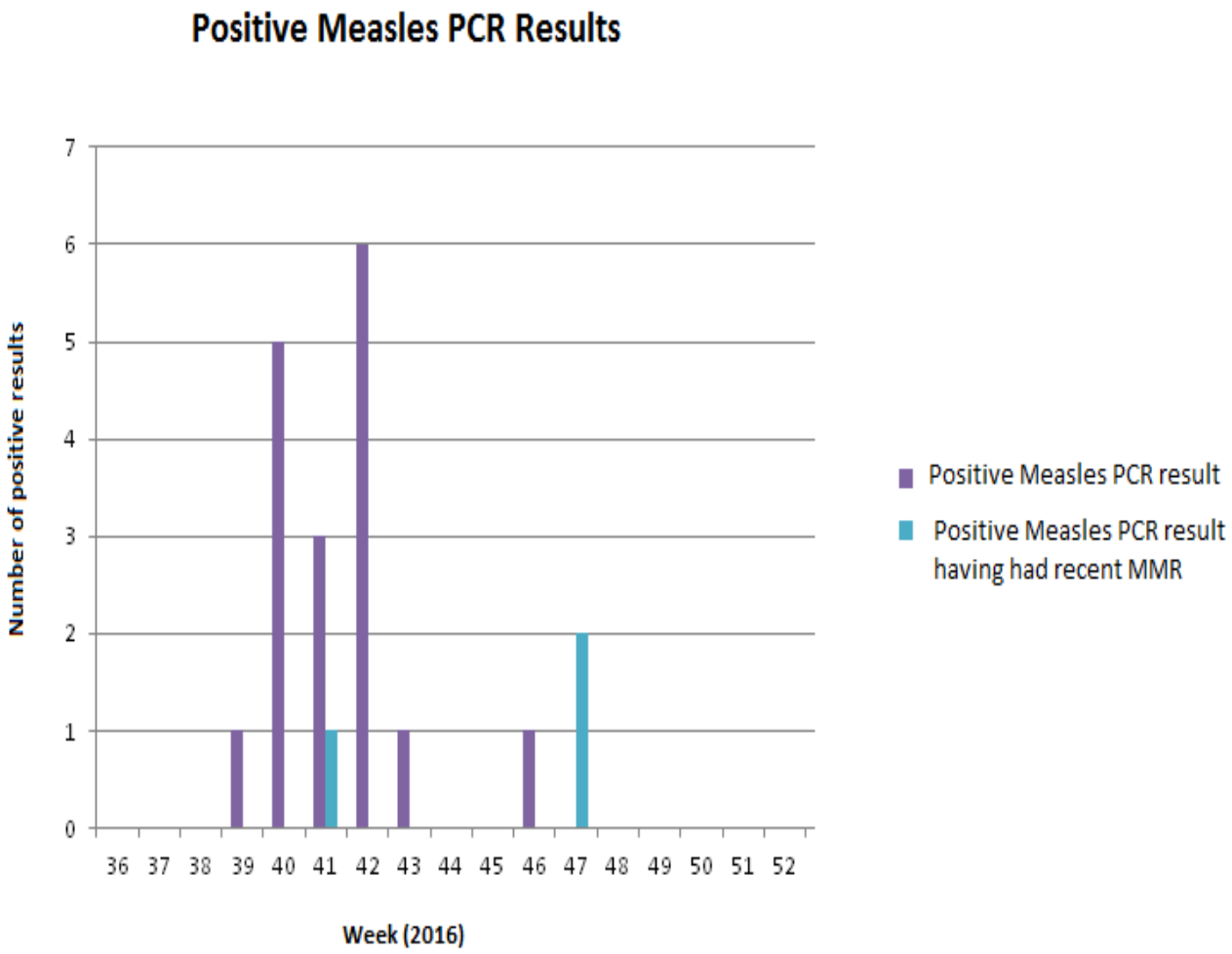


Table 5. PCR CT values of cases compared to MMR status and typing

Ct value	Definition	Typing
35.90	MMR	Untyped
32.84	MMR	Untyped
31.47	Case	Untyped
30.83	Case	D8
29.26	MMR	MMR
28.11	Case	D8
28.07	Case	D8
28.01	Case	D8
27.01	Case	D8
25.96	Case	D8
25.95	Case	D8
25.74	Case	D8
24.42	Case	D8
24.04	Case	D8
23.97	Case	D8
23.71	Case	D8
23.30	Case	D8
23.13	Case	D8
22.95	Case	D8
22.90	Case	D8

**Note the higher Ct values have less measles virus in the sample. Any sample with Ct >30 is less likely to be able to be typed, whether an actual case or an MMR strain. However, MMR strains can still give a Ct value within the same range as actual cases. The only way to definitely distinguish is by sequencing.*

Efficiency of PCR testing

NHS Lothian aims to perform measles PCR tests within 12 hours from receipt in the laboratory. 97% of tests met this aim. There were some internal information technology issues which delayed a few results. These have since been resolved. The results on two cases were delayed as they were MMR positive cases that required typing results from PHE Colindale.

Measles Typing

The virus strain in this outbreak was typed as genotype D8. This is one of the most common strains circulating in the world. The initial strain was compared to the worldwide database of measles sequences and had a closest match to a measles D8 strain circulating in South East Asia. It did not match measles D8 strains currently circulating in the rest of the UK. This would suggest that the index case's infection was acquired abroad rather than in the UK. This fits with the travel history of the index case.

Measles IgG testing

There were 1552 measles IgG samples tested in the outbreak period. The aim for performing this test is four days, with same day tests able to be undertaken in specific circumstances. The four day turnaround was achieved in 95% of cases. The normal activity for measles IgG is 30 to 40 per month. In October and November, 1465 (94%) of the total measles IgG tests undertaken in 2016 were performed.

During the course of the outbreak a testing programme for measles immunity (IgG) was undertaken in frontline staff members. Through this testing programme 1407 staff who were unaware of their measles immunity status were able to be reassured that they had measles IgG. Overall it was found that approximately 94% of staff tested were immune to measles (IgG positive) and 6% (n=86) of staff members were not immune to measles (IgG negative), table 6. The 86 health care workers who were IgG negative were aged 20 to 54 years. Only 13 (15%) of those who were IgG negative were aged 40 years or older (born before 1976) reflecting the widespread circulation of wild measles virus when that age cohort were children.

4. Risk Management

The NHS Lothian multidisciplinary response to the outbreak required an input from all parts of the integrated health system and our partners in education. It involved laboratory services, Primary Care, out-of-hours GP services, Occupational Health, Infection Prevention & Control, Emergency Department and Combined Assessment Units, Paediatrics, Maternity services, Infectious Diseases Unit, Pharmacy, Health Protection, the wider Public Health team and Communications. The response involved isolation of cases, infection control advice, contact tracing and exclusion of potential cases and management of individuals potentially exposed to measles, including follow up with MMR vaccine or Human Normal Immunoglobulin (HNIG) as required.

4.1 Management of Cases

All the cases recovered after illness. Five were admitted to hospital for supportive treatment with all requiring only a short stay or being discharged promptly.

Isolation

Most patients were treated in adult ward side rooms or rooms with negative pressure. Some cases were initially admitted to open wards or waiting rooms when being initially assessed. Exposed patient contacts were identified and followed up by the Infection Prevention and Control Team (IPCT).

Community cases were advised to self-isolate at home for the duration of their infectious period, formally excluded from nursery/school/university/work and given further written information about measles.

Cases were asked to contact their GP by phone if requiring further advice to avoid attending local GP practices and potentially exposing further people to the measles virus. A pathway for GPs with advice on management was drawn up with the support of the lead GP for immunisation and the GP sub-committee and sent out to all Edinburgh GP practices. GP adherence to the primary care pathway and their rapid identification of cases aided the prevention of further spread of the disease.

Epidemiological investigation
All confirmed and probable cases were added to a line listing and were interviewed by the Lothian HPT to establish significantly exposed contacts. This was done by interviewing each case and completing a contact tracing timeline grid plus a national surveillance questionnaire. Contact tracing out of hours was undertaken by the on call public health team.

4.2 Management of Contacts

Contact tracing was carried out on those who were either confirmed or probable cases as per the case definitions. Significant contacts were defined as per guidance from Health Protection Scotland as having had face to face contact or having been in the same room as a case for 15 minutes or more (5).

Over 1500 direct contacts of the confirmed cases were indentified and required follow up.

A step down management plan was discussed and it was agreed that if the number of cases increased beyond a certain point then contact tracing would cease and the main drive would be on community MMR vaccination.

Vulnerable contacts
Vulnerable contacts were defined as immunocompromised patients, children under one year old and pregnant women. A larger supply of HNIG was acquired for local hospitals to give to exposed vulnerable contacts.

At least two pregnant women reported some contact with measles cases to HPT. The level of contact was assessed and testing for immunity was arranged frequently. HNIG was required in a small number of circumstances. A pathway for delivery of HNIG was drawn up with the lead obstetrician and midwife and included using a side room in the Obstetric Department for the administration of HNIG.

A number of children were also assessed for potential post exposure prophylaxis. HNIG was kept at the local children's hospital where there were guidelines in place for its use.

At the affected secondary school one immunocompromised child was identified. The management of this contact included testing for previous immunity, provision of HNIG and exclusion from school until it was confirmed that no further measles cases had arisen.

Inpatients
Out of the 18 cases, 9 had come into contact with hospital and primary care services. Managing the risk in these areas involved liaising with the IPCT in hospitals affected and primary care services.

Patient contacts were considered immune if born before 1960, if they had two MMRs or if they could give a clear history of measles. The IPCT led on gathering this information with

the assistance of the HPT which was co-ordinated through the IMT (dates of meetings outlined in Appendix 2).

4.3 Occupational Health Response

Healthcare staff had contact with measles cases in busy areas such as Royal Infirmary Edinburgh, LUCS and GP practices, both in and out of hours. They required follow up with vaccination and at least three healthcare workers required formal exclusion from work under the Public Health (Scotland) Act 2008. Due to the highly infectious nature of the measles virus, the identification of healthcare workers considered immune to measles, and consequently safe for deployment to clinical areas, became time critical.

The Occupational Health Service (OHS) was requested to provide information on the measles immunity status of frontline clinical staff (MMR vaccine or Measles IgG status) to line managers. The record of work related vaccination or immunity status of healthcare workers within NHS Lothian is held by the OHS. At the commencement of employment in Lothian, employees are requested to complete a health questionnaire. Details of previous vaccinations received are part of the information provided to the OHS. This process facilitates the offer of work relevant vaccination to targeted staff groups depending on their roles. Within the NHS in Scotland, there is no mandatory requirement for staff to accept vaccinations offered with the exception of Hepatitis B vaccination in workers whose roles involve the performance of exposure prone procedures as part of their duties. Employees are required to complete a disclaimer form whenever they decline the offer a vaccination considered relevant to their work exposure or their duties. In other instances, employees offer to provide the OHS with documentary evidence of vaccinations previously received e.g. MMR. Employees failing to make this information available to the OHS once they have commenced employment can lead to a gap in their records. This was found following a request by the IMT for information regarding the measles immunity of clinical staff in this incident; the OHS indicated that complete immunisation records were available for less than one third of current NHS Lothian staff. The outcome is that despite multiple attempts by OHS staff to obtain this information or make the offer of vaccination available, OHS holds limited information about the immune status of employees, especially in relation to their immunity to measles. The risk created by this situation had been highlighted to the organisation following a number of notifications of measles in Lothian.

Many staff in at-risk areas were unaware of their vaccination status and required their immunity to be tested to determine whether any exclusion from work was required. Occupational health followed these staff contacts in working hours while HPT followed staff contacts up out of hours.

OHS began a survey to compile a database of all healthcare staff in areas likely to come into contact with possible new presentations of measles. It was agreed that operational managers in relevant areas would provide an up to date list of staff, including personal identifiers, to OHS to facilitate review of OH records to establish their measles immunity status. The lists provided comprised approximately 8000 staff. This required extensive

follow up, evidence of two MMR vaccinations submitted or testing of immune status at drop in Occupational Health clinics.

It became apparent very early in this process that the OHS did not hold current addresses for many employees. Additional work was undertaken to update the OHS database at the same time as reviewing OH records.

The limited information about vaccination status of individuals, combined with the relatively high long term rate of measles immunisation, led to the IMT decision to offer measles IgG testing to clinical staff without documentary evidence of having had two doses of a measles containing vaccine. Due to the number and disparate location of frontline staff the OHS nursing team did not have the resources to undertake this alone.

A process of 'peer venepuncture' was agreed by the IMT and NHS Lothian Partnership to increase cover and staff uptake. This process was coordinated with colleagues in Virology, operational line management in Primary Care, Lothian Unscheduled Care Service and the Hospital Division. In conjunction with this process, OHS staff undertook to update the immunisation records of NHS Lothian employees with the goal of improving operational resilience of the organisation for the future. Staff members found to be measles IgG negative were offered MMR vaccination by the OHS.

Table 6. Results of Staff Measles IgG Testing

Number of staff with positive IgG test	1321	94%
Number of staff with negative IgG test	86	6%
Total number of staff receiving measles IgG test	1407	100%

Work is continuing within the OHS to update the immunisation status of NHS Lothian staff. The resources invested in measles immunity testing during the period of the outbreak ensured that the organisation as a whole is in a better state of preparedness to identify staff members who can be safely deployed in the event of future measles outbreaks. By doing this, NHS Lothian continues to fulfil its general duty, under the Health & Safety at Work Act 1974, of ensuring the health, safety & welfare of its workforce, as far as is reasonably practicable.

The uptake from staff members of measles IgG testing over this period has been encouraging.

4.4 MMR Vaccination

Risk management involved the provision of a number of opportunities for wider vaccination of people at risk and those who had potentially been in contact with measles cases.

Fifteen MMR Vaccination clinics for staff and students were held at the University of Edinburgh at both campuses that were affected (King's Buildings and Bristo Square campuses) during the outbreak. These were set up by the HPT and delivered by trained bank staff members with support from the Community Vaccination Team. One further clinic was held at Queen Margaret University (QMU) due to a number QMU students having suspected contact with a confirmed case of measles.

The first clinic was held on 30th September 2016 at the University of Edinburgh, King's Buildings, in response to the index case after they presented to services. Those who had attended a large event with the index case were also invited to this first clinic. After the emergence of further cases, further clinics were advertised to a wider group of university staff and students. These were held at the University of Edinburgh throughout the outbreak. Further vaccination clinics were held at later dates in early 2017 to allow provision for those requiring 2nd MMR.

Two vaccination clinics were set up at the affected Edinburgh secondary school. Pupils who were not fully vaccinated were identified via the Scottish Immunisation & Recall System (SIRS) and were invited to attend. MMR uptake varies significantly in Edinburgh based on geographical location and the secondary school affected during the outbreak had previously been identified as an area of susceptibility with low MMR vaccination rates amongst pupils.

At the height of the outbreak, out-of-hours clinics were arranged in the evenings in the Outpatients Department at the RIE to allow for testing and MMR vaccination. Six of these clinics were arranged to allow MMR vaccination for contacts of confirmed cases out of hours. These were arranged out of hours to encourage people to attend and to minimise the delay in getting vaccinated. Subsequent out-of-hours clinics were cancelled due to a decrease in the number of cases and all vaccination needs could be accommodated by patients' GP practices.

Table 7. Numbers Receiving Vaccination at Clinics during Outbreak – includes those attending a repeat clinic for second dose of MMR

	Number of Clinics	**Number of MMR vaccinations given**
University of Edinburgh Clinics	15	1100
Queen Margaret University Clinics	1	12
Out-of-Hours Clinics	6	21
School Clinics	2	97
Total	**22**	**1230**

Co-ordination of the response

A Problem Assessment Group (PAG) was initially convened when the index case was identified. After the measles outbreak was declared, IMT meetings were convened led by a Consultant in Public Health at NHS Lothian. The IMT included Health Protection Scotland, Virology, IPCT, OHS, acute services, Paediatrics, Obstetrics & Gynaecology, Infectious Diseases, communications and Pharmacy (see Appendix 1). An incident control room was set up at NHS Lothian for the first two weeks of the outbreak for IMTs and meetings to co-ordinate the response. Twelve PAG and Incident Management Team (IMT) meetings were convened to manage the outbreak throughout this period. In the first two weeks meetings were held 2 to 3 times a week and were held with decreasing frequency as the number of measles cases fell.

5. Risk Communication

Communication with the University of Edinburgh

After the emergence of the index case, the HPT liaised closely with staff at the University of Edinburgh to provide measles information to students and staff on the same course. Emails were sent out to classmates or students of the confirmed cases at the University of Edinburgh with more detailed advice advising they had been in contact with a confirmed case of measles.

After the emergence of further cases, a statement was sent out to all university students advising about the increase in measles cases, that full protection required two doses of MMR and informing them of drop in MMR vaccination clinics.

Information on the increase in measles and MMR vaccination clinics was offered via the library, university gym, Edinburgh University Student Union Association, electronic boards around the University, with public health staff from the wider team and health promotion team handing out leaflets on campus and encouraging people to attend. Active engagement with those in the area was also carried out while drop in clinics were being undertaken.

Communication with the wider public

The NHS Lothian communications department co-ordinated the wider communications to the public throughout the outbreak. The key messages agreed were:

- Symptoms of measles can take two weeks to develop and include a runny nose, fever and rash. Those affected were requested to call their GP or NHS 24 before going to a medical facility.
- Two doses of MMR vaccine are needed for protection.
- Edinburgh has high rates of MMR vaccination and so most people will be protected from the virus.

A press release was issued to the media and was taken up by a several news outlets. The number of cases was updated daily on the NHS Lothian website. Social media messages were distributed through NHS Lothian social media accounts. An NHS 24 helpline was set up specifically to deal with measles enquiries. The helpline was not widely used and the number of calls managed by the helpline are outlined in Appendix 3.

Communication with clinicians

Information for Primary Care was distributed to all Edinburgh GPs, particularly the medical practices linked to the University of Edinburgh. Primary Care clinical guidance was distributed and updated periodically. Information was frequently relayed to this group, including the Director of Public Health and Health Policy attending the GP subcommittee to brief them. This was crucial as the rapid response of primary care, particularly in advising patients to phone ahead and fast tracking patients into a consulting room to prevent the avoidable exposure of others in waiting rooms, was vital in limiting of the spread of infection.

Further communications were distributed to those in acute services, particularly in emergency departments and assessment units. These included information on the possible presentation of cases and included occupational health advice.

6. Resource use

Over the duration of the outbreak additional costs were incurred. These additional costs are outlined in table 8. The estimated extra costs of these items are £52,698, however this is likely to be an underestimate as some categories were not included including staff overtime and hospital admissions.

Table 8. Additional costs accrued over the duration of the outbreak

Expenditure area	*Cost*
Laboratory testing	£27,852
MMR Vaccine	£12,161
Staff bank-vaccination clinics	£11,900
Instruments and sundries including clinical waste, dressings	£379
Catering	£406
Total	**£52,698**

Extra laboratory investigations made up the majority of excess costs incurred during the outbreak. The table below shows how these costs were incurred. The IgG testing performed includes the 1,407 tests performed by Occupational Health.

Table 9. Cost of measles IgG and PCR testing

Test	Number	Cost per test	Total cost
Measles PCR	263	£9.32	£2462
Measles IgG	1552	£16.36	£25,390
Total			£27,852

7. Discussion and Conclusions

This outbreak illustrated the ease by which measles infection can spread within a further educational setting in Scotland. Currently there is a cohort of measles susceptible individuals in UK educational settings, including universities and secondary schools. Our highly interconnected population of university students were children during the MMR scare linking MMR vaccine with autism and were not vaccinated as children. In addition, there are a large number of international students at the University of Edinburgh who may have grown up in countries with suboptimal rates of MMR vaccination.

Despite the University of Edinburgh advising that all students should be fully vaccinated with two doses of MMR before matriculation it would appear that many are either unvaccinated or unsure of their status. Closer working between the universities and NHS Lothian will help with prevention and preparedness for future outbreaks.

The success in containing this outbreak and preventing spread to the wider population was due to the extensive work undertaken in and out of hours that led to the prompt detection and exclusion of cases and their unvaccinated contacts, the high background MMR vaccination rates in Lothian and the prompt setting up of drop in MMR vaccination clinics at the University. Over 1200 MMR vaccinations were given to staff and students.

A multiagency debrief was held on 9th December 2016. On review, the response was considered to be robust with effective working between many different departments and agencies. These departments were both within the NHS, such as the Occupational Health or Infection Control departments, and external agencies such as the University of Edinburgh.

During the outbreak there were practical issues with infection prevention and control measures in primary care and for ambulance staff. These included procurement of personal protective equipment and the practicalities of using respiratory protection (FFP3 masks/Jupiter Hoods). These issues also surfaced during the management of suspected MERS cases in primary care and in the 2009 response to the pandemic Influenza A (H1N1). On each occasion, practical and pragmatic solutions have been identified. To ensure that a robust response is sustainable, NHS Lothian needs to ensure that the major outbreak plan that covers the primary and secondary care response for a highly infectious disease like measles or an emerging infection and that it is sufficiently explicit about the procurement and deployment of personal protective equipment and other environmental interventions (e.g. negative pressure rooms) that are designed to reduce exposure.

Practical difficulties did occur throughout the outbreak such as organising clinical sampling (throat swabbing) and virological testing for suspected cases out of hours. This required the provision of a bank nurse who was available to provide testing.

This outbreak has once again identified the challenges the NHS Lothian Occupational Health Service faces in establishing complete immunisation records for employees. Staff members are currently within their rights to decline the offer of vaccination. NHS Lothian, as an

organisation, however needs to determine the position it will adopt based on assessment of the risk in the following scenarios:

- Where staff members decline the offer of measles vaccination despite being employed in high risk work areas.
- Where employees who have previously declined the offer of vaccination that could offer them protection and consequently protect their patients (where it was not contraindicated) have to be excluded from work in the event of an outbreak.

For newly appointed healthcare workers, a similar approach to MMR vaccination as is currently in place for Hepatitis B vaccination should be considered. This would greatly enhance the preparedness of the organisation in relation to future measles outbreaks.

The following themes were identified at the debrief:

Promotion of MMR vaccination

This was an avoidable outbreak as measles is a vaccine preventable disease. NHS Lothian will work to continue efforts to ensure all target groups are fully vaccinated with two doses of MMR, especially with those who may have missed MMR in childhood and are now in secondary school or university. In addition, international students are a highly susceptible population for measles.

Procedures for ensuring adequately vaccinated frontline staff

NHS Lothian frontline staff should be fully protected against vaccine preventable infections. The Occupational Health Service is reviewing staff records to update a database on the measles immunity status of staff. This will allow rapid staff follow up in the event of another outbreak as well as ensuring those staff without immunity or vaccination are offered MMR.

Infection prevention and control measures in primary care

The infection prevention and control measures used in the outbreak were discussed including procurement of personal protective equipment and the practicalities of using respiratory protection (FFP3 masks/Jupiter Hoods) in primary and secondary care. There should be a clear set of practical recommendations around the procurement and use of personal protective equipment for measles and other emerging infections.

Clear co-ordination and communication with other agencies and departments

Better feedback and communication between agencies can prevent the distribution of inappropriate wider communications to the public. GP feedback reported that clear clinical guidance without frequent changes would have been more useful.

Rapid vaccination and measures to implement this when needed is highly important for similar outbreaks

There were some logistical and planning difficulties in quickly implementing vaccination clinics. Targeting vulnerable groups (unvaccinated children at schools or university students) was an effective strategy and the NHS Lothian Community Vaccination Team is critical to this function. The mass vaccination plan for NHS Lothian should be updated and include practical appendices.

8. Recommendations

1. Prevention of similar outbreaks: This was an avoidable outbreak as measles is a vaccine preventable disease. NHS Lothian is recommended to continue efforts to ensure all target groups are fully vaccinated with two doses of MMR, especially with those who may have missed MMR in childhood and are now in secondary school or university. Lead: LICOG

2. NHS Lothian should have a clear set of practical recommendations for the use of personal protective equipment in primary care and secondary care for measles and other emerging infections. Lead: NHS Lothian Health Protection Team /IPCT/LICAC

3. NHS Lothian Health Protection Team to clarify the arrangements for flight contact tracing with Health Protection Scotland. Lead: NHS Lothian Health Protection Team

4. NHS Lothian should clearly recognise that the department of Occupational Health has a crucial role in protecting staff from vaccine preventable diseases before staff exposure occurs. The Occupational Health Service, together with management, to ensure that staff in vulnerable areas are protected against measles and other vaccine preventable infections. Lead: Occupational Health/LICAC

5. NHS Lothian to review and test the NHS Lothian mass vaccination plan to ensure it covers a range of scenarios and practical issues e.g. venues, staffing, how to set up a vaccination clinics, ordering supplies, waste disposal. Lead: NHS Lothian Health Protection

6. NHS Lothian Communications department to set up intranet site for similar situations so that the clinical guidance is accessible during an outbreak. Lead: NHS Lothian Communications

7. Joint working with Universities: NHS Lothian to develop outbreak plans (including information cascades) with universities in advance of an outbreak. Lead: NHS Lothian Health Protection

8. Scottish Ambulance Service to review their measles protection and infection prevention and control in non-Special Operations Response Team (SORT) ambulances. Lead: Scottish Ambulance Service

9. References

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2. David N. Durrheim, Natasha S. Crowcroft, Peter M. Strebel. Measles – The epidemiology of elimination. *Vaccine*, 2014, 32 (51): 6880-6883.

3. Health Protection Scotland. (2017). *Measles Surveillance & Epidemiology - Immunisation and Vaccines - HPS*. [online] Available at: http://www.hps.scot.nhs.uk/immvax/measlesdata.aspx [Accessed 14th April 2017]

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5. Health Protection Network. Guideline for the Control of Measles Incidents and Outbreaks in Scotland. Health Protection Network Scottish Guidance 4 (2014 Edition). Health Protection Scotland, Glasgow, 2014.

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10. Appendices

Appendix 1 – IMT membership

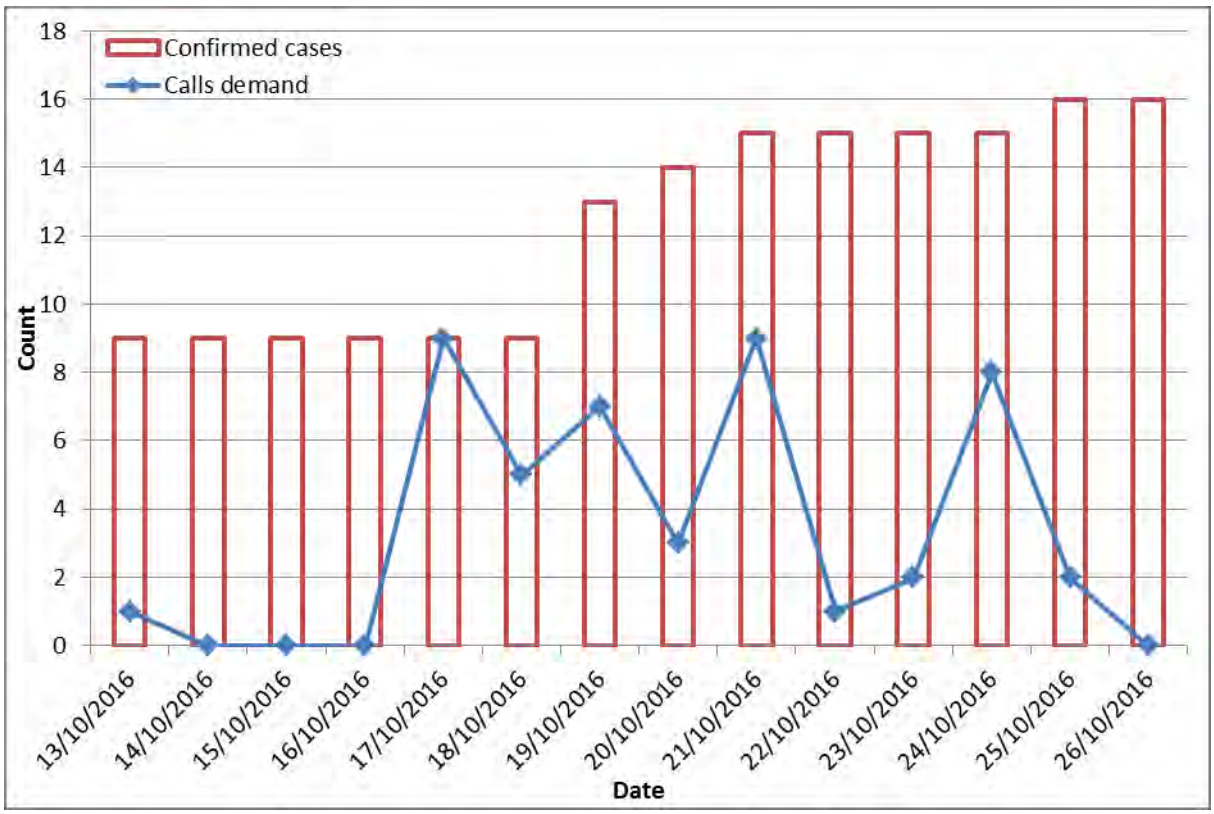
NHS Lothian - Directorate of Public Health and Health Policy	Duncan McCormick– Consultant in Public Health Richard Othieno – Consultant in Public Health Christine Evans – Consultant in Public Health Lorna Willocks – Consultant in Public Health Janet Stevenson – Consultant in Public Health Dona Milne – Consultant in Public Health Allison McCallum – Director of Public Health Louise Wellington – Lead Health Protection Nurse Lindsay Davis - Lead Health Protection Nurse Jenni Strachan - Health Protection Nurse Peter Harrison - Health Protection Nurse Audrey Pringle - Health Protection Nurse Josie Murray – Public Health Speciality Registrar Amir Kirolos – Public Health Speciality Registrar Hannah Austin – Public Health Speciality Registrar Catriona Waugh – Surveillance Officer
NHS Lothian Infection Prevention & Control	Lindsay Guthrie – Lead Infection Prevention and Control Nurse Jean Harper – Infection Prevention and Control Nurse Emma Franklin – Infection Prevention and Control Nurse Eithne Greenshields – Infection Prevention and Control Nurse Carol Calder – Geographic Lead North, Infection Prevention and Control Nurse Victoria Cosgrove – Infection Prevention and Control Nurse Carol Horsburgh – Infection Prevention and Control Nurse
NHS Lothian Occupational Health	Funbi Ogundipe – Occupational Health Consultant Allison McClintick – Chief Nurse, Occupational Health Karen Rule – Occupational Health Nurse Freda McGlyn – Occupational Health Nurse Kirsty Hickie – Occupational Health Nurse Alistair Leckie – Lothian Occupational Health, Director Elaine Clibborn – Occupational Health Advisor Jane Rintoul – Senior Occupational Health Nurse Emma Brown– Occupational Health Emma Robinson– Occupational Health
Virology/Microbiology	Ingolfur Johannessen – Consultant Clinical Virologist and Director of Laboratories Kate Templeton – Consultant Clinical Scientist John Bremmner – Consultant Clinical Virologist Donald Inverarity – Consultant Microbiologist Pota Kalima – Consultant Microbiologist Intisar Alshukri – Speciality Registrar Katherine Hylands – Speciality Registrar Michael McKenzie- Speciality Registrar
Infectious Diseases	Rebecca Sutherland – Consultant in Infectious Diseases, Western General Daire O'Shea – Consultant in Infectious Diseases, Western General David Wilks – Consultant in Infectious Diseases, Western General
Primary Care	Sian Tucker – Clinical Director, Lothian Unscheduled Care Service Lizzie McGeechan – Primary Care Contractors Organisation Nigel Williams – Medical Director, Primary Care
Pharmacy	Sheila Noble – Senior Pharmacist Garry Todd – Principal Pharmacist

Women and Children's services	Laura Jones – Consultant Paediatrician Fiona Mitchell – Site Director, RHSC Paul Leonard – Lead Clinician, RHSC Lynda Cowie – Chief Nurse, Women and Children's Services Sharon Russell – Senior Charge Nurse Simon Dunns – Deputy Associate Nurse Director Edward Doyle – Associate Medical Director Frances McGuire – Maternity
Western General Hospital	Chris Stirling – Site Director Catriona Rostron – Associate Nurse Director
Royal Infirmary Edinburgh	Angela Tuohy – Service Manager for Capacity & Site Management Chris Connelly – Clinical Nurse Manager Pauline Smith – Clinical Manager for maternity inpatients
St Johns	Aris Tyrothoulakis –Director
Resilience Team, Directorate of Public Health and Health Policy	Louise Addison – Business Continuity Lead
NHS Lothian	David Richardson – Health and Safety Adviser Alexis Burnett – Communications David Ridd - Communications Fiona Ireland – Deputy Director, Nursing Gill Bowler – Procurement Janice Alexander – Associate Chief Nurse
Health Protection Scotland (HPS)	Claire Cameron – Strategic Lead, Vaccine Preventable Diseases Ross Cameron – Epidemiologist Gill Hawkins – Consultant in Public Health Kevin Pollock – Senior Epidemiologist Alison Smith Palmer – Senior Epidemiologist Eleanor Anderson – Consultant in Public Health Robert Seremani – Epidemiologist
NHS 24	Stephen Hart-Service Manager
Scottish Government	Mary Stewart – Health Protection Team Leader

Appendix 2 – List of PAG/ IMTs

PAG/IMT	Date
PAG	27 September 2016
PAG	30 September 2016
PAG	7 October 2016
PAG	8 October 2016
PAG	9 October 2016
IMT	10 October 2016
IMT	12 October 2016
IMT	14 October 2016
IMT	18 October 2016
IMT	21 October 2016
IMT	25 October 2016
IMT	3 November 2016

Appendix 3 - NHS 24 calls



NHS LOTHIAN

Lothian NHS Board meeting
21 June 2017

1.6

Professor Alison McCallum

VACCINATION TRANSFORMATION PROGRAMME (VTP)

1 Purpose of the Report

1.1 The purpose of this report is to brief the NHS Lothian Board on the NHS Scotland Vaccination Transformation Programme and provide an update of progress and planning to date within NHS Lothian.

2 Recommendations

2.1 That the Board supports the programme and the overall aim to provide an immunisation service which is person centred, safe and effective by at least maintaining, and ideally improving, uptake and reducing variation.

2.2 That the Board notes and supports that this is a three year programme. No change will be undertaken to current models, including in general practice until a delivery model is identified and put in place which is safe and sustainable.

3 Discussion of key issues

Background

3.1 Vaccination is one of the most effective public health interventions. The rapid curtailment of the measles outbreak in Edinburgh in autumn 2016 (in contrast to many other similar outbreaks across Europe including elsewhere in the UK) was in a large part due to the high levels of immunity from prior vaccination in the Lothian population.

3.2 The vaccination schedule has increased in complexity in recent years. Since 2013, six major new programmes have been introduced as well as various catch up programmes.

3.3 An estimated 3.5m vaccines are administered annually in Scotland, the vast majority (3m) in primary care. Between birth and the age of 14 years, children now receive 20 doses of 11 different vaccines.

Overview of VTP

3.4 In February 2017, Scottish Government (SG) announced a Vaccination Transformation Programme (VTP). Prior to this, SG had been undertaking a review of the delivery of vaccinations in Scotland, prompted by a number of developments including transformation in primary care, the GMS review and by the recent significant extension of the vaccination schedule. This review identified the need for a programme to develop, test and implement models for future delivery of vaccinations.

3.5 The VTP is a nationally led programme, working together with NHS Boards to develop local models suitable to local need.

3.6 The VTP will be a three year programme and commenced on 2 May 2017 at national level. The scope of the programme covers vaccinations administered in primary care, however gives the potential to modernise delivery of other vaccination

programmes. SG has indicated funding will be available for implementation and delivery of the VTP.

3.7 A strategic vaccination group within NHS Lothian, chaired by the Director of Public Health has been convened to oversee the VTP.

3.8 The SG has requested that NHS Boards identify a Business Change Manager, who will be the liaison point between the Programme and the NHS Board. Funding will be made available for backfill of NHS Board staff to lead the programme for the next 3 years. NHS Lothian has bid for a full time programme manager, 0.5 admin support 2 days of Immunisation Co-ordinator (CPHM) time and a public health scientist to provide analytical and improve support.

3.9 Within NHS Lothian the key aspects to the VTP will be transition of vaccinations away from the School Nurse role, alternative arrangements for childhood vaccinations which are currently delivered in primary care through a mixed delivery model of Health Visiting staff and General Practice staff, and alternative delivery of vaccinations delivered by GPs.

Immunisations in schools: transfer from school nursing

3.10 CEL 2013 (13): Public Health Nursing, Future Focus creates a new pathway for school nursing and removes the delivery of vaccination from the school nurse role. Planning is already at an advanced stage within Lothian for the Community Vaccination Team (CVT) to take over the full range of school vaccination programmes from School Nursing.

3.11 CVT already deliver flu vaccination in all 254 primary schools and deliver HPV vaccination and teenage booster/meningitis ACWY vaccination in independent secondary schools. This will expand their role to encompass immunisations in all 77 Lothian secondary schools. The expected timescale of CVT taking over the full remit of school programmes is January 2018, with recruitment from June 2017. Excellence in collaboration with school nurses will remain a crucial aspect in ensuring successful uptake.

3.12 Funding for additional term time staff to be recruited to the CVT has been identified from within the expanded immunisation programme budget and through a realignment within the CVT budget. It is hoped that this supplementary funding will be recouped from the national VTP.

Childhood immunisations and health visiting staff

3.13 Within Lothian there is a ‘mixed economy’ of delivery of infant and pre school immunisations. All in West Lothian and most within the other areas are undertaken by health visiting staff (predominantly staff nurses). In quite a number of practices they are undertaken by practice nurses and in a few by GPs.

3.14 CEL 2013 (13) creates a new pathway for Health Visiting and also removes the delivery of vaccination for the childhood programme from Health Visitors

3.15 The Lothian VTP will prioritise the change to delivery of childhood immunisations next to the school nursing transition. Staffing, accommodation, IT and funding requirements are included with the options appraisal. Key options being explored include potential retention of band 5 health visiting staff nurses with an immunisation remit and expansion of CVT.

Primary care transformation: General practice

3.16 General practice is crucial to all community vaccination programmes and also currently directly offers a range of vaccinations through various contractual arrangements such as Directed Enhanced Services and Local Enhanced Services e.g. flu vaccination (adults and children), pertussis in pregnancy, shingles

vaccination (adults), travel vaccination and various ad hoc immunisations for people at risk. As part of the work to modernise primary care GPs have requested transfer of responsibility of immunisation and as such will no longer be the preferred provider. This work is the core of the VTP.

4 Key Risks

4.1 There is a risk that the current high levels of childhood vaccination could be compromised by changes to the delivery of these programmes. The VTP must ensure mitigation of this risk and at worst retain the current levels of uptake and at best improve them and reduce variation.

4.2 There is a risk that the requirement for additional staff and the ability to recruit sufficiently may not be achievable.

4.3 Safe sharing of data is necessary to support vaccination activity and there could be a risk in this process if the requisite governance is not in place or followed.

5 Risk register

5.1 No elements have been added to the register as yet. This will be kept under review.

6 Impact on inequality, including inequalities

6.1 No formal impact assessment has been carried out to date. However, we have detailed data about our immunisation across Lothian, and comparisons with the rest of Scotland. Lothian has always had a very good record of 0-5 immunisation uptake, but this has recently fallen and may be linked to queue systems in some practices which are struggling to deliver efficiently. This offers a health protection risk but also has an impact on inequalities as the uptake can be lower in areas of multiple deprivation.

7. Duty to inform, engage and consult with people who use our services

7.1 This will be an integral part of the work, nationally and within NHS Lothian.

8. Resource implications

6.2 Substantial resources will be required. SG has indicated that 'funding will be made available to assist Boards to set up and deliver the new model'.

Ruth Burns and Lorna Willocks
Immunisation Coordinator
14 June 2017
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List of Appendices

Appendix 1: Current delivery of immunisations

NHS Lothian Vaccination Programme Information April 2017

Immunisations	Age	Delivered By	Notes
Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) vaccine Pneumococcal vaccine Rotavirus vaccine (oral) Meningitis B	2 months	Primary Care	Differs across and within localities which staff deliver e.g. HV teams, Practice nurses
Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) vaccine Rotavirus vaccine (oral)	3 months	Primary Care	Differs across and within localities which staff deliver e.g. HV teams, Practice nurses
Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) vaccine Pneumococcal vaccine Meningitis B	4 months	Primary Care	Differs across and within localities which staff deliver e.g. HV teams, Practice nurses
Hib /Meningitis C MMR Pneumococcal Meningitis B	Between 12 and 13 months	Primary Care	Differs across and within localities which staff deliver e.g. HV teams, Practice nurses
Diphtheria, tetanus, pertussis (whooping cough), polio MMR	3yrs 4 months (Pre school booster)	Primary Care	Differs across and within localities which staff deliver e.g. HV teams, Practice nurses
Secondary School Programmes			
HPV – usually January of each year	S1, S2	School Nursing / Community Vaccination Team	Changed to 2 dose schedule from January 2015, 12 months apart (some exclusions to this timescale apply). School sessions include catch up for S3-S6 who have not already received this)

		(CVT) Primary care – some practices have signed LES to vaccinate girls who have not received vaccination at school	Post programme mop-ups offered in school or clinic via school nursing / CVT
Teenage Booster Diphtheria, Tetanus and Polio Meningitis ACWY	S3	School Nursing and CVT	Mop-ups for S4-S6 if have not already had vaccination Spring term
MMR Mop-up	Secondary schools	CVT	As required
Flu Vaccination Programme - Autumn			
Clinical at risk groups Pregnant women	6m – under 65 yrs NA	Primary Care Primary Care	NB Primary school aged children in a clinical at risk group can be vaccinated via the school programme or at GP surgery if practice has signed up to the LES covering this option to provide choice for vaccination early in the season.
Preschool children	2-5yrs and not yet at school	Primary Care	
Primary school aged children	P1-P7	CVT	Via schools
Over 65 yrs	65+ yrs	Primary Care	
Staff Flu		NHS Lothian vaccinators	Practices may also carry out some of these vaccinations
Other programmes			
Pertussis – pregnant women	16-38 wks gestation	Primary Care	
Pneumococcal Clinical at risk groups Over 65 yrs	6m – under 65 yrs 65+ yrs	Primary Care	
Zoster - programme runs 1 September – 31 August each year	70,76, 77, 78 & 79yrs	Primary Care	Cohort details awaited for 2017 programme

Hepatitis B	Babies and adults	Variation in who delivers	LES in place for primary care
BCG- children at risk	Babies to <6yrs	CVT	Community clinics TB service in acute sector also vaccinate
Post natal MMR if required		Midwifery or medical staff	
Travel vaccinations		Travel clinic or primary care	

NB CVT also provide vaccination to Gypsy Traveller Communities on site.

NB for 2017 – final details awaited for:

Hexavalent 6:1

HPV MSM

NHS LOTHIAN

Board Meeting
21 June 2017

1.7

Board Chairman

COMMITTEE MEMBERSHIPS AND MIDLOTHIAN INTEGRATION JOINT BOARD APPOINTMENTS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to confirm the following appointments to NHS Lothian Committees and Midlothian Integration Joint Board. Any member wishing additional information should contact the Chairman in advance of the meeting.

2 Recommendations

2.1 The Board is invited to confirm the following appointments to NHS Lothian's Committees and the Integration Joint Boards:

NHS Lothian Committees

- Audit and Risk Committee: To confirm Michael Ash as Chair
- Remuneration Committee: To confirm Alison Mitchell as Member
- Organ Donation Sub Group: To confirm Kay Blair as Chair
- Pharmacy Practices Committee (PPC):
  - Ms Fiona O'Donnell To confirm as Chair
  - Mr Derek Milligan To confirm as Deputy Chair
  - Mr Shahzad Aziz To appoint as Deputy Contractor Member

Midlothian Integration Joint Board

- To appoint John Oates as Chair/Vice Chair
- To appoint Tracey Gillies as member

3 Discussion of Key Issues

3.1 Mrs Julie McDowell, who previously chaired the Audit & Risk Committee, came to the end of her Health Board membership on 31 May 2017. Therefore a new Audit Chair was necessary and Mr Michael Ash has been nominated. A replacement member for Mrs McDowell was also required for the Remuneration Committee; Mrs Alison Mitchell has been nominated. Mrs Kay Blair is to take over as chair of the Organ Donation Sub Group from Dr Richard Williams. This is to allow Dr Williams more time to concentrate on chairing the Board's Healthcare Governance Committee

3.2 Mr Peter Johnston, who had been chairing the Pharmacy Practices Committee, has recently stepped down as a non-executive member of the NHS Board. Cllr Catherine Johnstone (Deputy Chair) will not be the Midlothian Council representative on the NHS Board following the 2017 local council elections. Therefore there is a requirement to appoint both a new Chair and Deputy Chair for the PPC.

3.3 It is proposed that Councillors Fiona O'Donnell and Derek Milligan be appointed as the chair and deputy chair respectively for the Pharmacy Practices Committee. The appointments will coincide with their appointments as members of the NHS Board. The proposed appointments have been discussed with the individuals and they have agreed to undertake these positions upon the Cabinet Secretary for Health, Wellbeing and Sport confirming their appointments to the NHS Board.

3.4 There is also a vacancy on the Pharmacy Practices Committee for a deputy contractor pharmacist. The Lothian Area Pharmaceutical Committee has identified and nominated Mr Shahzad Aziz for this position.

4 Key Risks

4.1 The proposed appointments ensure that there is adequate non-executive representation on the Board's committees, and that the Board has its voting members in place on integration joint boards.

In relation to the Pharmacy Practices Committee, failure to make these appointments would mean that the Board cannot fulfil its statutory responsibility to consider applications for admission to the Pharmaceutical List in accordance with regulatory timescales. NHS Lothian cannot currently convene its Pharmacy Practices Committee and is significantly out with the regulatory timescale with two pharmacy applications due to existing conflicts of interest.

5 Risk Register

5.1 There is no requirement for the matter to be on a risk register at the current time.

6 Impact on Inequality, Including Health Inequalities

6.1 An integrated impact assessment is not required.

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

7.1 The nature of this paper is administrative, with no obvious and direct link to the content of future changes or decisions that may lead to impacts on people.

8 Resource Implications

8.1 There are no resource implications; this is a purely administrative matter.

Chris Graham
Secretariat Manager
13 June 2017
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1.8

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9:30 on Wednesday 15 March 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr M. Hill, Non-Executive Board Member (Chair); Mrs K. Blair, Non-Executive Board Member; Miss T. Gillies, Medical Director; Ms S. Goldsmith, Director of Finance; Cllr R. Henderson, Non-Executive Board Member; Mr. P Johnston, Non-Executive Board Member; Prof. A McMahon, Executive Director, Nursing, Midwifery and AHPs; Mr P. Murray, Non-Executive Board Member; Prof. M Whyte, Non-Executive Board Member and Ms L. Williams, Non-Executive Board Member.

In Attendance: Mr C. Marriott, Deputy Director of Finance; Mr R. Sedgley, Senior Project Manager E&P, Finance Department, NHS Lothian (Item 62); Mr M. Egan, Director of eHealth, NHS Lothian (item 64.2); Mr D. Small, Chief Officer, East Lothian Health & Social Care Partnership (Items 64.3 & 64.4); Mr I. Graham, Director of Capital Planning and Projects; Ms J. Campbell, Acting Chief Officer, Acute Services; Mr J. Crombie, Chief Officer, Acute Services; Mr A. Tyrothoulakis, Pan Lothian Service Director (DATCC) and Site Director (Interim) at St Johns Hospital; Mr C. Stirling, Site Director, Western General Hospital (Item 64.1); Ms L. Cullen, Senior Communications Officer, NHS Lothian and Mr C. Graham, Secretariat Manager (Minutes)

Apologies for absence were received from Mr B. Houston.

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. The Chair welcomed members to his first meeting as Chair.

58. Minutes from Previous Meeting (18 January 2017 & 30 November 2016 amendment)

58.1 The minutes from the meeting held on 18 January 2017 were approved as a correct record. The Committee also agreed the minor amendments to the 30 November 2016 minutes in order to provide an extract for MacRoberts/Consort on the Domestic Services Commercial Agreement.

59. Running Action Note

59.1 The updated cumulative action note had been previously circulated.

60. Matters Arising

60.1 Members' Development Session Update - It was noted that the F&R Members training session would be held on 21 April 2017. The session was an important opportunity for the group to consider the role of the Committee moving forward.

60.1.1 In relation to the F&R integration development session held on 3 March, Mrs Goldsmith reported that a note of the session had now been prepared. The challenge was to now turn the output into something meaningful for the Committee's terms of reference around integration joint boards (IJBs) and their ownership. The Committee needs to be assured when work relating to IJBs comes in front of the Committee. Draft revised terms of reference would come to the May F&R Meeting.

SG

60.1.2 The Chair added that the integration session had been very useful and there had been wide ranging discussion with a range of actions emerging. There was a piece of work around performance management for the Committee to map out and how the Committee could add value if the Committee had better oversight of the IJB system. The Chair suggested that some time could be allowed at the session on 21 April for further discussion on the Committee terms of reference. Mr Marriott and the Chair would look to arrange the training session agenda to allow for this.

CM/MH

60.2 Cancer Centre Update - Ms Campbell stated that as previously reported the strategic assessment had been submitted to the Scottish Government in December 2016. It was noted that investment in the programme infrastructure had been approved and that the substructure programme and work around haematology were now moving forward.

60.2.1 Mrs Goldsmith added that there needed to be consideration of the point at which the Scottish Government were engaged as there would be the opportunity for help around at least the bridging project. The Chair asked if it was clear that the Scottish Government were likely to support the project.

60.2.2 Mr Crombie stated that the importance of the project had been flagged to the Scottish Government and there was the desire to put a formal framework around this work given the scarcity of NHS capital. This required the strategy to be well thought out and for the Cancer Centre to be considered as an East of Scotland asset.

60.2.3 Mrs Blair pointed out that there needed to be clarity around the bridging project; the centre was in urgent need of repair. Whilst the care was considered wonderful the facility itself was dreadful. Mrs Goldsmith and Mr Crombie would continue to lead on keeping up momentum and pressure on the progress of the work.

61. Financial Performance

61.1 Month 11 2016-17 Financial Position

61.1.1 Mr Marriott spoke to the previously circulated paper. Mr Marriott outlined that the position was in the trajectory phase towards a break even position. The £1.4M year to date overspend was noted. Mr Marriott stated there was significant assurance of a break even position at the end of the year.

61.1.2 The Committee discussed some of the highlights from the report including junior doctors pressure; recent successes within nursing; the focus on the permanent nurse staffing position; strong leadership within nursing and GP prescribing.

61.1.3 The Committee also expressed concerns around efficiency savings. It was noted that teams were working on delivery of savings and also the reduction of the gap. The Chair thanked Mr Marriott for his overview and stated that there was significant assurance of balance at the year end and this was as good a position as could be expected.

61.1.4 Mrs Blair asked about work around efficiency savings and what learning and best practice was being taken from this. Mr Marriott explained that there was a multi faceted approach with the number of projects going on. Work with all business units was continuous throughout the year looking at delivery of savings and controlled expenditure.

61.1.5 There was further discussion on the nursing success in year and the work around sustainability and value. It was recognised that strong leadership to support projects was crucial and if there was not strong leadership along with additional support then there was less chance of delivery.

61.1.6 Professor McMahon stated that whilst leadership was important, team effort was also a large part of the success. Within nursing there had been discipline in setting dates and timelines for example the stopping of agency use. The establishment of the rolling programme of site recruitment had also proved successful whilst not compromising patient safety or quality of care. The Chair acknowledged the hard work undertaken, particularly within nursing.

61.1.7 Members accepted the recommendations laid out in the paper.

61.2 2017-18 Financial Plan - Mrs Goldsmith reported that there had been a number of financial planning meetings to scrutinise the numbers. As had been the case in the past couple of years the Board would be unable to produce a financial plan that balances for the 1st April.

61.2.1 Mrs Goldsmith covered the detail contained within the Plan, it was noted that there would be no recurring flexibility and that all reserves would be played in, meaning going into 2018/19 with no reserves which was would add to pressure. Mrs Goldsmith added that the next key piece of work would be moving from the current position to one of recurring balance.

61.2.2 There was discussion on financial plans and opportunities within business units; benefits of one off asset sales; GP prescribing pressures; IJBs financial plans and concerns about the Board carrying more risk than IJB partners; benefits to the system of reducing delayed discharges; regional plans and opportunities regionally; the acute forecast and use of the independent sector and the benefits of the Quality Improvement approach.

61.2.3 It was also noted that the Directors of Finance across Scotland were looking to work together in different ways in relation to areas such as funding from other sources and VAT opportunities. Mr Murray asked for clarity around the Barnet consequentials. Mrs Goldsmith stated that these had not yet been factored in.

61.2.4 The Chair thanked Mrs Goldsmith for pulling together such a complex set of issues. It was important to keep pressure on the Scottish Government about additional funding and NRAC. Mrs Goldsmith stated that the main focus would be on recurring positions.

61.2.5 Ms Williams raised a point about the tangibility of the recovery. The Chair agreed this was an important point, noting that within the £25M recovery plan only £1.5M was accounted for by service redesign and this was not acceptable; there needed to be more fundamental thinking around this.

61.2.6 Professor Whyte asked about strategies in place to tackle the prescribing issues. Miss Gillies stated that there were underlying differences between the GP prescribing budget and actual spend. GP prescribing was relative stable but there were other factors that impacted this such as demographic and population growth. There was work ongoing to look at areas of value around medicines prescribing and patient benefit and poly-pharmacy reviews were part of this.

61.2.7 It was noted that within Acute prescribing, which is a massive area of spend, there was a £2M "war chest" provided to help tackle the issues. Miss Gillies pointed out that Acute already had poly-pharmacy schemes and that the "war chest" was to look at additional schemes, not duplicate those already present.

61.2.8 Members accepted the recommendations laid out in the paper. The Plan would now go to the April Board meeting following further refinement and Mrs Goldsmith would bring an outline financial strategy to the May F&R Meeting.

SG

62. Theatres Improvement Programme (TIP)

The Chair welcomed Mr Sedgley to the meeting.

62.1 Mr Sedgley spoke to the circulated paper giving an update on progress since the previous F&R meeting. The Committee noted the moderate assurance level along with the appropriate caveats.

62.2 It was noted that the TIP started last year and had taken time to get resources arranged. There had been three engagement events and the feedback from these events had been used and built into seven projects. There was discussion on the risks and challenges the programme faces; the need for measurable benefits to be clearly identified and agreed at early onset and the need to take time to start each project and understand how to move each one forward.

62.3 The Committee noted that the programme did not have a budget with backfill for project staff; salary costs for the senior programme manager and equipment and accommodation costs. The programme did however benefit from external Scottish Government funding.

62.4 The Chair thanked Mr Sedgley for the comprehensive update and asked if the Board's Acute Committee had been involved. Mrs Blair confirmed that the Acute Committee had received several presentations on the topic and was supportive of the longer time it had taken to get to this stage given the larger scope from the Deloitte

report. Mrs Blair suggested that the moderate assurance level may be too high as the work was not really at the first stage yet.

62.5 Mr Tyrothoulakis stated that in relation to clinical engagement and the three events that had been held there had been good engagement with clinical teams, theatres and surgical specialities. There was discussion on cultural and behavioural change; factors within the scope of the programme and the relevance of the regionalisation agenda moving forward.

62.6 The Chair raised the suggested moderate assurance level for discussion given concerns that were expressed. After discussion it was agreed that the Committee would be happy with the moderate assurance level as long as this was rephrased to clarify it related to the programme approach rather than delivery.

62.7 The Committee were content to receive the report on progress to date and agreed the moderate assurance level, clarifying this was to the approach rather than the deliverability at this stage.

63. Property and Asset Management

63.1 Property and Asset Management Investment Programme - Mr Graham spoke to the previously circulated paper and highlighted the following points of interest:

- Spend of allocation was as expected, £25.3m against £300m of construction underway
- The prioritisation of some programmes is being revised following Corporate Management Team review last month. Further information would come back to F&R as part of the Capital Investment Programme.
- Royal Edinburgh Hospital – fit out complete and the building has been handed over. Commissioning underway and the anti-ligature work was ongoing
- Royal Hospital for Sick Children and Department of Neuroscience – Currently 800 operatives on site; still a lot of work to do and commissioning underway
- Lothian Bundle – work ongoing, there is a West Lothian visit to be arranged
- East Lothian Community Hospital – first phase underway, part of the car park has been handed over
- Bio Quarter – City deal still ongoing, Eye Pavilion formal output report awaited
- St. John's Hospital - Improving fire protection through backlog maintenance
- Western General Hospital / Cancer Centre - Biological research facility, opportunity to “piggy back” improvements to operational requirements

Disposals

- Marketing of Royal Hospital for Sick Children in full flow, aiming to mitigate double running costs. There were seven shortlisted bids with second bids coming round shortly
- Marketing of Bangour Village Hospital recommencing, these costs to be offset against monthly saving
- Royal Edinburgh Hospital and Astley Ainslie Hospital disposal plan - Programme to demonstrate stages of project business case, revisiting scope and scale of project

63.2 Mr Murray asked if the capital plan had any relationship to the primary care board and was there any influence over the IJBs. Mr I Graham stated that there was no particular influence and that projects were looked at based on criteria.

63.3 Members accepted the recommendations laid out in the paper, including approval to the marketing of Bangour Village Hospital.

64. Other Items for Discussion

64.1 Renal Expansion at Western General Hospital – Initial Agreement

The Chair welcomed Mr Stirling to the Meeting.

64.1.1 The Committee noted that the incorrect initial agreement had been attached to the circulated paper. Mr Stirling outlined the proposal to replace the current, thirty year old, renal satellite port-a-cabin at the Western General Hospital with a new purpose built facility. It was noted that there had previously been a business case for this which had been put on pause as part of the site master planning works a few years ago.

64.1.2 Mr Stirling stated that the rationale for the facility had not changed, although the detail within the previous business case had requested expansion for up to 14 renal chairs, the demand had now flattened and the current business case would be for 12 chairs. This was also in part due to the continuing work around Realistic Medicine.

64.1.3 The Chair thanked Mr Stirling for the outline and asked the Committee how they wished to proceed with the item given they had not received the correct Initial Agreement document.

64.1.4 It was noted that this would be a major spend. Mrs Goldsmith confirmed that this would come from capital and was below the Scottish Government limit. The Chair asked if delaying further consideration of the item to the next F&R meeting would have any major impact. This was felt not to be the case as pieces of design work could progress in the meantime.

64.1.5 The Committee agreed to defer this item for fuller discussion at the next meeting on 10 May and in the light of the full initial agreement . If anything urgent did arise Mrs Goldsmith and Ms Campbell would address this.

SG/JCam

64.2 Upgrade to Telecomms Systems – Updated Initial Agreement

The Chair welcomed Mr Egan to the Meeting.

64.2.1 Mr Egan gave an overview of the updated Initial Agreement. The first iteration had come to the F&R Committee in August 2016. Following this the document had gone to the Scottish Government Capital Committee for consideration. The Capital Committee had then request an external review in order to bolster the options appraisal and benefits of the case.

64.2.2 Mr Egan then recapped the issues with the current telecoms system which is now reaching 25 years old. It was also noted that there had recently been a 16 hour telephone outage at the Western General Hospital, fortunately the business continuity planning processes had been well executed.

64.2.3 The options original presented in August 2016 had changed slightly as the market place had developed and NHS Tayside were currently upgrading their system and were five months ahead which gave NHS Lothian the benefit of some intelligence. The options were noted as:

1. Do nothing option against background risk
2. Fully designed solution from successful vendor, NHS Lothian retains assets
3. Hybrid digital solution with level of resilience to smaller sites
4. Fully managed solution - vendor owns all hardware

64.2.4 Mr Egan stated that the preferred option was Option 4, the fully managed solution. This option offered the most flexibility and would build in future resilience and allow the new medical devices strategy to be fully taken advantage of. This option would have a revenue implication of £1.7M per annum.

64.2.5 The Committee noted that at the moment NHS Scotland Boards all benefit from a national approach (lines and minutes). This is currently up for renewal and was being led by National Procurement. If NHS Lothian wished to keep its options open then they would not be in a position to sign up to the National Procurement contract. It was also noted that National Procurement were offering the successful vendor exclusive rights which could complicate matters further. The National Procurement approach was not the same move forward which NHS Lothian was considering.

64.2.6 Mr Murray asked about the revenue costs of the preferred solution against an IP solution and when the preferred solution would then need to be replaced. Mr Egan confirmed this would be a seven year deal. There was a concern that the capital costs of the preferred solution appeared to be too good to be true. Mr Egan stated that this reflected the competition in the area and that there would be significant savings to be made. The move to an outline business case would maximise the opportunities for competitive overall costs and would aim to be revenue neutral, at least with the possibility of revenue savings. Mr Egan also confirmed that consideration had been given to working with NHS Tayside; however Tayside had felt they were too far ahead to wait. There was discussion about a register of capital projects between health boards.

64.2.7 The Committee agreed to approve the development of the outline Business Case

64.3 <u>Extension and Refurbishment of Cockenzie Health Centre Standard Business Case</u> - Mr Small gave an overview of the business case. He highlighted a couple of corrections to the paper:

- Recommendation 2 should read – To ask F&R to approve moving to stage one costing subject to capital being available
- At paragraph 8.3 the Revenue Gap should read £81,000; the residual gap remains at £23,000.

64.3.1 Mr Small explained the objective of the extension and refurbishment was to increase the capacity at Cockenzie Health Centre given the projected population growth in the area and to bring the centre up to the standards for modern general practice for the people of Cockenzie, Prestonpans and Longniddry.

64.3.2 Mr Small added that there were also plans being submitted to East Lothian Council at the end of March for the new Blindwells development, which was on the site of a former open-cast coal mine north of Tranent. If this site was approved the plan would be for there to be a medical practice, however Cockenzie would provide the *seed practice* ? for this before moving into the development. Following approvals and depending on capital, the plan would be for the main build to start in 2018/19.

64.3.3 Mr Johnston asked if there had been any discussion with East Lothian Council about opportunities to incorporate council services within the extended building. Mr Small confirmed that at Cockenzie there would be no such opportunities but at Blindwells there would be, this would not be a standalone medical practice.

64.3.4 Mr Murray asked if the model would be around the future ideal of a primary care facility with the intention to build in that infrastructure of pharmacy, physiotherapy etc. Mr Small stated that in line with the new GMS contract the plan would be for more NHS staff within GP practices and there would be additional space for NHS employed staff under the new model.

64.3.5 The Chair stated that before approval to proceed could be given there was still the issue of the recurring revenue gap to be addressed. There needed to be a way of closing the revenue gap against the current financial challenges. Mr Small reported that the residual gap was a facilities cost and would not be bottomed out until 2018/19. The Chair added that there had to be ways found to reach revenue cost neutral or even cost savings. Mrs Goldsmith reminded the Committee that any new facilities cost now becomes a pressure within the facilities budgets. The challenge with every new facility was because they were bigger this required more energy and cleaning but they were more energy efficient. The revenue gap would need to be made clear moving into the next stage.

64.3.6 The Committee approved moving to stage one costing subject to capital being available and the other points around finance being addressed. Mrs Goldsmith would start the appropriate governance processes.

64.4 Musselburgh Health Centre - Post Project Evaluation - Mr I Graham reported that this was the first full post project evaluation to be brought to the Committee, however the normal target would be to report within two years rather than five. It was noted that there were participants mentioned in the report that no longer worked within NHS Lothian. The report was welcomed, although it showed there had been some challenges around contracting and operationally but the community facility was now well received.

64.4.1 Mr Small added that when the services within the new facility were compared to what was available previously, the difference was night and day. Moving into the new

modern fit for purpose building had transformed community and primary care in the area and allowed the closure of Edenhall Hospital.

64.4.2 However there had been some issues, in particular the use of the 'mall' as a public space, and the overall management of the building. There was a need for better use of shared spaces and better coordination of use. It was noted that the substantial increase in service charge costs to practices within the new facility had been sighted by the 2c practice as a contributing factor to its financial difficulty. Mr Small confirmed that the practices had been made very aware of the service charge costs at an early stage of the project and had signed up in principle being aware of this.

64.4.3 The Chair asked about mechanisms for taking lessons from this project about culture change issues and working in different ways and applying these to other projects. Mr Murray added that he would be keen to see lessons learnt incorporated into the Cockenzie project.

64.4.4 There was discussion on developments within Haddington where three practices are sharing the same building. There is one reception and shared treatment room space. It was hoped that lessons learnt around shared public space can influence design here. It was noted that Wester Hailes was a good example of a shared multi-purpose building.

64.4.5 Professor McMahon suggested that it may be helpful if lessons around culture change and service redesign issues could be picked up at the Clinical Change Forum sessions. Mr Crombie added that things have changed within primary care and the evolving culture shift should recognise that. Mr Crombie agreed to take this through the Primary Care Investment and Resdesign Board.

JC

64.4.6 There was discussion on the IJBs involvement and position around this. It was acknowledged that whilst the IJBs do not own buildings or have capital budgets they still have a large part to play in provision of services. The IJBs take the lead role in strategic direction and the Health and Social Care Partnership leads the realising of the vision on the ground.

64.4.7 The Committee noted that the Scottish Government premises review was expected in the next few weeks.

65. For Information

65.1 Property and Asset Management Investment Programme 2016-17 Capital Business Case Monitor had been circulated for information.

65.1 The circulated paper was noted.

66. Any Other Competent Business

66.1 There was no other business.

67. Date of Next Meeting

67.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 10 May 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

67.2 Further meetings would take place on the following dates in 2017:
- Wednesday 12 July 2017;
- Wednesday 20 September 2017;
- Wednesday 15 November 2017.

DRAFT

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9:30 on Wednesday 10 May 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr M. Hill, Non-Executive Board Member (Chair); Ms S. Goldsmith, Director of Finance; Mrs K. Blair, Non-Executive Board Member (until 12:45pm); Prof. M Whyte, Non-Executive Board Member; Ms L. Williams, Non-Executive Board Member (teleconference); Mr P. Murray, Non-Executive Board Member; Miss T. Gillies, Medical Director (from 10am) and Mr B. Houston, Board Chairman.

In Attendance: Mr C. Stirling, Site Director, Western General Hospital (Item 1); Dr C. Whitworth, Consultant Nephrologist, Clinical Lead, Renal & Transplantation (Item 1); Mr C. Marriott, Deputy Director of Finance; Mr I. Graham, Director of Capital Planning and Projects; Ms J. Campbell, Acting Chief Officer, Acute Services; Mr J. Crombie, Chief Officer, Acute Services (from 10.20am); Ms S. Cosens, RHSC & DCN Reprovision Project Manager; Mr A Bone, Asst. Head of Finance (Surgical) (Item 7.5); Ms J Alexander, General Manager RIE (Item 7.5); Ms L Seville, E&P Programme Manager (Item 6.3); Ms L. Cullen, Senior Communications Officer and Mr C. Graham, Secretariat Manager (Minutes).

Apologies for absence were received from Mr. P Johnston; Prof. A McMahon; Prof. A McCallum; Rob McCulloch-Graham and Ms Katie McWilliam (Item 7.4)

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.

1. Western General Hospital Renal Unit Reprovision

1.1 The Chair welcomed Mr Stirling and Dr Whitworth to the meeting.

1.2 Mr Stirling apologised to the Committee for any confusion caused at the previous meeting and reported that the proposal now included revenue consequences and was looking at providing 9-10 dialysis stations. The point had now been reached where the master planning process had finished and supported the preferred option as outlined in the initial agreement. The service redesign was being led from the RIE and the revenue consequences, clinical demand and change in service provision had all now been considered.

1.3 Dr Whitworth reported on the current arrangements whereby if any unit were to be unusable there would be no capacity to accommodate patients in another area, unless this was on a Sunday or between midnight and 7am. If the WGH unit closed because of its current physical state NHS Lothian would be in a very difficult situation. In 2008 there had been planned expansion to dialysis facilities including St. John's Hospital, RIE and Borders. The WGH was the missing piece of this expansion.

1.4 Dr Whitworth added that due to change in practice and conservative care there had been a reduction in growth of patient numbers. The experience shared across Scotland was now a 1-2% annual growth. There was potential to open a new fit for purpose facility which would enhance patient experience and cost effectiveness and could provide additional capacity if the option to have 12 stations went ahead, this would also future proof the service.

1.5 Mrs Blair asked about provision within the new centre for children and younger people. Dr Whitworth pointed out that children and younger people requiring hemodialysis are normally cared for at home or from the RHSC satellite unit which was managed from Glasgow in conjunction with the use of new technology. Dr Whitworth added that the average age of patients starting dialysis was 66 and there were very few patients under the age of 20 requiring regular dialysis.

1.6 There was discussion on financial threshold and the risks associated with retaining the unit in its current structure and not reproviding. This included risk of infection and difficultly with patient access. It was noted that external inspection reports had been highly critical of the current unit's environment. The Chair stated that this was understandable for those who had seen the condition of the unit and the current space available.

1.7 Mrs Goldsmith pointed out the early release of funds being sought to progress this project. Once the initial agreement was approved, money would come from Capital for the project team and design case. This would only go against Revenue if the project could not progress.

1.8 The Committee approved the initial agreement and accepted the recommendations as outlined in the report. The reprovision and expansion of the unit was supported, on the basis that the new unit costs as indicated would take the number of stations available from 9-10, whilst noting that capacity for additional expansion beyond that (up to 12 stations) would be available and would require a separate business case.

2. Minutes from Previous Meeting (15 March 2017)

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

3. Running Action Note

3.1 Cancer Centre - Mrs Goldsmith gave an update on the Cancer Centre. There was to be a Capital Investment meeting at the Western General Hospital next week where there would be dedicated time for discussion on the Cancer Centre, in order to maintain momentum ahead of any Scottish Government announcement. Mrs Goldsmith and Mr Crombie would be meeting Christine McLaughlin, Director for Health Finance, on 15 May to go over this. The implicit understanding is for progress on the initial agreement to continue. There was discussion around the delay of a Scottish Government announcement and whether there was anything further the Board could do to escalate this. It was agreed to await the outcome of the 15 May meeting and to look at flagging concerns through the Board's Annual Report and Governance Statement.

SG/JC

Mr Stirling and Dr Whitworth left the meeting.

3.1.2 F&RC Draft Revised Terms of Reference (Integration Joint Boards) - There was discussion on the two recent F&R training sessions. There had been one session around Integration Joint Boards and a session on Induction. Mr Marriott pointed out that the Induction session had not covered issues raised at the IJB session and the implications for the Committee's Terms of Reference. Mr Marriott agreed to bring a paper back to the next Committee meeting. **CM**

3.1.3 Musselburgh Health Centre Post Project Evaluation – Item to remain on Running Action Note, Jim Crombie to bring back as appropriate. **JC**

4. Matters Arising

4.1 Committee Administration – Mrs Blair raised the governance issue of receiving committee papers on time. The Chair agreed that papers should be issued timeously and this should be good practice where possible. Mrs Goldsmith apologised for the late distribution of the Longer Term Financial Strategy Outline development paper, however it had been felt important to bring Item 6.2 to the Committee today and she would give a presentation on this item.

5. Members Annual Report

5.1 Mrs Goldsmith drew the Committee's attention to the change in format of report. The new format drew a better direct relationship to the terms of reference of the Committee, however the report could further reflect some of the terms of reference. For example it did not cover the Committee's work stream around business cases.

5.2 With reference to the report providing the assurance needed, Mrs Goldsmith reported that the Board's Corporate Governance Manager had been supporting this process and with the move towards papers coming to the Committee providing levels of assurance this would help develop the assurance approach.

5.3 There was discussion on the legalities around property and asset management, and the need to show agreed levels of assurance for completeness if using the reporting template. The need for a separate paper around what constitutes evidence on a property case by case basis was considered. The Chair stated that the Committee had to provide confirmation that the Board's estate was duly managed and responsibilities adequately set out.

5.4 The Committee agreed that a separate paper was not required but the PAMS report should be more explicit on covering levels of assurance. The Committee agreed the format and content of the Annual Report, subject to the revision of the wording from passive to active (use of agree rather than receive) and that no boxes should remain empty with evidence given around agreed levels of assurance.

5.5 There was further discussion around the Committee's terms of reference and to what extent these may be reviewed or amended for next year's annual report to take account of the Integration Joint Boards. Mr Marriott would bring a paper to the next meeting around these discussions. In the meantime the Committee were content with the report's content and agreed that the Chair and Mrs Goldsmith would complete and submit the document.

MH/SG/CM

5.6 The Committee also agreed that the Governance Statement should highlight to the Scottish Government concerns in relation to risks and delays over the Cancer Centre (see 3.3 above) and PAEP.

6. Financial Performance

6.1 2016/17 Draft year end and 2017/18 Financial Plan - Mr Marriott spoke to the previously circulated paper. Mr Marriott outlined that a forecast deficit of £20M was expected and that table one in the paper showed the work undertaken to bring this back into a balanced position without ant recurring support. Mr Marriott also highlighted some positives and negatives at the year end, including the increase in substantive nurse staffing and the primary care £8.3M overspend position. It was also hoped that there would be additional resource from the centre to address access targets; however, this would be non-recurring.

6.1.1 There was discussion on the distribution of finances to IJBs and the IJBs year end position and it was noted that the break even position had not been achieved against the resources provided. The financial plan for next year would be based on using all reserves and would include the fair proportion of resources to IJBs. Mr Murray pointed out the need for meaningful engagement with IJBs around finance; potential impact and making the books balance.

6.1.2 The Chair stated that Mrs Goldsmith and her team should be congratulated for hitting the balanced financial position in 2016/17. It had taken a huge amount of work and effort to achieve and consideration now should be around how this is moved forward. Mrs Goldsmith added that the main positive for the year had been that there were no surprises and that the financial position had remained consistent, stable and predictable.

6.1.3 The Committee noted the recommendations in the paper and recognised the work required around financial management moving forward to be done in partnership with the IJBs. Positive relationships would be necessary as tougher times are encountered.

6.2 Developing a Longer Term Financial Strategy - Outline - Mrs Goldsmith gave a presentation on the item which had been distributed late as it had been hoped that more developed information around the financial strategy may have been available. Unfortunately this had not happened and the paper had turned into a report setting out what was needed to be done rather that including details of what had been done and setting out the context of the financial strategy.

6.2.1 The paper outlined strategic direction locally, regionally and nationally. It was noted that NHS Lothian's Chief Executive had taken on the role as regional lead. The national work included the national clinical strategy and realistic medicine.

6.2.2 Mrs Goldsmith's presentation looked at increased diversion of resources to primary care and community services; house of care and service models; population growth; the challenge of moving from a deficit position on 1st April to a balanced position through the year and what the challenge would look like over the next five years based on the assumption of no uplift from the Scottish Government. Based on this there would have to be a delivery of approximately £190M of efficiency savings over the next five years just to be in a standing still position.

6.2.3 The Committee discussed health improvement responsibilities; skill mix and workforce; the area of prescribing – drug investment, effective prescribing, realistic medicine; more investment in AHPs and rehabilitation to save bed days and improve cost and outcomes; better discovery work, use of our data and benchmarking around improvement opportunities and the embedding of the Quality approach as tool in our services to deliver change over the next five years.

6.2.4 Mrs Goldsmith stated that the next steps of this work would see a significant piece of work and consultation with key individuals and the Executive team. Regional work also added a different dimension and there would be more specificity around IJBs directions.

6.2.5 There was also discussion around the transformation agenda and it was agreed that a paper should come to the next meeting outlining how the transformation agenda will be managed and governed.

SG/CM

6.2.6 The Chair thanked Mrs Goldsmith for her presentation and for setting out the task ahead. Mr Crombie added that there had been similar discussions at the Chief Executives' Forum. It was also hoped that the approach to regional financial planning would be the same. The Committee acknowledged that the discussion had been a good starting point for future conversations.

6.3 Sustainability and Value - Ms Seville reported that the paper described work that NHS Lothian was responding to as part of potential productive opportunities (PPOs) which had been identified using the Discovery diagnostic tool by the Scottish Government Quality and Efficiency Support Team (SG QuEST); as well as those overseen by the National Sustainability and Value Group.

6.3.1 Ms Campbell stated that NHS Lothian's benchmarking group was now well established and meeting monthly. The Chair commented that this work was fascinating and asked if the governance around this sat with the Acute Hospitals Committee. Ms Campbell confirmed that at the moment this was sitting at the DCAQ with service level and peer benchmarking through the Acute Hospitals Committee.

6.3.2 The Committee agreed to endorse the progress towards comprehensive coverage of all identified opportunities and looked forward to further reports at future meetings.

Ms Seville left the meeting.

7. Property and Asset Management

7.1 Property and Asset Management Investment Programme - Mr Graham spoke to the previously circulated paper and highlighted the following points of interest:

- NHS Lothian's main PAM paper to be with Scottish Government by 2 June 2017, noted that last year's national PAM report is still to be published.
- Backlog maintenance and estates – To come to next F&R Meeting as some amendments required.
- Projects Monitoring – report format to be updated for next meeting with more meaningful information to help the Committee with monitoring of approved projects.

- The Royal Hospital for Children and Young People (RHCYP) & DCN – Seeking assurance on completion date remains challenging, delayed until 12 October 2017, IHSL advised of discontent around delay.
- Royal Edinburgh Hospital – Retrofit works ongoing.
- Partnership Bundle - Competition to name new Muirhouse partnership centre. Work on three bundle projects continues tours available on request.
- East Lothian Community Hospital – Noted that the credit agreement allows for syndication or transfer of debt to another lender. As a result of such a transfer taking place the Board require to enter into a Supplemental Agreement to the Funders Direct Agreement and a Supplemental Deed to the Security Trust and Intercreditor Deed (together the "Contracts" .Mrs Goldsmith to sign off on the Contracts and any ancillary documents required in connection therewith. An implication of the transfer of debt to another lender would be the involvement of more banks which could lead to longer process if a consent is required in terms of the credit agreement.
- Primary Care Estate – Assisting with Scottish Government Survey to look at GP Premises Conditions nationally.
- Bangour Village Hospital - Marketing commenced still waiting on Scottish Government Ministers decision on planning appeal.
- Royal Victoria Hospital - Council established asset integration group. One area of interest is to use RVH for housing and/or a care home. Confirmation being sought and would come to next F&R meeting.
- Bio Quarter - City deal progressing, investment identified but scaled back, currently looking at alternative ways to support the structure.
- St. John's Hospital - Ward 20 complete and will be operational from 30 June 2017.
- Royal Edinburgh Hospital and Astley Ainslie Hospital – Outline Business Case for Phase 2 ongoing. Looking at alternative options. Assurance requested for statutory compliance under key risks.

7.1.1 The Committee supported the recommendations in the paper to note the achievement of the Capital Resource Limit (CRL) and associated targets as had been forecast for 2016/17. The Committee also agreed the investment programme for five years from 2017/18, noting the prioritisation process to manage the forecasted over commitment and acknowledged the syndication of senior debt on the East Lothian Community Hospital project agreement.

7.2 Estate Rationalisation Programme - The Committee noted the commercial in confidence nature of the report providing an update on the actions taken to rationalise NHS Lothian's estate during 2016/17 in support of the Board's Asset Management Strategy.

7.2.1 There was discussion around East Lothian Council's interest in the Herdmanflat site at Haddington. The Hospital was due to be vacated as part of the new East Lothian Community Hospital. It was noted that market value for the site was a higher amount than the Council had come up with. The Council had an interest in the site for affordable housing. This was the same situation as with City of Edinburgh Council and the Liberton Hospital site. Mrs Goldsmith suggested that a Committee position on the terms of engagement around this situation would be helpful.

7.2.2 The Committee accepted the significant assurance given that this aspect of the Board's property portfolio is being appropriately progressed and managed and approved the continued engagement with East Lothian Council regarding the Herdmanflat site in Haddington.

7.3 Disposal of Royal Hospital for Sick Children at Sciennes - Mr I Graham reported that it had been hoped to bring the preferred bidder to the committee today for approval. However the marketing of the site had been halted on 24 March due to a Community Right to Buy bid, under Section 37 of the Land Reform Scotland Act. A ministerial decision on this bid was expected on 15th May. This meant that all other bids (7) were now on hold and may or may not stand should the Community Right to Buy be refused.

7.3.1 The paper suggested expending further resources and the risks associated with the late Community Right to Buy application. It was noted that no details of the bid needed to be provided until after a decision was made, a detailed business case would then be required and may take some time, which opens NHS Lothian up to potential risk after the decommissioning stage. The Committee noted that there could be a continued period of uncertainty and cost implications around appeals etc. It was also noted that if the Community bid is accepted then that takes precedent as preferred bidder. Mr Crombie pointed out that a key element of the project had been to hand over liability of the site promptly. The Community bid now brings in legal costs; protraction of appeals and leaves NHS Lothian with the liability burden of a very exposed campus.

7.3.2 The Committee agreed to wait and see the recommendations from Ministers and there would be an update at the next meeting. **IG**

Mrs Blair left the meeting.

7.4 Extension to Ferryfield House Contract - The proposals were agreed by the Committee in principle whilst accepting that the negotiations would continue. There needed to be a more detailed look at contingencies and care home negotiations and a robust explanation of the issues was required. It was agreed to bring this Item back to the next meeting where hopefully Mr McCullough-Graham or colleagues would attend to address some of these points. **RMG**

7.5 Changes to Medical Assessment Services at the Royal Infirmary of Edinburgh (RIE) - Ms Campbell reported that last year's business case had been developed in advance of Integration Joint Boards being established. The Paper now details inclusion of the IJBs as part of the discussion around the planning process.

7.5.1 The paper detailed the RIE as the largest scheduled care site across Scotland. There was discussion on the growth in population; work to prevent admissions; the reduction in unscheduled bed days and reducing the demand on inpatients. It was noted that attendances at the front door impact on the volume of admissions which for RIE was just over 29%.

7.5.2 The Medical Assessment Unit (MAU) carry out rapid assessment and review to try and prevent admissions from the front door and aligns to the IJBs strategic plans. Since November there had been discussion with IJBs about what would be required for IJBs not to invest in the MAU (It was noted that West Lothian IJB had not been included in

discussions as they do not use the Unit at RIE). The required reduction in admissions would be:

- Midlothian 1-2 per day
- East Lothian 1-2 per day
- Edinburgh 12-14 per day

Mr Marriot left the meeting.

7.5.3 The Committee noted that Edinburgh IJB had no confident, detailed plans for preventing 12–14 admissions per day and that in principle the relevant IJB Officers had offered support to investing in the expansion of the Unscheduled Care MAU.

7.5.4 The Chair stated that he had found this a particularly complicated paper, looking for approval for a phase of a larger project and it was expected to have this in place before Winter 2017. Ms Campbell confirmed that it was expected to have Capital and Change in place for Winter. Mrs Goldsmith added that this was dependent on Consort.

7.5.6 There was discussion on Edinburgh IJBs inability to provide alternatives for the admissions. Mr Crombie confirmed that this had been brought to their attention in October/November last year and there was no vehicle for this. Although there was a level of confidence from Midlothian and East Lothian that they could address these admissions, consideration had to be given to the current rapid population growth within these areas.

7.5.7 The Chair questioned how risk would be managed going forward and what the process would be to ensure that non recurring expenditure was actually non recurring. Mr Crombie stated that the data sets could help to look at the tracking of impact. The Data looked at what was actually happening; the yield to front door attendance; admissions and subsequent length of stay. This enabled alternative models to be considered and allowed front door impact to be reviewed.

7.5.8 The Committee noted the ongoing discussions between Acute Services and the IJBs around admissions and revenue costs and approved the capital expenditure required to make sure facilities can be in place for winter 2017-18.

8. Any Other Competent Business

8.1 There was no other business.

9. Date of Next Meeting

9.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 12 July 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

9.2 Further meetings would take place on the following dates in 2017:
- Wednesday 20 September 2017
- Wednesday 15 November 2017

NHS LOTHIAN

Board Meeting
21 June 2017

1.9

Director of Finance

NHS LOTHIAN PATIENTS' PRIVATE FUNDS – ANNUAL ACCOUNTS 2016/17

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to recommend that the patients' funds accounts for the year ended 31 March 2017 for Lothian NHS Board be approved. These accounts were presented to the Audit and Risk Committee for recommendation on 19 June 2017. The report has been prepared prior to the Audit and Risk Committee meeting and the recommendations have been prepared on the presumption that the Committee shall agree to them.

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

2 Recommendations

The Board is invited to:

2.1 Agree the draft Patients' Private Funds accounts for the year-ended 31 March 2017.

2.2 Agree that the Chairman and Chief Executive sign the "Statement of Lothian NHS Board Members' Responsibilities" on the Board's behalf.

2.3 Agree that the Director of Finance and the Chief Executive sign the "Abstract of Receipts and Payments" (SFR 19.0).

2.4 Agree that the Board approve the draft Patients' Private Funds accounts for the year-ended 31 March 2017.

3 Discussion of Key Issues

3.1 The attached draft Patients' funds Annual Accounts consist of :

- A statement of members' responsibilities
- The statement of receipts and payments
- A note on the basis of accounting

3.2 The Auditors, Scott-Moncrieff intend to report that in their opinion the abstract of accounts which have been prepared on the basis required by the NHS Scotland Manual of Accounts, presents fairly the state of the funds administered by the Board on behalf of its patients, as at 31 March 2017. Their full audit report on Patients' Private Funds is attached.

The report indentifies no errors in their receipts and payments testing and made two recommendations through their site visits. The recommendations identified do not have any significant impact on the control environment.

4 Key Risks

4.1 The key risk covered in this process is assurance on the control of Patients' Private Funds administered by NHS Lothian on patients' behalf

5 Risk Register

5.1 There are no risks on any risk register, as this is a well-established process which has operated successfully for many years.

6 Impact on Inequality, Including Health Inequalities

6.1 This is not relevant to this paper, as the paper relates to an external reporting requirement with no proposals for action or change that will impact on people.

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

7.1 This is not relevant to this paper as it does not relate to the planning and development of health services.

8 Resource Implications

8.1 There are no resource issues arising from this paper.

Susan Goldsmith
Director of Finance
15 June 2017
susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Patients' Private Funds Year Ended 31 March 2017
Appendix 2: Management Letter

LOTHIAN NHS BOARD

Patients' Private Funds
Year Ended 31 March 2017

STATEMENT OF LOTHIAN NHS BOARD MEMBERS' RESPONSIBILITIES

The Scottish Government Health and Social Care Directorate, through the Unified NHS Board Manual of Accounts, requires Lothian NHS Board ('the Board') to prepare a consolidated abstract of receipts and payments, on a cash basis, of Patients' Private Funds for each financial year which fairly presents the funds administered by the Board.

NHS Lothian Board members are responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position of the Patients' Private Funds and enable them to ensure that the statement complies with the Unified NHS Board Manual of Accounts. They also have a general responsibility for safeguarding the assets held on behalf of the patients and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As members of Lothian NHS Board, we confirm that the above responsibilities have been discharged during the period 1 April 2016 to 31 March 2017 and in preparing the abstract of receipts and payments.

…….. (Chairman)
Brian Houston

…….. (Chief Executive)
Tim Davison

NHS LOTHIAN **SFR 19.0**

PATIENTS PRIVATE FUNDS

FOR THE YEAR ENDED 31 MARCH 2017

2016 £		TOTAL £
	RECEIPTS	
	Opening Balances:	
50,500	Cash in Bank	25,000
16,775	Cash on Hand	16,775
979,923	Other Funds	1,141,731
1,047,198		1,183,506
1,411,167	From or on behalf of Patients	1,669,832
1,295	Interest on Patients' Fund Account	1,269
2,459,660	**Total Receipts**	**2,854,607**
	PAYMENTS	
1,276,154	To or on behalf of Patients	1,618,646
0	Extra Comforts etc.	0
	Closing Balances:	
25,000	Cash in Bank	25,000
16,775	Cash on Hand	15,975
1,141,731	Other Funds	1,194,986
1,183,506		**1,235,961**
2,459,660	**Total Payments**	**2,854,607**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
1,183,721	Credit Balances	1,235,980
(215)	Less: Debit Balances	(19)
1,183,506		1,235,961
0	Interest Received but not Credited	0
1,183,506	**Total Closing Balance**	**1,235,961**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance _____ Date _____

The abstract of Receipts and Payments was submitted at the NHS Board Meeting on 22 June 2016 and duly approved.

Chief Executive _____ Date _____

NHS LOTHIAN
PATIENTS' PRIVATE FUNDS
YEAR ENDED 31 MARCH 2017

NOTES TO THE ABSTRACT OF RECEIPTS AND PAYMENTS

Note 1

The Scottish Government Health and Social Care Directorate require Lothian NHS Board to prepare, on an annual basis, an abstract of receipts and payments of patients' private funds administered by Lothian NHS Board. The abstract of receipts and payments of the patients' private funds has been prepared by the board, on a cash basis, in accordance with the requirements of the 2016-17 NHS Board Accounts Manual.

Independent auditor's report to Lothian NHS Board

We have audited the Abstract of Receipts and Payments of Patients' Funds in accordance with approved Auditing Standards. In our opinion the statement presents fairly the state of the funds administered by the Board on behalf of its patients, as at 31 March 2017.

Scott-Moncrieff
Registered Auditors

Exchange Place 3
Semple Street
Edinburgh
EH3 8BL

Scott-Moncrieff
business advisers and accountants

The Board of Directors
c/o Doreen Howard
NHS Lothian
Pentland House
47 Robb's Loan
Edinburgh
EH14 1TY

8 June 2017

Our Ref: GD/MXL/RAG

Dear Sirs

NHS Lothian – Patients' Private Funds
Management Letter for year ended 31 March 2017

We have audited the Abstract of Receipts and Payments of Patients' Private Funds in accordance with approved Auditing Standards. We plan to report that in our opinion the statement presents fairly the state of the funds administered by the Board on behalf of its patients, as at 31 March 2017.

In the course of our audit of the abstract of receipts and payments of patients' private funds for the year ended 31 March 2017 we examined the principal internal controls and accounting practices which the Board has established to safeguard patients' funds and to enable it to ensure, as far as possible, the accuracy and reliability of its records both centrally and at individual wards.

The examination of the system of internal control which we carried out cannot necessarily be expected to disclose every weakness, since our audit work is designed primarily to enable us to report on the Board's abstract.

Background

The Board is responsible for the safeguarding of the patients' funds. The total funds under the control of the Board were £1,235,962 as at 31 March 2017.

Scope

Our review consisted primarily of an examination of the cash book and supporting documentation (in particular detailed testing of a selection of receipts and payments), examination of the bank reconciliations throughout the year and the property registers.

The Board of Directors

8 June 2017

Each year we will vary our visits to ensure coverage of all hospital sites on a cyclical basis. Our review this year included ward visits and sample testing of patients' funds transactions for individuals at: Ellen's Glen (Ground Floor), Ferryfield (Willow), Royal Edinburgh (North Wing and Murray Park), St John's (Maple Villa) and Learning Disabilities (Camus Tigh and Primrose Lodge).

The total of the patients' funds as at 31 March 2017 was £1,235,962 of which our testing was based at individual wards within areas holding £688,264 (56% of the total). We are pleased to report that we found no significant errors in our receipts and payments testing and we did not identify any significant control weaknesses through our site visits. We have however noted the following recommendations to further improve controls:

Issues and recommendations:

1. It is standard practice that all patients' funds should be separately identifiable. However, in three wards visited funds were not held on a patient by patient basis. The Board should ensure that all patients' funds held are separately identifiable.

2. Sample testing of patient receipts identified one cash receipt of £50 that was not supported by the standard paperwork. We were able to verify the receipt being received in the bank and the error was not deemed significant in the context of our testing as a whole. The Board should ensure that all payments and receipts are supported by the standard paperwork.

If you require any further information on any matter reported in this letter we will be pleased to assist with your request.

This letter has been prepared solely for internal use of the Board of NHS Lothian and therefore no responsibility can be assumed towards any third parties who might seek to rely upon the information and recommendations it contains. It is requested that the contents of this letter are not made available to third parties without our prior written consent.

Yours faithfully

Scott-Moncrieff

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9:00 on Tuesday 14 March 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr R. Williams, Non-Executive Board Member (chair); Ms S. Allan, Non-Executive Board Member; Ms P. Eccles, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Ms C. Hirst, Non-Executive Board Member; Mr A. Joyce, Employee Director; Mr J. Oates, Non-Executive Board Member; Mr A. Sharp, Patient and Public Representative.

In Attendance: Ms M. Barton, Head of Health, West Lothian Health and Social Care Partnership; Ms J. Bennett, Associate Director for Quality Improvement and Safety; Ms J. Campbell, Acting Chief Officer, Acute Services; Ms K. Dimmock, Information Analyst (observing); Ms M. Don, Senior Project Manager, Efficiency and Productivity (item 63.1); Ms T. Gillies, Medical Director; Mr R. Mackie, Senior Information Analyst (observing); Dr Z. Maung, Consultant Haematologist; Professor A. McCallum, Director of Public Health and Health Policy; Ms T. McIntosh, Clinical Service Development Manager (item 64.5); Professor A. McMahon, Nurse Director; Ms A. McNeillage, Primary Car Contracts Manager (on behalf of Mr Small); Ms J. Morrison, Head of Patient Experience; Ms B. Pillath, Committee Administrator (minutes); Mr A. Short, Head of Primary Care and Older People's Services, Midlothian Health and Social Care Partnership; Mr S. Watson, Chief Quality Officer.

Apologies: Ms S. Ballard-Smith, Nurse Director, Acute Services; Dr B. Cook, Medical Director; Mr J. Crombie, Deputy Chief Executive; Mr J. Forrest, Chief Officer, West Lothian Health and Social Care Partnership; Mr B. Houston, Board Chairman; Ms F. Ireland, Non-Executive Board Member and Chair of Area Clinical Forum; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership; Professor Angela Timoney, Pharmacy Director.

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. Dr Williams declared a non-financial interest in item 64.5 on the agenda, as his Practice had be involved in making this proposal and its approval would affect the way of working at his Practice. Ms Hirst agreed to chair the meeting for this item while Dr Williams absented himself from the meeting room.

58. Patient Story

58.1 There had been discussions between the Chair and the Patient Representatives as to how the Patient Story could be better used by the Committee. There was no patient story at this meeting but these would resume from the next meeting.

59. Minutes from Previous Meeting (17 January 2017)

59.1 The minutes from the meeting held on 17 January 2017 were approved as a correct record.

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

60. Matters Arising

60.1 Respiratory Managed Clinical Network – MCN Lead

60.1.1 Professor McMahon advised that attempts at recruitment for MCN lead remained unsuccessful. This would now be taken forward by Ms Gillies. The MCN team continued to progress the MCN actions in the meantime.

61. Committee Effectiveness

61.1 Corporate Risk Register

61.1.1 The risk register had been previously circulated. Ms Bennett noted that the current waiting times risk was focussed on meeting waiting times targets, but that there was a plan to either amend this risk or add a risk to include review of patients on the waiting list.

61.1.2 Although corporate risk register updates were quarterly, the risks were discussed and reviewed monthly. Any significant change agreed would be described in the report.

61.1.3 A recent internal audit report on the corporate risk register had stated that no weaknesses were apparent in the system.

61.1.4 Members approved the recommendations in the paper and accepted significant assurance that the risks identified were appropriate and actions were being taken.

61.2 Quality and Performance Improvement Report

61.2.1 The paper had been previously circulated. All the areas included in the report were covered on the meeting agendas. Dr Watson had taken on executive leadership of the Quality and Performance Team.

61.2.2 Members approved the recommendations in the paper.

61.3 Draft Assurance Need Statement

61.3.1 The paper had been previously circulated. This statement would inform the Healthcare Governance Committee's annual report to the Board. Members were asked to assess the levels of assurance given for each item and send these to Robert Pritchard. **ALL**

62. Midlothian Health and Social Care Partnership Update

62.1 Mr Short spoke to the previously circulated paper. In response to a question about whether Health and Social Care Partnerships were discussing areas where they

could work together, Mr Short advised that the immediate focus was on needs for individual Partnerships; once these were well understood then more could be done in collaboration.

62.2 'Hot Topics' events were used to update the Patient and Public Forums and voluntary organisations on specific policy and strategy areas, and this allowed feedback. Development of a more effective feedback relationship was planned.

62.3 It was noted that to date the Health and Social Care Partnership updates had considered governance processes, which was appropriate for this stage. The next stage would be to update on patient outcomes.

62.4 There was discussion about the governance relationship between the Health Board and the Integration Joint Board; this was still being worked on. Mr Short advised that any problems would be escalated to the Integration Joint Board Chief Officer, who would determine whether this should be escalated to the Health Board or to the Integration Joint Board and the Council or both.

62.5 Members accepted the recommendations in the paper and accepted moderate assurance on governance process in place.

63. Person Centred Culture

63.1 Complaints and Feedback Update

63.1.1 Ms Morrison and Ms Don gave a presentation on complaints data and on the complaints improvement project.

63.1.2 The Western General Hospital was highlighted as an area where more work was required to reduce the time to respond to complaints, but improvements had already being achieved. Data was reported to the clinical team regularly.

63.1.3 Ms Hirst noted that the 20 day response time was a national target, but there also needed to be a focus on other measures including rate of complaints upheld by the Scottish Public Services Ombudsman, and these measures would be included in future reports.

63.1.4 There was a plan to recruit additional capacity to the Complaints and Feedback Team for this project as the team had been under resourced for some time in comparison to the staffing levels in other Boards.

63.1.5 There had been meetings with three of the four Health and Social Care Partnerships to consider joint management of complaints responses. Edinburgh Council had different strategic directions on this and more work was required.

63.1.6 National complaints reporting was not consistent and the new model expected from National Services Scotland had not yet been made available. NHS Lothian needed to decide on its own measures and reporting. Front line local resolution was under reported but happened every day in clinical areas. Staff had raised concerns about

their capacity to record local resolution. This would be considered at the Staff Governance Committee.

63.1.7 It was agreed that this sort of culture change would take time and that it may not be possible to fully implement this within the timescales laid out.

63.1.8 Members approved the recommendations laid out in the paper and agreed to receive papers every second meeting in future to allow time for progress to be made between updates. Moderate assurance was agreed. **AMcM**

63.2 Patient Experience Update

63.2.1 Ms Morrison spoke to the previously circulated paper. Mr Sharp noted the decision to use volunteers to help distribute patient questionnaires and expected to see a significant improvement in response at the Western General Hospital as a result.

63.2.2 Work was in progress to make a questionnaire that would be more appropriate for children and their families for use in the Royal Hospital for Sick Children. Ms Gormley advised that the Child Community Council volunteers would be willing to help with this.

63.2.3 Ms Morrison noted that it was positive that NHS Lothian had implemented a questionnaire, noting that no other Board had an equivalent. More work was required on implementation and learning from feedback.

63.2.4 Members approved the recommendations laid out in the paper and agreed to receive update papers every second meeting in future to allow time for progress to be made between updates. **AMcM**

64. Safe Care

64.1 REAS and Prison Healthcare Update

64.1.1 Professor McMahon spoke to the previously circulated paper. Dr Williams noted that the Committee had asked for an update in this area as it had not been sighted on assurance arrangements for new work at the Royal Edinburgh Hospital.

64.1.2 There remained high capacity demand; Professor McMahon advised that this was monitored daily and that if the reductions required to move into the new facility did not occur then the move would be delayed until it was safe to do so. There were plans in place to achieve this.

64.1.3 To provide further assurance, Professor McMahon agreed to bring an update on the alternative services being made available to allow patients to be treated in the community instead of as inpatients. **AMcM**

64.1.4 An internal audit report on prison healthcare had shown no weaknesses and that access to healthcare was excellent. Three day complaints resolution was currently being worked on. A Joint Inspection on prison healthcare was due which would give further assurance.

64.1.5 Members accepted the recommendations in the paper and accepted moderate assurance on both prison healthcare and REAS, subject to the request for additional information about community services.

64.2 GP and Primary Care Sustainability

64.2.1 Ms McNeillage presented the previously circulated paper. Mr Short noted that problems experienced by different practices were different and solutions had to be considered on an individual practice basis. There were also complications with a lack of clarity on direction from the Scottish Government and a discrepancy between what senior GPs were saying and what individual practices required. The current model was not sustainable; transformational change was required.

64.2.2 Ms Gillies was now chairing the Primary Care Programme Board which was working on bringing together different workstreams. There would not be a single overall solution and different models would be developed in different areas of Lothian. The aim was to support a small number of capacity building projects which practices could implement at their own pace.

64.2.3 Members were disappointed that there had been no significant change since the previous update and accepted only limited assurance that progress was being made. A further update including a detailed action plan with timescales was to be requested from Mr Small for the meeting on May 2017 as well as each Integration Joint Board's primary care transformational plans at the meeting in July 2017. **DS**

64.2.4 It was noted that the Primary Care Programme Board would have a strategic overview on actions but not a governance role. Governance should be within the remit of NHS Lothian as the body responsible for the delivery of service, but should also be with the Integration Joint Board. Lack of GP and Primary Care Sustainability affected all services as it could lead to increase in Accident and Emergency attendances, complaints, significant adverse events, etc.

64.3 Community Nursing

64.3.1 A paper had been previously circulated. There had been improvement in the health visiting staffing situation, but this had been followed by problems of the same kind in community nursing due to retirement and imminent retirement of a large proportion of the workforce and a difficulty recruiting. Staff shortages were being managed on a weekly basis. This needed to be managed in association with other systems for instance increase of advanced nurse practitioner posts in medical practices was reducing the workforce.

64.3.2 There were plans to increase the number of places on the community nursing training course and also to offer the course in modules as an alternative to full time to attract more applicants.

64.3.3 There had been no recorded increase in datix reports or complaints due to the situation.

64.3.4 Members accepted the recommendations in the paper and accepted moderate assurance that systems were in place to manage the situation.

64.4 Healthcare Associated Infection Update

64.4.1 The paper had been previously circulated. It was expected that NHS Lothian would meet the HEAT target on reduction of the incidence of *Clostridium difficile* Infection having made significant improvements. There had not been a sustained reduction in *Staphylococcus aureus Bacteraemia* (SAB) and work was being done on this.

64.4.2 Professor McCallum noted that following the centralisation of decontamination units at the acute sites the next step for the Decontamination Project Board was to consider arrangements for local decontamination. Ms Hirst noted that on a visit to the Leith Community Treatment Centre the endoscopy clinic had been cancelled that day; Ms Gillies agreed to find out why this was. **TG**

64.4.3 Members accepted the recommendations in the paper and accepted moderate assurance overall that progress had been made, although there was significant assurance in terms of the *Clostridium difficile* Infection target.

64.5 Non Registered Nurse Vaccination

64.5.1 As Dr Williams had declared a non-financial interest in this item, he left the room and Ms Hirst chaired the meeting for this item.

64.5.2 Ms Hirst welcomed Ms McIntosh to the meeting and she spoke to the previously circulated paper. This paper had been previously approved at the Area Drug and Therapeutics Committee, a sub committee of the Healthcare Governance Committee, and was also supported by Professor McCallum.

64.5.3 It was confirmed that there was a system of standard record keeping in place for recording Patient Group Directions. It was confirmed that registered nurses would be clear that they were responsible for the non-registered nurses who they had delegated the task to but agreed that this should also be discussed at the Staff Governance Committee. **AMcM**

64.5.4 Non-registered nurses were already carrying out vaccinations in general practice, but not in NHS Lothian. The new arrangement would allow 2c general practices have non-registered nurse carrying out these vaccinations. The arrangement was specific to influenza vaccinations and did not cover any other vaccination.

64.5.5 Ms McIntosh noted that staff were supportive of this change as it allowed the workforce to be used to its maximum capacity.

64.5.6 Members approved the recommendations laid out in the paper.

64.5.7 Dr Williams returned to the meeting.

64.6 Child and Adolescent Mental Health Service – Interim Report

64.6.1 A paper had been previously circulated. Professor McMahon advised that there had been improvement in bringing down the length of the longest waits, but that the service were still not able to reach waiting time targets. It had been agreed to focus on the longest waits first although this would mean that national targets would not be met.

64.6.2 Members acknowledged that progress had been made by accepted only limited assurance overall and requested a further update at the next meeting in May 2017 followed by a formal update in July 2017 where clinicians from CAMHS would be invited to present their paper. **AMcM**

64. 7 Alcohol and Drug Partnerships

64.7.1 A paper had been previously circulated. The Alcohol and Drug Partnerships were separate groups which were funded by NHS Lothian through the Integration Joint Boards. The contents of the paper on suggestions for meeting reduction of funding in each of the Integration Joint Boards; these measures had not yet been agreed.

64.7.2 Professor McCallum noted that the reduction of services for this vulnerable group of people was unacceptable, that there had been an increase in issues, and that funding should be found. Professor McMahon advised that more work had been done and there would be investment in some areas to ensure that harm would not be increased.

64.7.3 Dr Williams noted that the response to this paper from the Lothian Medical Council had been that the Scottish Government had expected that the funding gap for Alcohol and Drug Partnership should be met by the Board so that performance did not fall, and that the proposal outlined did not give assurance on either of these areas.

64.7.4 Members acknowledged the amount of work done but accepted limited assurance that the changes proposed would not reduce performance and access to services. A detailed update would be submitted to the next meeting. **AMcM**

64.8 Review of Cardiac Arrests

64.8.1 A paper had been previously circulated. Ms Gillies advised that the national target was to reduce cardiac arrests by 50%. As NHS Lothian already had low numbers of cardiac arrests a further reduction of 10% only was expected from the current programme of improvement. The paper laid out a recommendation that a review be carried out on what additional work would be required to achieve a 50% reduction.

64.8.2 Members agreed with the recommendation and asked for an update to be submitted to a future meeting once the review had been carried out.

65. Effective Care

65.1 Cancer Care Update

65.1.1 The paper had been previously circulated. Due to the complexity and size of the multidisciplinary and multisite service a robust system of governance was required.

Dr Maung advised that a new structure had been agreed and implementation was ongoing. Members accepted moderate assurance on the governance process as this had recently been put in place. An update along with performance against national access standards would be brought to a future meeting. **TG**

65.2 Tissue Viability Annual Update

65.2.1 The previously circulated paper was an update on the Tissue Viability Service. A full update report would follow at the meeting in November 2017. **AMcM**

66. Exception Reporting Only

Members noted the following previously circulated papers:

66.1 Tissue Governance Annual Report;
66.2 Organ Donation Data Report;
66.3 Clinical Management Group Terms of Reference;
66.4 Clinical Policy and Documentation Annual Report;
66.5 Controlled Drugs Team Annual Report;
66.6 Nursing and Midwifery Council Annual Report.

67. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

67.1 Area Drug and Therapeutics Committee, 3 February 2017;
67.2 Clinical Management Group, 13 December 2016, 10 January 2017;
67.3 Organ Donation Sub Group, 23 February 2017;
67.4 Public Protection Action Group, 15 February 2017;
67.5 Feedback and Improvement Quality Assurance Working Group, 13 December 2016;
67.6 Health and Safety Committee, 29 November 2017;
67.7 Acute Hospitals Committee, 6 December 2016; 22 February 2017.

68. Date of Next Meeting

68.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 9 May 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

68.2 Further meetings would take place on the following dates in 2017:
- Tuesday 11 July 2017;
- Tuesday 12 September 2017;
- Tuesday 14 November 2017.

HEALTHCARE GOVERNANCE COMMITTEE

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

Present: Dr R. Williams, Non-Executive Board Member (chair); Ms S. Allan, Non-Executive Board Member; Ms P. Eccles, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Ms C. Hirst, Non-Executive Board Member; Mr A. Joyce, Employee Director; Mr J. Oates, Non-Executive Board Member; Mr A. Sharp, Patient and Public Representative.

In Attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr C. Bruce, Equalities and Human Rights Lead (item 5.1) Ms J. Campbell, Acting Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Ms K. Dimmock, Information Analyst (observing); Ms T. Gillies, Medical Director; Dr P. Graham, Consultant Clinical Psychologist (item 6.1); Mr B. Houston, Board Chairman; Dr B. Hacking, Consultant Clinical Psychologist and Head of Service (item 6.1); Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership; Ms C. Lawrie, Clinical Nurse Development Manager (item 7.1); Mr R. Mackie, Senior Information Analyst (observing); Professor A. McCallum, Director of Public Health and Health Policy; Professor A. McMahon, Nurse Director; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Mr A. Short, Head of Primary Care and Older People's Services, Midlothian Health and Social Care Partnership; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership; Dr P. Shankar, Consultant (observing) Dr D. White, Strategy Planning and Quality Manager, Edinburgh Health and Social Care Partnership.

Apologies: Ms M. Barton, Head of Health, West Lothian Health and Social Care Partnership; Dr B. Cook, Medical Director; Mr T. Davison, Chief Executive; Ms W. Fairgrieve, Partnership Representative; Ms F. Ireland, Non-Executive Board Member and Chair of Area Clinical Forum; Ms E. McHugh, Chief Officer, Midlothian Health and Social Care Partnership; Ms J. Morrison, Head of Patient Experience; Mr J. Oates, Non-Executive Board Member; Professor Angela Timoney, Pharmacy Director.

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.

1. Patient Story

1.1 A video was shown in which a nurse described the events leading up to the death of a patient in ARU at the Western General Hospital before admission when there were a total of 47 patients on trolleys waiting for admission. The nurse emphasised the need for wards to discharge patients efficiently so that patients could be admitted. Mr Sharp introduced the video with a few words about his own more positive experience in the same unit.

1.2 It was agreed that although flow process and analysis had been done, there were still problems in the system and the pressure at the front door was a result of the pressure throughout the hospital.

2. Minutes from Previous Meeting (14 March 2017)

2.1 The minutes from the meeting held on 14 March 2017 were approved as a correct record subject to one addition to item 63.1.

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

3. Matters Arising

3.1 Waiting List Management

3.1.1 Ms Campbell gave a verbal update on the work to reduce the length of wait for patients referred to services, and to devise a system to assess risk to those on the waiting list by specialty and sub specialty.

3.1.2 Outpatients waiting lists had now been assessed criteria based on probability that the patient's condition would deteriorate over time and probability that an important diagnosis would be missed. A plan to use non recurrent funding to use private treatment for patients on the waiting list of lower risk in order to free time for those of higher risk. A paper discussing the process of risk assessment would be submitted to the next meeting. **JCa**

3.1.3 The risk on the Risk Register associated with waiting times would now be split into two risks: the risk of non compliance with performance targets; and the patient safety risk of those patients on the waiting list.

3.2 Respiratory Managed Clinical Network Update

3.2.1 Professor McMahon gave a brief update on the vacant post of Clinical Lead for the Respiratory Managed Clinical Network. There had now been applications from two clinical nurse specialists and it was expected that an appointment would be made.

4. Committee Effectiveness

4.1 Healthcare Governance Committee Annual Report and Assurance Need

4.1.1 Ms Bennett spoke to the previously circulated paper. The annual report laid out areas identified by Members as significant control weaknesses in the Committee's remit.

4.1.2 Members expressed their difficulty in responding to the large quantities of information given to the Committee and determining what response was required. It was agreed that the recent change to focus on level of assurance achieved helped to focus the response. It was suggested that papers be more explicit in identifying clinical governance risks associated with topics presented.

4.1.3 It was also noted that there was no training or induction for members coming to the Committee which should be a necessity for those who had no background in the area. It was agreed that separate training for non executive and public members would make participation easier. Ms Bennett would contact Members for further information on what training was required. **JB**

4.1.4 Members advised that they found it difficult to list the assurance needs to advise the annual report and felt they would have benefitted from a session with all members to agree assurance needs collectively. It was agreed that this would be arranged for the next annual report in 2017/18.

4.2 Corporate Risk Register

4.2.1 Ms Bennett spoke to the previously circulated paper. It was noted that an assurance section had been added to show levels of assurance agreed at previous committees. Ms Bennett felt that the Committee should be doing more to consider the delivery of action plans but in place to respond to the clinical governance risks identified.

4.2.2 Members approved the recommendations laid out in the paper and were significantly assured that all risks identified were included on the register.

4.3 Quality and Performance Improvement Report

4.3.1 Ms Bennett spoke to the previously circulated paper noting that agenda planning for the Committee was based on items with exception reporting required using the risk register and the quality and performance improvement reports. For areas which were improving or on target an annual report was received. For areas where there was not significant assurance additional papers were received. Members were content with this process. Assurance given should be assurance achieved on patient centred effective care, as the remit of the Committee.

5. Person Centred Culture

5.1 Equalities and Human Rights Outcomes Report

5.1.1 Mr Bruce presented the previously circulated paper. Mr Bruce advised that the collaboration would include those already working in the area but that as many interested people should be involved as possible, suggestions were welcome.

5.1.2 The Chair note that the Committee had previously raised concerns about the lack of a equality and diversity lead and that this work was welcome. It was agreed that the Committee would see the final action plan before it was confirmed, and that it would be accompanied with a paper showing how the targets would be met in areas where the previous plan did not meet targets. The recommendations laid out in the paper were approved. **CB**

6. Safe Care

6.1 Psychological Therapies Update

6.1.1 Dr Hacking and Dr Graham gave a presentation. Professor McMahon felt that the work presented showed a mature and methodological approach that was patient centred. Members were significantly assured and requested an update in 6 months' time. **AMcM**

6.2 Child and Adolescent Mental Health Service Update

6.2.1 Professor McMahon spoke to the previously circulated paper. There had now been improvements on the number of longest waits following the implementation of the agreed action plan. The overall waiting list was still large but improvements would follow. There had been a reduction in referrals to the team as patients were being referred to more appropriate services.

6.2.2 Ms Allan noted that problems with the North Edinburgh CAMHS team were noted in the report but no details or actions were given. Professor McMahon agreed to update on this. **AMcM**

6.3 Alcohol and Drug Partnerships

6.3.1 Professor McMahon spoke to the previously circulated paper which was an update on the current stage of the process, offering limited assurance on the impact of the changes proposed but moderate assurance that a process was in place. The Committee needed to ensure that patient access to services was maintained. This would be monitored using the access target performance in the Quality and Performance Improvement Report. A further paper on actions to mitigate the impact of the changes would be submitted to the Committee at the meeting in September 2017. **AMcM**

6.4 Healthcare Associated Infection – Antibiotic Prescribing

6.4.1 Ms Gillies spoke to the previously circulated paper which detailed the trend in use of the broad spectrum antibiotics associated with a risk of *Clostridium difficile* Infection. The trend showed that a reduction in ciprofloxin had been replaced by an increase in use of another antibiotic of the same family which was also associated with a higher risk of CDI and needed to be monitored. A full report on the risks and actions to mitigate risks would be requested for the next meeting. **TG**

6.4.2 Ms Gillies added that broad spectrum antibiotics were often appropriate treatment when it was not clear at the time of prescribing what organism was causing the infection, meaning a narrow spectrum antibiotic may not be effective. This was a decision made by the prescriber on an individual patient basis.

6.5 Healthcare Associated Infection – End of Year Updateu

6.5.1 Ms Gillies spoke to the previously circulated paper. A further update on the CDI infection rate would be included in the paper at the next meeting. Members approved the recommendations laid out in the paper.

6.6 Scottish Patient Safety Programme Walkrounds Update

6.6.1 Ms Bennett presented the previously circulated paper. Ms Hirst noted that the non-executive walkrounds were valuable and were also valued by staff as they allowed time for reflection on how the service was working and what actions could improve any problems.

6.6.2 Members agreed that the report was useful but also felt that more information on the impact of walkrounds on culture change and patient safety, and information on whether the commitments made by the Executive Directors on the walkrounds were followed through. Ms Bennett agreed to include this information in the next report.

6.6.3 It was agreed that patient representatives could be included in walkrounds as patients often found it easier to speak with volunteers rather than staff.

6.7 Management of Adverse Events

6.7.1 Ms Bennett spoke to the previously circulated paper. It was noted that the priority for this year was to have a robust system for sustainable response to adverse events. This would use existing mechanisms including team meetings, huddles and handovers. The process for reviewing significant adverse events was now in place, so this was the next step.

6.7.2 The number of open cases had now been reduced; the high number had previously been a concern. A constant system of monitoring and supporting reviews was in place.

6.7.3 Draft legislation on the duty of candour was awaited but work would be taken forward on how this would apply to the review process.

6.7.4 Members approved the recommendations in the paper and agreed that significant assurance had been achieved. An update would be submitted in 6 months' time.

JB

6.8 GP and Primary Care Sustainability Action Plan

6.8.1 Mr Small introduced the previously circulated paper. There were still around 50 GP practices across Lothian with restricted lists and there had not been much improvement. The number of practices NHS Lothian is supporting due to difficulties was now 23; this was due to a number of factors. Funding from three different sources was now with the Integration Joint Boards for investment and further funding would be received specifically for pharmacy in practices.

6.8.2 Mr Small discussed the priorities for the East Lothian Health and Social Care Partnership Primary Care Sustainability Action plan, Mr Short discussed the Midlothian Health and Social Care Partnership plan, Dr White the Edinburgh Health and Social Care Partnership plan and Ms Hughes the West Lothian Health and Social Care Partnership plan.

6.8.3 Professor McMahon noted that capacity in Health Visiting and Community Nursing was still fragile though training places had been increased. There was a risk of a

future shortage of practice nurses also due to the demographics of the workforce; this was being monitored.

6.8.4 It was noted that actions included expanding the size of practices which would require recruitment of more GPs. 100 additional training posts for GPs had been funded across Scotland, but many were unfilled. Work was required to make GP placements desirable for medical students and building up the workforce would take time.

6.8.5 Mr Small noted that the action plan offered limited assurance. It was expected that measures would start to take effect in around 6 months. Data was being collected now to measure impact and assurance and depending on the outcome this might lead to moderate assurance that the process would lead to improvements. All the actions laid out in the plan were based on decisions that could be made by NHS Lothian or the Integration Joint Boards rather than nationally.

6.8.6 It was noted that national decisions were also of importance, for instance the new GP contract could be fundamental in whether retired doctors continue some sessions and whether young doctors decide to start partnerships. Voting would take place on the new contract on 1 December 2017. Property ownership changes in the contracts could also have financial implications for the Health Board.

6.8.7 The chair thanked those present for the work that had gone into this area and asked for an overview update report from Mr Small at the next meeting followed by another Integration Joint Board level report at the meeting in September 2017. **DS**

6.9 Public Protection Update

6.9.1 Professor McMahon spoke to the previously circulated paper. It was noted that a joint inspection of Children's Services in West Lothian Health and Social Care Partnership had taken place and the report would be submitted to the next meeting. **AMcM**

6.9.2 It was agreed that the Gender Based Violence Action plan would be brought to the Committee with the next update. **AMcM**

7. Effective Care

7.1 Hospital Based Complex Clinical Care

7.1.1 Ms Lawrie gave a presentation. Ms Gormley commended the impressive and thorough attempt to understand patients needs, noting that this sort of work really added benefit for patients, especially when they were able to contribute with their own ideas. Professor McMahon noted that this was an element of the ongoing work in response to the Healthcare Improvement Scotland review of Hospital Based Complex Clinical Care on improving the quality and experience of care for both patients and carers.

7.1.2 Ms Myles noted that work was also ongoing in Midlothian in response to the recommendations from the review on changing culture in the wards and giving staff the skills to make changes.

7.1.3 The response to the recommendations from the review would be submitted to the next Healthcare Governance Committee. **AMcM**

8. Exception Reporting Only

8.1 Occupational Health Clinical Governance Annual Report

8.1.1 The Chair noted that the annual report included information on process and structures but did not include data on activity and outcomes. Ms Gillies agreed to bring further information to the next meeting. **TG**

8.2 Members noted the following previously circulated items for information:

8.2.1 Additional Needs and Diversity Information Taskforce Update;
8.2.2 Voluntary Services Annual Report.

9. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

9.1 Area Drug and Therapeutics Committee, 31 March 2017;
9.2 Clinical Management Group, 14 February, 14 March 2017;
9.3 Feedback and Improvement Quality Assurance Working Group, 25 January, 28 February, 21 March 2017;
9.4 Information Governance Assurance Board, 18 January 2017;
9.5 Lothian Infection Control Advisory Committee, March 2017;
9.6 Clinical Policy, Documentation and Patient Information Group, 24 January 2017;
9.7 Vulnerable Adults Group, 2 March 2017.

10. Date of Next Meeting

10.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 11 July 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

10.2 Further meetings would take place on the following dates in 2017:
- Tuesday 12 September 2017;
- Tuesday 14 November 2017.

1.11

NHS LOTHIAN

ACUTE HOSPITALS COMMITTEE

Minutes of the meeting of the Acute Hospitals Committee held at 14:00 on Wednesday 30 May 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms K. Blair, Non-Executive Board Member (chair); Ms T. Gillies, Medical Director; Ms F. Ireland, Non-Executive Board Member; Mr A. Joyce, Employee Director; Ms A. Mitchell, Non-Executive Board Member; Mr J. Oates, Non-Executive Board Member; Professor M. Whyte, 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; Mr B. Cook, Medical Director, Acute Services; Ms K. Dimmock, Senior Information Analyst; Dr E. Doyle, Associate Divisional Medical Director, Children's Services; Mr R. Mackie, Senior Information Analyst; Mr C. Marriott, Deputy Director of Finance; Ms F. Mitchell, Site Director, Royal Hospital for Sick Children; Ms B. Pillath, Committee Administrator (minutes); Mr A. Tyrothoulakis, Theatres and Critical Care; Dr S. Watson, Chief Quality Officer.

Apologies: Mr A. Jackson, Associate Director, Strategic Planning; Ms R. Kelly, Associate Director of Human Resources.

Chair's Welcome and Introductions

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

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

1. Minutes from Previous Meeting (22 February 2017)

1.1 The minutes from the previous meeting were approved as a correct record.

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

2. Performance Assurance

2.1 Diagnostics

2.1.1 A paper had been previously circulated and Mr Tyrothoulakis gave a presentation. In response to a question, Mr Tyrothoulakis explained that the faecal calprotectin clinic set up to test patients on the waiting list to determine whether they needed to be treated in secondary care and begun with a pilot in which of 297 patients with negative results at the clinic came back to secondary care for treatment. The clinic

had now been rolled out to all GP practices. The test used was a recognised and recommended test.

2.1.2 Ms Campbell noted that work was being done on triaging referrals marked as 'urgent' to see if any could be downgraded to 'routine'. A large number of referrals marked 'urgent' were found not to have required urgent notice once the patient had been seen, but it was difficult to determine which ones. Clinical criteria were being introduced to help the referring GP decide on referral status.

2.1.3 Ms Gillies noted that colonoscopy rates were increasing in Lothian as well as all areas in the UK.

2.1.4 Mr Tyrothoulakis noted that overbooking of appointments was common practice in outpatient specialties as it compensated for the Did Not Attend rate in outpatients; this system was successful.

2.1.5 Members accepted the recommendations laid out in the paper and accepted limited assurance only that performance was improving; this was mainly due to the continued long waiting lists for combined testing and it was acknowledged that improvements had been made in other areas. A further update would be brought to the next meeting. **AT**

2.2 Radiology

2.2.1 A paper had been previously circulated and Mr Tyrothoulakis gave a presentation. Members accepted the recommendations laid out in the paper and accepted moderate assurance that performance was improving.

2.3 Inpatient and Day Case Treatment Time Guarantee ≤12 week performance

2.3.1 An update paper had been previously circulated. Ms Campbell noted that limited assurance only had been accepted on performance at the previous meeting, but that performance had now improved and was comfortably within target.

2.3.2 Problems were still being experienced in two areas: Urology, where there were a number of consultant vacancies and had had to reduce the number of weekend sessions offered due to staff shortage; and Orthopaedics which was fully staffed but where there had been high unscheduled care activity including orthopaedic patients and patients boarding from medical specialities which had lead to some elective list cancellations.

2.3.3 Neurosurgery was also outwith its performance target due to high unscheduled care activity. Cleft Palate Services were also outwith target but this service was moving to a central service based in Glasgow.

2.3.4 A new trajectory for 2017/18 had been calculated using the same methodology as last year. This was based on the stance that there would be no third sector activity. Last years' trajectory also expected no third sector activity but non recurring funds were subsequently used to purchase this.

2.3.5 Members accepted the recommendations laid out in the paper and accepted moderate assurance that performance was improving.

2.4 Outpatients ≤12 week performance

2.4.1 A paper had been previously circulated. Ms Campbell noted that there had been big improvements on waiting times but that high numbers of patients were still waiting longer than 12 weeks for treatment. During the year 2016/17 non recurring money had been used for third sector treatment in areas with the longest waiting lists and areas were delayed diagnosis would be of higher impact.

2.4.2 The trajectory for 2017/18 showed an expected 40,000 patients waiting longer than 12 weeks for treatment. Again, this assumed no access to third sector treatment. A process was being introduced to reassess and identify the risks associated with those patients on the waiting list

2.4.3 £7.4 million of non recurring funding had been allocated to manage high risk outpatient and day case patients and reduce waiting lists. Regional and national collaboration was also expected to find ways of reducing costs. The trajectory calculated did not include this funding which was planned to be used for redesign of services for sustainable improvement rather than wholly to buy third sector activity. Some third sector activity may also be purchased for the highest risk areas.

2.4.4 It was noted that national data showed Lothian in the lowest quartile for performance compared to other Scottish Health Boards. Ms Campbell advised that this used December 2016 data and that more recent unverified data showed an improved relative position.

2.4.5 Members approved the recommendations laid out in the paper and accepted moderate assurance that a process was in place for improvement of performance.

2.5 Corporate Risk Register

2.5.1 The risk register had been previously circulated. Ms Campbell noted that the waiting times risk had now been split into two parts: the organisational risk of missing the target; and the patient safety risk to patients on the waiting list.

2.5.2 Members approved the recommendations laid out in the paper.

2.6 Quality and Performance Improvement

2.6.1 The paper had been previously circulated. Dr Watson advised that the performance measures would be reviewed to ensure the most relevant measures were captured and that presentation of data to Committees was in an easily understandable format.

3. Corporate Governance

3.1 Theatre Improvement Programme

3.1.1 A paper had been previously circulated and Mr Tyrothoulakis gave a presentation on the work being done to ensure that the number of theatre lists carried out matched the capacity in each area, and in reducing cancellation by ensuring patients were offered the best treatment for them.

3.1.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance that a system was in place to make improvements.

3.2 Leadership and Engagement

3.2.1 The Chair welcomed Dr Watson to the meeting and he introduced the previously circulated paper. The impact of the training would be seen in the engagement with quality improvement clinical projects using the quality improvement methodology taught. The training was focused both on those leading services and those delivering services, with two separate courses.

3.2.2 The patient level costing system being introduced by the Finance Directorate would allow the cost of care to be mapped out and variations identified so that resources could be focused on high impact improvements and for defining a good standard of care and working towards delivering it.

3.2.3 Update of the Lothian training programmes was increasing. NHS Lothian had input on NHS Education Scotland (NES) Board so would be able to influence the direction of national training.

3.2.4 Members accepted the recommendations laid out in the paper and accepted moderate assurance that a process was in place for leadership engagement in NHS Lothian. It was requested that the next update would include evidence of impact and outcomes of training as well as the wider clinical quality strategy. **SW**

3.3 Acute Hospitals Committee Annual Report

3.3.1 The Chair noted that a workshop would be arranged to discuss assurance timetabling and develop a Committee Assurance Statement. **KB**

3.3.2 Members approved the Annual Report.

4. Clinical Governance

4.1 Paediatrics Programme Board

4.1.1 A paper had been previously circulated giving an update on the situation one year since the completion of the Paediatrics service review. The full service option had been expected to take two years to implement, but implementation was not on target as there had been no improvement in medical recruitment and not all existing staff had signed up to the new working arrangements. Several doctors were on long term sick. Consultant posts were currently being advertised nationally for the third time. There was a chronic shortage of paediatricians in the UK as a whole.

4.1.2 Dr Doyle advised that costs of providing the service had gone down as triple time overtime was no longer being offered, but that this made finding locum doctors more difficult.

4.1.3 Covering the rota was still difficult with occasions when only one doctor had been on duty at the weekend as opposed to the required two. There had not been any situations of high clinical risk.

4.1.4 It was noted that neonatal services were not affected by the problems, staff could be recruited, the role of advanced neonatal nurse practitioners was well developed and there was a good link between neonatal services in St John's Hospital and the Royal Infirmary.

4.1.5 It was agreed that it would be recommended to the Board that the Royal College of Paediatrics be asked to review progress in adopting option 1 of the recommendations from the review to see if any recommendations for improvement could be made. **FM**

4.1.6 In addition a further paper would be brought to the Committee setting out the position against the other options proposed in the Royal College of Paediatrics review and proposals for a way forward. **FM**

4.1.7 Members accepted the recommendations laid out in the paper and thanked Ms Mitchell and Dr Doyle for their hard work to keep the service going in a difficult situation.

5. Fiscal Governance

5.1 Divisional Financial Performance

5.1.1 A paper had been previously circulated. It was noted that spend on medical supplies was still high but had improved compared to previous years; this would be difficult going forward as the budget is for 4% uplift each year but the cost of medical supplies was increasing by more than this.

5.1.2 The Royal Infirmary and the Western General Hospital were in a good position having made savings. Anaesthetics, Theatres and Critical Care continued to have an overspend as demand increased. Usage of agency staff was high at St John's Hospital. Nursing and drugs spend were both in a better position.

5.1.3 Members accepted the recommendations laid out in the paper.

6. Minutes for Information

Members noted the minutes from the following meetings for information:

6.1 Edinburgh Integration Joint Board Flow Programme, 27 March 2017;
6.2 Healthcare Governance Committee, 14 March 2017;
6.3 Staff Governance Committee, 29 March 2017;
6.4 Health and Safety Committee, 28 February 2017.

7. Any Other Competent Business

7.1 General Medical Council Visit

7.1.1 Professor Whyte noted that the GMC would visit the medical school in October 2017 as part of a visit to all Scottish Health Boards. The purpose of the visit would be to review undergraduate and post graduate training run by NHS Education Scotland (NES) and would focus on Medicines of the Elderly at the Royal Infirmary, and Paediatrics services. Following the visit there would be a formal report with recommendations. A series of internal meeting had been set up in preparation for the visit and would be chair by the Deputy Chief Executive.

8. Date of Next Meeting

8.1 The next meeting of the Acute Hospitals Committee would take place at **14.00** on **Tuesday 4 July 2017** in **Meeting Room 7**, Second Floor, Waverley Gate.

8.2 Further meetings would take place on the following dates in 2017:
- Tuesday 29 August 2017;
- Tuesday 7 November 2017.

DRAFT

1.12

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of a Meeting of the Staff Governance Committee held at 9:30am on Wednesday 29 March 2017 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs A Mitchell (Chair); Mrs J Butler; Mr A Joyce; Professor A McMahon; Mr J Oates and Miss T Gillies.

In Attendance:
Mr J Crombie (Deputy Chief Executive); Mrs J Campbell (Acting Chief Officer); Mrs R Kelly (Associate Director of Human Resources); Ms C Harris (Head of Communications); Ms A Jarvis (Project Manager - Review of Nursing in the Community); Professor A McCallum (Director of Public Health & Health Policy); Mr C Bruce (Lead on Equalities and Human Rights); Mr S Haddow (Head of Medical Workforce Planning & iMatter Operational Lead) Mr G Curley (Director of Operations – Facilities); Mr D Richardson (Lead Health & Safety Adviser) and Mr C Graham (Board Secretariat).

Apologies for Absence were received from Cllr Donald Grant; Councillor C Johnstone; Mr B Houston; Dr A Leckie; Mr I Wilson; Mr S McLaughlin and Mr T Davison.

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.

66. Presentations

66.1 Celebrating Success Awards - Ms Harris presented on the Celebrating Success Awards, now in its ninth year. The Awards would again be held at the Edinburgh Corn Exchange venue, in June. Nominations for the awards had been launched in February and it was likely that the deadline for nominations would be the 14th April 2017.

66.1.1 The Committee noted that the awards look to showcase multidisciplinary teams and highlight positive work across NHS Lothian. The awards include the Lynn Jackson Nurse of the Year Award and the Health Hero Award which is run in association with the Evening News.

66.1.2 The awards are well promoted ahead of the event through social media and there is also interactive social media on the night of the awards. Videos of the awards ceremony are also posted shortly after the event.

66.1.3 It was noted that a survey of staff attending and involved with the event was carried out each year and on the whole the event is seen as inspirational and something to feel valued and proud of. This feedback is incorporated into discussion around the following year event and consideration is given as to how to roll out the brand throughout the whole year. The Chair stated that it was wonderful that staff were receiving such robust recognition through the Celebrating Success Awards, but that it was important that recognition should not be limited only to this annual event, but also spread throughout the year through a range of other initiatives. It was suggested that it

would be beneficial to bring sites' "Team of the Month" Awards under the celebrating success banner.

66.1.4 Mr Joyce stated that as a member of the judging panel for the previous four years there had been a noticeable increase in the number of nominations for long service. It was highlighted that the organisation no longer carries out long service awards but, given the demographics around staff age nominations relating to long service may increase. It was noted that long service awards may not be a bad thing but the celebrating success awards were about doing extra. There was discussion on the issue of long service awards. The Committee felt that there was a piece of work that could be developed around staff length of service, contribution and public recognition.

66.1.5 The Chair thanked Ms Harris for her thought provoking presentation.

66.2 Carer Positive (Example of Healthy Organisational Culture) - Ms Jarvis and Mr Joyce's presentation looked at the 80,000 carers within Lothian. It was noted that 1 in 7 people were juggling their paid job with their unpaid caring role. Within NHS Lothian this equated to around 3,000 whole time equivalent staff. There was a lot of evidence around the negative impact, stress and struggle that can arise as a result of combining paid and unpaid work.

66.2.1 Ms Jarvis reported that £600 had been provided from the Edinburgh and Lothian's Health Foundation. This has so far been used to hold around 20 staff road shows to highlight recognition of the challenges facing carers and these sessions have been tailored as appropriate for different staff groups. The money has also been used to create digital stories and to produce posters and information fliers.

66.2.2 Ms Jarvis showed a short digital story in which the Chief Executive talked about the importance of recognising the carers within the organisation. It was noted that a LearnPro module for working carers was being developed for staff.

66.2.3 The Committee felt that this was an inspiring piece of work. The Chair asked if iMatter could also be linked as well as the NHS Lothian Values. Mrs Butler stated that iMatter was not as specific and the next step would be to look at triangulating some annual staff survey feedback and workforce indicators. This was a fantastic piece of work, which the senior management team should be looking at to see what support could be provided to move this forward, bearing in mind the work that had been achieved given an extremely modest budget.

66.2.4 The Chair thanked Ms Jarvis and Mr Joyce for the presentation. The Committee agreed that they would be keen to continue to support this work and the Chair asked Ms Jarvis to feedback the positive comments to the individuals involved with this uplifting piece of work.

Ms Jarvis left the meeting.

67. Minutes of the Previous Meeting

67.1 The Minutes of the Staff Governance Committee Meeting held on 25 January 2017 were approved as a correct record. The Committee agreed that moving forward a running action note would be helpful.

68. Matters Arising

68.1 Monitoring – Scottish Government advice regarding new arrangements is awaited.

68.2 Health and Safety – See Item 75 below.

68.3 Induction Pack – Information awaited, add to running action note.

68.4 Fire Training Compliance - Mrs Butler reported that there had been a further deterioration in performance of 1.3%. Amanda Langsley was working with the Fire Training Officers and Facilities Directorate to look at the model and delivery of the training. Mrs Butler would report back on actions around performance improvement at the next meeting.

JB

69. Corporate Risk Register

69.1 Roadways/Traffic Management [3328] - Mr Crombie explained the risks as outlined in the paper. The Committee noted that the addition of this item to the corporate risk register had trigged the requirement for quarterly updates. Mr Crombie highlighted the recent investments to support the reduction in risks; accidents at the Royal Infirmary of Edinburgh over the last year and ongoing scrutiny work to focus down to site/campus level to reduce risks.

69.1.1 The Chair asked about independent expert reviews in relation to activity and how these were undertaken so that the Committee could be reassured of ongoing, active monitoring. Mr Crombie stated that reviews were undertaken and that action plans came from those reviews which were then tracked. Mr Curley added that actions are reviewed monthly within the multi disciplinary groups and are also reported to NHS Lothian's Health and Safety Committee.

69.1.2 The Chair asked how often the independent expert reviews occurred. Mr Curley stated that there were annual reviews and that NHS Lothian paid for these as part of the assurance process. There was still significant investment required around design solutions on some sites.

69.1.3 The Chair also asked about risks around infrastructure which was monitored and maintained by an external provider. Mr Curley confirmed that the same output and consistency as NHS Lothian's own audit applied and any items would remain on the risk register. It was noted that NHS Lothian also retained rights under contract to take back absolute control of the site if the private provider fails to meet legal responsibilities. There was also the option of financial recourse. Mr Curley also confirmed that confidence in site safety and control remained however the RIE site was out with NHS Lothian's direction.

69.1.4 The Chair asked about the risk of accidents on other sites. Mr Curley reported that other sites had seen a small number of accidents, mostly vehicles bumping into each other in car parks but no incidents involving patient or staff injury in the last two years. It was recognised that there was more rigorous control in place. The progress made to date was endorsed by the Committee and the actions in relation to the RIE campus were supported.

69.1.5 The Committee agreed to the requested moderate assurance level and also agreed the recommendations within the paper.

69.2 Management of Violence & Aggression [3455] - Miss Gillies pointed out that there was a significant risk control failing associated with training issues in relation to management of violence and aggression. It was noted that there had previously been an improvement notice around violence and aggression. Internal Audit had also looked at this area of concern. This work had identified that improvement had to be made around understanding what had happened in an incident and to close this off to a substantive assurance level.

69.2.1 The Committee noted that there were several different types of training available to staff, however work needed to be undertaken to address the high levels of staff that do not turn up to training courses. It was noted that Dr Leckie was undertaking a review of the management of violence and aggression which includes training, the terms of reference for this had been agreed. The result of the review would come back to the Staff Governance Committee when available. Until the point that the review was complete only limited assurance could be given. It was hoped that the review would be completed in 90 days and be available in the summer.

69.2.2 It was also noted that the entry on the risk register required to be updated as the risk was not around the availability or capacity of training. Staff were not accessing the right type of training and there was a high Did Not Attend (DNA) rate.

69.2.3 There was discussion on the DNA rate, Mr Joyce highlighted previous work undertaken by staff side to look at this. One issue was staff going on shift, and then failing to be released for training, the suggestion was to start shifts in training and not on the ward.

69.2.4 The Chair added that there was also work needed on the cultural element around the importance of training. It was disappointing to see training offered but not being utilised.

69.2.5 The Committee accepted the limited level of assurance. It was agreed that there were two separate pieces of work to undertake in relation to the review output and training DNA Rates. The Committee expected to receive updates on this work at the July 2017 meeting.

TG

69.3 Medical Workforce Sustainability [3527] - Miss Gilles reported that medical workforce sustainability has been an issue for all health boards for some time. Issues around employed medical workforce; vacancy rates; recruitment and the trained and trainee workforce were all being considered.

69.3.1 There was discussion on gaps within small teams and the disproportionate impact of this as well as the impact nationally around trainee gaps. Significant gaps were now also increasing as a result of the introduction of parental leave. The use of clinical development fellows and nurse practitioners to provide additional capacity and broaden out the workforce was noted.

69.3.2 The Committee noted that the National Workforce Plan was in progress and the first iteration was awaited.

69.3.3 There was discussion on what work was happening internally to make NHS Lothian attractive to trainees. Miss Gillies reported that work with the Director of Medical Education was ongoing and that in collaboration with Mr Crombie and Ms Campbell a short term programme board approach had been taken to look at issues and to make

the educational offering as good as it can be. It had also been agreed to look at establishing a chief resident type post on one site.

69.3.4 It was noted that NES were also looking at what attracts people; organisational culture and the environment of Edinburgh as a city to come and live and work in.

69.3.5 The Committee agreed the moderate assurance level as outlined in the paper.

70. Staff Governance Arrangements for the IJBs

70.1 Mrs Butler stated that the question of oversight of staff governance arrangements for the IJBs had been raised by the Audit and Risk Committee.

70.2 The Committee agreed that it was reasonable for the IJB's to rely on the Staff Governance Committee for oversight of NHS board employment matters as the IJBs were commissioning bodies and not an employer.

70.3 There was discussion on the mechanism of how the Committee would see any issues that arose. Mrs Butler stated that the issues would come back to NHS Lothian as the employer and be escalated to her and also Mr Joyce as the Employee Director; this was the same as the process in the acute setting. It was recognised that this was an unusual situation.

70.4 It was agreed that the response to the Audit and Risk committee would outline the discussion and confirm that the Staff Governance Committee would be comfortable to continue providing assurance. Mrs Butler would draft the letter and also write to each of the IJB chairs confirming the arrangements.

JB

71. Staff Governance Work Plan

71.1 Mrs Butler reminded the Committee that it had been previously agreed that the Staff Governance Committee agenda be based around the 5 Everyone Matters: 2020 Workforce Vision priorities. In line with this it was felt appropriate to take a similar approach to the Committee's statement of assurance. This would require the 28 actions within the traditionally based staff governance standard being mapped to the 5 Everyone Matters priorities.

71.2 Ms Campbell pointed out that under "showcase presentations" in the work plan, ophthalmology was not just St. John's and whether it would be helpful to look at the wider service. Mrs Kelly agreed to look at this. It was also suggested that indicative dates should be added to the work plan items

RK

71.3 The Committee approved the Staff Governance Work plan for 2017/18 and agreed the use of Everyone Matters: 2020 Workforce Vision for the future Statement of Assurance. The Chair added that it would also be helpful for the Committee to have sight of the mapping of the 28 actions into the 5 priorities to be assured that nothing had been missed.

JB

72. Healthy Organisational Culture

72.1 iMatter Update - Mr Haddow reported that the implementation plan was on target. Estates and Facilities were the most recent areas to go live with iMatter. There would be work with the remaining groups of staff within Health and Social Care Partnerships on 29 May 2017. This would then mean all staff had gone through one cycle of iMatter.

72.1.1 There was discussion on how the Committee would like the information to be presented in the future. It was agreed that team response rates and the conversion of team reports to action plans would be key performance measures for the Committee going forward.

72.1.2 The Committee noted that it was planned that at the end of this year there would be a Scottish Government Questionnaire circulated to complement iMatter. Mr Haddow stated that it was important not to confuse this complementary questionnaire with the iMatter questionnaires. It was noted that the complementary questionnaire would carry completely different and distinctive branding.

72.1.3 Mrs Butler commended the work of Mr Haddow and his team in becoming nationally recognised ambassadors for iMatter. This was a real measure of success for the organisation. Mr Haddow stated that it was hoped to bring a full report based on all iMatter responses to the Board in either December 2017 or January 2018.

72.1.4 The Committee agreed the significant assurance level and passed on its thanks to Mr Haddow and his team for their hard work. The Committee also agreed that it would be useful for the Committee to receive examples of iMatter success stories reflecting changes and the effect this had on staff.

73. Sickness Absence – Assurance Level

73.1 The purpose of this report is to consider the current position with sickness absence within the organisation and recommend a level of assurance to members of the Committee for consideration and approval based on the detailed paper that was presented to the Committee in January 2017.

73.2 Mrs Butler introduced the report which followed on from discussions held at the January Staff Governance Committee around sickness absence systems and processes to help to support the management of staff absence and assist with achieving the 4% target.

73.3 The shift towards a health and wellbeing strategy was noted as in progress with an event planned for late April to pull this work together with a stakeholder group. Dashboards with risk profiling and target setting were also being developed. Part of this was the translation of sickness absence into financial value. It was planned to test the dashboards at St John's Hospital and with West Lothian Health and Social Care Partnership by the end of April.

73.4 The Committee accepted the moderate assurance level based on the information contained within the paper. Mrs Butler would bring a further paper to the May meeting outlining specific actions in service areas and provide an update on the development of dashboards.

JB

74. Whistleblowing Monitoring Report

74.1 Mrs Kelly outlined that this was the first whistleblowing monitoring report. The report updated the Committee on actions taken to date in relation to whistleblowing and monitoring data for the whistleblowing cases raised within NHS Lothian between October 2016 and 10 March 2017.

74.2 It was noted that the policy had been finalised and was now online. The named contacts training had also taken place. There was still work to do on managers and staff side training over the next 12 months. The Chair explained the monitoring process in her role as whistleblowing champion and it was noted that six cases had been raised to date.

74.3 There was discussion on themes and lessons learnt. It was noted that in some cases whistleblowing was not the main element of some cases as they were frequently mixed with personal grievance or employment matters. There was also discussion on the approach or framework adopted by other health boards.

74.4 Mrs Kelly stated that Lothian was ahead of other boards and had undertaken more work to make sure processes were in place. The Chair added that at the whistleblowing champions meetings, NHS Lothian had been complimented on its work around this. The Chair congratulated Mrs Kelly, Mrs Butler and their team for the progress around strengthening the whistleblowing policy and process.

74.5 The Committee agreed the moderate assurance level as detailed in the paper given the early stages of the work. It was agreed that there should be regular reporting to the Staff Governance Committee and a paper to the Board in the near future to have the process ratified. It was also agreed to add a sub category to the monitoring report to identify if personal grievance issues were involved.

RK/JB

75. Health and Safety Governance/Management Structure

75.1 Miss Gillies provided an update to the Committee on the current Health & Safety management structure and committee reporting within NHS Lothian. It was noted that a review of the reporting routes for the Health and Safety Committee had been requested by the Chief Executive.

75.2 The Committee noted that going forward Miss Gillies would be chairing the Health and Safety Committee and was requesting that the Staff Governance Committee continued to receive the Health and Safety Committee minutes until the clarity around the reporting arrangements is received. Miss Gillies added that within other health boards at least four have health and safety reporting through the Staff Governance Committee.

75.3 The Chair expressed concern about receiving the Health and Safety Committee minutes as a mechanism of assurance as there was no depth behind the minutes.

75.4 It was agreed that Miss Gillies and the Chair should meet to go over the best way for the update report to be submitted to provide the required assurance and to look at adjusting the Health and Safety Committee minutes to best show performance against key risks.

TG/AM

76. Equality and Rights Progress Report

76.1 Professor McCallum reported that this paper outlined the plan for preparation of NHS Lothian's outcome report. Given the narrow timescale involved it had been felt appropriate for the Committee to receive the detailed plan but not to hold up areas of work.

76.2 Chris Bruce stated that the statutory report was due at the end of April and that this endpoint was not negotiable. Work to make the report accessible was ongoing and there had been a workshop with learning disability clients and groups around the report.

76.3 The Committee noted the paper and looked forward to receiving the full robust report at the next meeting.

AKM/CB

77. Equal Pay Statement and Pay Gap Analysis

77.1 Mrs Kelly reported that the statement and information was published every two years and was now due. It was noted that after 2015 most boards in Scotland had been criticised for not providing enough detail. The documents were to be published on all health boards' websites by the end of April. The extra details in the tables now being provided had been agreed across all health boards. The Committee noted the work undertaken to make the report more meaningful. Professor McCallum added that once the report was published work on a new approach and improvement plan will commence.

78. Equality and Diversity Monitoring Report – 2016/17

78.1 The Committee noted the Monitoring Report.

79. Staff Engagement and Experience Programme Board – Terms of Reference

79.1 Mrs Butler reported that as part of the need to strengthen governance arrangements, it was now suggested that a programme board reporting to the Staff Governance Committee be established. This proposal had been supported by the Lothian Partnership Forum and the Corporate Management Team. The programme board's annual work plan would also be ratified by the Staff Governance Committee.

79.2 The Committee agreed to the establishment of the programme board and it was agreed that Mr Chris Bruce would be a member of the programme board.

80. Sustainable Workforce

Mr Joyce left the meeting.

80.1 Workforce Report - Mrs Kelly informed the Committee that a new version of the report had been developed. The report now included information on work coming out of the workforce data:- this allowed the Committee and Lothian Partnership Forum to have oversight of ongoing work and allow the interrogation of workforce data from a high level. It was noted that this was a first draft report to cover concerns previously raised by the Committee and thoughts on anything else required were welcomed.

80.1.1 The Committee welcomed the report. It was suggested that it would be useful for the content of the report to be used for context when other relevant items were discussed.

80.2 Workforce Planning and Development Programme Board – Terms of Reference - Mrs Butler reported that there was a lot of ongoing work at local level. The Programme Board had been created to develop a coherent plan across professional group and to deal with multi professional issues. The draft plan would come to the Staff Governance Committee before going to the Board. Once approved the performance of the plan would be measured against delivery. The Committee agreed the proposed Terms of Reference.

81. For Information and Noting

81.1 The Committee noted the following items:

- Scottish Workforce and Staff Governance Committee – Flash Report
- NHS Lothian High Level Strategy for Nurses, Midwives & AHP's
- Minutes of the Health and Safety Committee held on 29 November 2016
- Report from the Remuneration Committee held on 21 February 2017
- Minutes of the Lothian Partnership Forum held on 24 January 2017

82. Date of Next Meeting

82.1 It was noted that the next meeting of the committee would be held on Wednesday 31 May 2017 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

DRAFT

1.13

STRATEGIC PLANNING COMMITTEE

Minutes of the meeting of the Strategic Planning Committee held at 9.30 on Tuesday 13 April 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; Ms T. Gillies, Medical Director; Mr D. Grant, Non-Executive Board Member; Mr M. Hill, Non-Executive Board Member; Ms F. Ireland, Non-Executive Board Member; Mr P. Johnston, Non-Executive Board Member; Non-Executive Board Member; Professor A. McCallum, Director of Public Health; Professor A. McMahon, Executive Nurse Director; Mr P. Murray, Non-Executive Board Member.

In Attendance: Ms J. Butler, Interim Director of Human Resources; Ms J. Campbell, Interim Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Ms S. Egan, Associate Director, Strategic Planning; Ms C. Gorman, Strategic Programme Manager; Ms L. Irvine, Strategic Programme Manager; Mr A. Joyce, Employee Director; Mr C. Marriott, Deputy Director of Finance; Mr R. McCulloch-Graham, Chief Officer, Edinburgh Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Ms A. White, Head of Adult Services, Midlothian Health and Social Care Partnership.

Apologies: Mr C. Briggs, Associate Director, Strategic Planning; Mr T. Davison, Chief Executive; Ms S. Goldsmith, Director of Finance; 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.

1. Minutes and Actions from Previous Meeting (13 April 2017)

1.1 The minutes from the meeting held on 13 April 2017 were approved as a correct record.

2. The People's Health

2.1 Children's Services

2.1.1 The Chair welcomed Ms Egan to the meeting and she spoke to the previously circulated paper. It was noted that the delegation of children's services was different in each of the Integration Joint Board which made overall planning complicated. The Children's Services Plans from each of the Integration Joint Boards had been completed with the exception of the Midlothian plan which was to be submitted to the Community Planning Partnership before coming back to the Strategic Planning

Committee for final sign off. It was agreed that it would be circulated electronically around the Committee as draft in the meantime. **AMcM**

2.1.2 There was discussion about the need for clarity in the statutory requirements of signing off these documents in terms of the difference between operational management and governance. It was agreed that Professor McMahon would find out the Scottish Government's view on an acceptable approval process when submitting the documents. **AMcM**

2.1.3 It was noted that the 'named person' part of the children's Act had not yet been implemented as the court decision on the legislation was not expected to be confirmed until 2020. The other parts of the Act were the way of working in NHS Lothian already.

2.2 National Maternity Strategy Implementation

2.2.1 Ms Egan gave a presentation on The Best Start Review which gave a number of recommendations about the future of maternity services in Scotland. It was noted that the change would be a significant human resource, estates and financial challenge. The Cabinet Secretary was expected to give further detail on implementation in the future. Ms Campbell noted that the current focus should be on the forum that would be used to work on the recommendations and how to engage with the national group. It was proposed that the Programme Board would be the forum used.

2.2.2 Mr Marriott noted that the work must take place but that it would be very difficult with the current resources and no resource would be supplied by the Scottish Government to implement the recommendations as it was expected to be cost neutral by changing the use of existing resources. It was likely that some bridging funding would be required and the possibility for taking cost savings and reinvesting should be considered.

2.2.3 Mr Ash suggested that instead of the strategy being developed separately to the financing, finances should be considered alongside the strategy from the beginning and cost neutral solutions or cost saving solutions identified.

2.2.4 It was agreed that the changes recommended would deliver benefits to care and that it did not need to be cost neutral within the service as long as it was cost neutral overall. Professor McMahon would bring a further paper back to the Committee when some agreement on implementation had been made.

2.3 Mental Health and Wellbeing

2.3.1 The Chair welcomed Ms Irvine to the meeting and she spoke to the previously circulated paper.

2.3.2 In answer to a question from Mr Murray, Ms Irvine advised that the proposal for mental health training for those who support young people in the educational setting had not been to the trades unions for consultation but was part of the Curriculum for Excellence for there to be a focus on the wellbeing of the child.

2.3.3 The paper gave an idea of the scope of the Lothian wide strategy, but local delivery would be the responsibility of the Integration Joint Boards. It was agreed that the Committee needed to keep an oversight of this work to ensure the Integration Joint Boards and NHS Lothian were working towards the same aims.

2.3.4 The Committee was pleased to see this strategy and that progress was being made in improving the quality of the mental health service which had previously lacked quality measures which would a give a focus for improvement. There was an opportunity to reduce cost and improve quality in the service.

2.3.5 Ms Gillies noted that with the new roles proposed training must be undertaken across the Integration Joint Boards to prevent workforce becoming a barrier to progress.

2.3.6 The Committee agreed to support the recommendations laid out in the paper. A final draft of the strategy would be submitted to the Committee in the autumn 2017. **AMcM**

3. Integration

3.1 Integration Joint Board Directions and Health and Social Care Delivery Plan

3.1.1 Mr McCulloch-Graham gave a presentation on the Edinburgh Integration Joint Board Delivery Plan. The formal directions would be submitted by May 2017. The move to 24/7 services was discussed. It was noted that Edinburgh Council would now be able to spend infrastructure money received when a new housing development was built on GP practices as well as on roads and schools.

3.1.2 It was noted that different accounting systems were used in Health and the Councils with the Council budget including expected savings in targeted schemes and the Health budget including only identified schemes. The Council must produce a balanced budget by law and this was achieved by using investment and reserves but was not robust.

3.1.3 In response to a question from Ms Egan, Mr McCulloch-Graham advised that the legislation did not prevent cross boundary working where a community crosses the local authority boundaries and there had already been a system of working together which would continue.

3.1.4 The Midlothian, East Lothian and West Lothian Directions and Delivery Plan had been previously circulated.

3.1.5 There was discussion about disaggregating services, for example diabetes where patients with diabetes in hospital may not be in hospital due to their diabetes. There was an understanding that if the best place for delivery of care was in the hospital and not local then this would continue. This was also relevant to Allied Health Professional services. This was part of considering all the Integration Joint Board Directions together as a system to ensure disaggregation did not have a detrimental effect on service provision. The Strategic Planning Committee had a role in this.

3.1.6 It was agreed that although there was a representative from acute services sitting on each Integration Joint Board, it was not clear how this individual fed back to acute services. Ms Gillies and Ms Campbell agreed to discuss this further. **TG / JCa**

3.1.7 It was noted that the Integration Joint Boards had adopted different ways of presenting their Directions and Delivery Plans. West Lothian had high level Directions with a detailed delivery plan, whereas the other IJBs had put the detail in the Directions; but the result was similar.

3.1.8 Professor McMahon advised that all four Directions would be responded to formally. There would be detailed consideration of performance actions and finance processes outwith the Committee and this would be discussed by the Clinical Management Team before being brought back to this Committee with a covering paper focusing on the important aspects where a view was required. **AMcM**

3.1.9 The discussion had raised questions about how the Strategic Planning Committee could better engage with the Integration Joint Boards. This would be discussed amongst the executive team. **JCr**

4. Lothian Hospitals Plan

4.1 Royal Edinburgh Hospital Phase 1

4.1.1 Professor McMahon advised that the Robert Fergusson Unit at the Royal Edinburgh Hospital had opened as part of phase one of the redevelopment and patients were already benefiting from the new environment. Psychiatry of old age was expected to move in June and adult mental health in July this year. These may be phased moves.

4.1.2 Phase 2 was being progressed starting with rehabilitation at the Astley Ainslie Hospital, women with multiple and complex needs, and learning disabilities services moves hoped to take place in the summer 2017.

5. Pan Lothian Business

5.1 Regional Delivery Plan

5.1.1 Professor McMahon advised that the Boards had been asked to consider how regional working with neighbouring Boards could work, and to submit a plan to the Scottish Government in September 2017. This would include plans for how the Integration Joint Boards are evolved as stakeholders.

6. Date of Next Meeting

6.1 The next meeting of this group would take place at **9.30** on **Thursday 8 June 2017** in **Room 7**, second floor, Waverley Gate.

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

NHS LOTHIAN

1.14

AUDIT & RISK COMMITTEE

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 24 April 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; 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 & Safety; Mr C Brown, Scott Moncrieff; Ms J Brown, Chief Internal Auditor; Mr J Crombie, Deputy Chief Executive; Mr D Eardley, Scott Moncrieff; Ms S Goldsmith, Director of Finance; Mr B Houston, Chairman; Ms D Howard, Head of Financial Services; Mr C. Marriott, Deputy Director of Finance; Professor A McCallum, Director of Public Health and Health Policy; Professor A McMahon, Executive Director for Nursing, Midwifery and AHPs. Mr J Old, Financial Controller; Mr A. Payne, Corporate Governance Manager; and Ms L Baird, Committee Administrator.

Apologies: Cllr. D Grant.

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.

1. Minutes from the Previous Meeting (27 February 2017)

1.1 The minutes from the meeting held on 27 February 2017 were approved as a correct record.

2. Matters Arising

2.1 Matters arising from the Meeting of 27 February 2017 – The Committee accepted the update on the actions detailed within the Running Action Note.

3. Risk Management (assurance)

3.1 NHS Lothian Corporate Risk Register

3.1.1 Mr Murray expressed disappointment that the issues raised surrounding variation and waste from the February 2017 meeting had not been incorporated into the corporate risk register. He acknowledged that though there was some narrative in the action note it would have been beneficial to see the impact on the risk register.

3.1.2 Members discussed in detail the decoupling of the financial priorities with the content of the risk register, and the need for the Board to purposely make decisions on how to deploy its resources in response to its most significant

risks. The risk register should be able to highlight what the Board is doing in response to the risks, and be a source of assurance that resources are being used appropriately. At the moment the members are finding it difficult to draw this information from the current report. Members acknowledged that many of the Board's financial priorities were driven by Scottish Government directives and therefore out with the control of the Board, however there was agreement that there should be a mechanism that allows the Board to use the information in the corporate risk register to affect change when risks become stagnant.

3.1.3 Mrs Goldsmith advised the Committee that the Board has had an explicit debate with respect to the use of resources and waiting times, but acknowledged that this has not necessarily been the case for other risks.

3.1.4 Ms Bennett advised the Committee that it was the first instance that the corporate risk register report reflected the levels of assurance that the other committees have taken with respect to the actions in place to mitigate the risks under their remit. She advised that this process had just started, and generally the committees are agreeing with the rating given to risks, but are less assured as to the plans that are in place to mitigate the risks.

3.1.5 The Committee agreed that it should ask the Finance and Resources Committee to look at the issues, and to design a process where that Committee properly considers the corporate risk register so that there is greater assurance that the Board is making the best use of its resources . **JMcD**

3.1.6 Mr Houston advised that he would lead a parallel holistic review of the system of governance, including addressing the issue of risks reported at committee level remaining static..

4. Internal Audit (assurance)

4.1 Internal Audit – Progress Report (April 2017)

4.1.2 Mr Murray thanked Ms Brown for achieving Key Performance Indicator No 4 (Draft reports are issued within 15 working days of completing field work) since the last committee meeting, detailed on page 6 of the report.

4.1.3 The Committee accepted the progress report.

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

4.3 Payroll (February 2017) – Members received assurance that the management actions due on 31 March 2017 were complete. Ms Howard advised that though the report stated there were no local procedures in place, the payroll department adhered to national procedures and systems, and anticipated that procedures could be easily captured or adapted from neighbouring boards. Once complete the procedure would be reviewed on

a three yearly basis but as not to delay or inhibit the progress any amendments to the procedure would be made as and when required.

4.3.1 The Committee accepted the report.

4.4 Anti-Ligature Arrangements at REH Phase 1 – Ms Brown advised that in a response to a request from the Interim Chief Executive the Internal Audit Team had undertaken a specific review of anti-ligature decisions at the REH Phase 1.

The original anti-ligature specification at the start of the project was not the final specification due to changes driven by anti-ligature needs, which in turn increased the cost significantly. The review was commissioned to determine what lessons can be learned from this. Ms Brown highlighted that there were opportunities to review the current anti-ligature policy, and that the report is likely to have some of the control objectives rated as AMBER. Ms Brown advised that the draft report is currently with management for their response and would be presented at the June committee meeting.

4.5 Whistleblowing incident – Ms Brown gave a verbal update on the progress of an investigation following a recent whistleblowing allegation regarding a contractor. The whistleblower questioned the contractors qualifications to carry out the duties, recording of gifts and hospitality received, and the tendering processed the contract was awarded. Internal Audit had looked at the spend over 12 months however the evidence collated did not prove or disprove the allegations made. It was anticipated that procurement would move to retender the contract in the near future and the final report will come to the June Committee.

4.6 Follow-up of Management Actions Report (April 2017) – Ms Brown gave a brief overview of the report noting that she had nothing new to add to the report.

4.6.1 In response to Mr Murray comments of the 50/50 amber and green rating for business continuity Professor McCallum refer to the extensive work required to sign off resilience plans for each site within NHS Lothian. She assured the committee that progress was in place but it would take time given the complexity of the task and that only two people are supporting the process. She advised the committee that the Resilience Committee had been assured that an adequate process is in place.

4.6.2 Professor McMahon provided a verbal update on the outstanding management actions relating to the prison services audit. He highlighted that there is a Quality Improvement Team in place, and minutes of the Senior Management Team are being appropriately circulated. Additionally management are now resolving 80% of all complaints through local resolution.

4.6.3 The Committee accepted the report.

4.7. Principles to Underpin the Working Relationship Between the NHS Lothian ARC and the IJB ARCs – Mr Payne gave a brief over of the development of the principles and what was required of the Committee.

4.7.1 In response to Ms Hirst's query Mr Payne confirmed that East Lothian IJB was represented and engaged within the process.

4.7.2 Ms Brown provided assurance to the Committee that quarterly meetings with the Chief Internal Auditors for each IJB and NHS Lothian were frequent, highlighting that future meetings would focus on plans to align internal audit plans to the risk registers.

4.7.3 The Committee agreed the principles and their dissemination to the Integration Joint Boards' Audit and Risk Committees for agreement. **AP**

4.8 Edinburgh Integration Joint Board (IJB) Internal Audit Report Performance Management (March 2017) –.

4.8.1 Mr Payne explained that this report had been referred to the Committee by the Edinburgh IJB Audit & Risk Committee in line with the above principles. It was the first time that such a report had been received. He explained that the report had already been sent to and considered by the Risk Management Steering Group, and the Committee was asked to consider what it wishes to do with these reports.

4.8.2 After discussion the Committee agreed the following process for future referred IJB internal audit reports:

- The secretary to the Audit & Risk Committee shall routinely send the reports to the Risk Management Steering Group. The Risk Management Steering Group will review the reports and assure itself that any reported actions/ risks are being appropriately addressed, and to determine what if anything should be done with it.
- The Risk Management Steering Group shall routinely provide the Audit & Risk Committee with a short report summarising what IJB reports it has received and a brief summary of any pertinent points.
- The Audit & Risk Committee will not normally receive the IJB audit reports, and will only do so at the recommendation of Risk Management Steering Group. **AP**

5. Counter Fraud (Assurance)

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

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

5.2 NHS Lothian: Patient Exemption Checking and Potential Fraud 2016 – Ms Goldsmith introduced the report. .

5.2.1 The Committee agreed to accept that report as a source of assurance of significant assurance that;

- The estimated levels of fraud/error with patient exemption charges in Lothian remain consistent with national positions. Lothian was 13% of the total.
- Lothian's (and Scotland's) overall estimated fraud/error had dropped from the previous year.
- Work continued to review efficiency of patient exemption checking processes.

6. External Audit (Assurance)

6.1 Interim Audit Report for the year ended 31 March 2017 – Mr Eardley took the Committee through the key points outlined within the report and highlighted that from the evidence provided there was a good basis to support the approval of the annual accounts in June 2017.

6.2 The Committee accepted the report.

7. General Corporate Governance (assurance)

7.1 NHS Lothian Information Commissioner's Office Audit Update – Professor McCallum advised that a small team strived to achieve compliance to standards that had emerged from England during the Information Commissioner's Office Audit visit. An enormous feat had been achieved in a very challenging time and as a result a repeat visit from the ICO was avoided. Actions to make the necessary improvement remained ongoing.

7.1.1 The Committee noted the significant progress in completing the actions identified within the follow-up audit report and progress had resulted in the ICO confirming there was no requirement to return to physically audit NHS Lothian.

7.1.2 The Committee noted the ongoing monitoring by the Information governance Assurance Board and the Healthcare Governance Committee.

7.2 Accounting Policies – The Committee reviewed and approved the accounting policies, confirming that they were appropriate for the Board at the present time for the purpose of giving a true and fair view.

7.3 Proposed Policy for the Provision of Non-Audit Services by the External Auditor – The Committee reviewed the proposed amendments to the standing financial instructions and agreed that the amendments be recommended to the Board **AP**.

7.4 Write-off of Overseas Debts – Members noted that due to the identifiable information detailed within the report it should be marked as restricted/ confidential.

7.4.1 The Committee reviewed appendices 1 and 2 and confirmed that the Director of Finance may approach the SGHSCD for its approval to write off the losses.

7.5 Results from the Members' Survey – The Chair advised that this item would be discussed in a private session of the Committee Members.

8. Any Other Competent Business

8.1 Chair of Audit and Risk Committee – Ms McDowell noted that it was her last meeting as Chair of the Audit and Risk Committee and proceeded to express thanks and best wishes for the future to those who had supported her during her term. In return the Chairman expressed his thanks for the support and hard work of Ms McDowell. He also advised that he would make a decision with regard to Ms McDowell's successor within 48 hours .

9. Date of Next Meeting

9.1 The next meeting of the Audit and Risk Committee would take place at **9.00** on **Monday 19 June 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 14 MARCH 2017.

Present

Voting Members – Danny Logue (Chair); Martin Hill, Susan Goldsmith, Alex Joyce, John McGinty, Anne McMillan, Frank Toner.

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

Apologies – Lynsay Williams, Elaine Duncan.

In Attendance – Alan Bell (Senior Manager, Communities and Information, WLC), Carol Mitchell (NHS Lothian), Marion Barton (Head of Health Services), Bridget Meisak (WL Voluntary Sector Gateway), Kenneth Ribbons (IJB Internal Auditor), Carol Bebbington (Senior Manager Primary Care and Business Support).

1. URGENT BUSINESS

The Chair referred to the report on Financial Assurance of 2017/18 Budget Contributions (Agenda Item 5) which had been circulated as a late report. The Chair ruled that the item would be taken as urgent business as the matter required a decision by 1 April 2017.

2. DECLARATIONS OF INTEREST

Danny Logue declared a non-financial interest as an employee of NHS Lothian.

3. MINUTES

(a) The West Lothian Integration Joint Board approved the minute of its meeting held on 31 January 2017.

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

(c) The West Lothian Integration Joint Board noted the minute of the meeting of the Strategic Planning Group held on 17 November 2016.

4. FINANCIAL ASSURANCE OF 2017/18 BUDGET CONTRIBUTIONS

The Integration Joint Board considered a report (copies of which had been circulated) by the Chief Finance Officer setting out the outcome of the financial assurance process on the contributions that West Lothian Council and NHS Lothian had identified to be delegated to the IJB for 2017/18.

The Chief Finance Officer explained that the matters to be taken into account as part of the financial assurance process were:-

- Assessment of prior year expenditure on IJB functions.
- Information on assumptions regarding estimated budget to be delegated to the IJB for 2017/18 and comparison against previous year spend and anticipated 2017/18 demands.
- Information on key budget risks associated with functions that would be delegated to the IJB.
- Information on the value of approved budget savings for 2017/18 that related to IJB functions.
- Details of any non-recurring funding included in the budget resources delegated to the IJB.

The Board was informed that West Lothian Council had approved its 2017/18 budget on 20 February 2017, including the 2017/18 level of resources associated with functions delegated to the IJB of £69,396 million. This took account of additional Scottish Government Health and Social Care funding to IJBs of £107 million specifically for social care. For West Lothian, the share of the funding had been confirmed as £3.060 million.

The 2017/18 Scottish Budget included an addition £100 million to be transferred from NHS Boards to Integration Authorities in order to protect investment in social care. A further £7 million was being provided directly to Integration Authorities towards disregarding the value of war pensions from social care financial assessments, and for pre- implementation work in respect of the new carers legislation. A breakdown of the additional £107 million was shown in the report.

A table within the report showed the 2017/18 budget, compared to the equivalent 2016/17 and 2015/16 budgets in respect of council functions delegated to the IJB. Appendix 1 to the report showed further details on the split of the resources against the various adult social care functions/services in each year.

The Board noted that a breakeven position was forecast against the 2016/17 budget. However there continued to be a number of pressure areas throughout the service due to increasing demands for social care services.

The 2017/18 budget resources totalled £69.396 million. This provided for the estimated additional costs associated with staff pay awards,

apprenticeship levy costs, demographic and demand led pressures and contractual inflation, including the estimated costs of continuing to meet the Living Wage commitment. The budget also reflected savings of £1.408 million which would require to be delivered to manage within the resources of £69.396 million delegated to the IJB. A number of key risks and uncertainties would require to be closely monitored during 2017/18, and these were identified within the report.

The 2017/18 financial plan assumptions in the report took account of total funding confirmed by the Scottish Government and the overall NHS Lothian budget figures that would be reflected in the report to NHS Lothian Finance and Resources Committee on 15 March 2017. After taking account of costs pressures, additional funding, financial recovery plans and in year flexibility, there was currently a remaining gap across NHS Lothian of £35 million. This represented 2.2% of the total recurring NHS budget.

In relation to NHS Lothian resources, the Chief Financial Officer considered that it was important to note that NHS Lothian financial planning was undertaken at Business Unit level, rather than IJB level, and the focus of NHS Lothian was to balance its budget at Business Unit level in the first place, which would then feed through to IJB.

The report contained a table showing a summary of NHS 2017/18 Contribution to IJB. Appendix 2 to the report showed further details of the split of the resources across the NHS Lothian contribution.

The Chief Finance Officer provided brief commentary relating to the 2016/17 budget position relating to NHS Lothian and outlined the key risks and uncertainties that would require to be closely monitored during 2017/18.

The report provided a summary of the key points of the financial assurance covering NHS Lothian and the council.

In relation to future financial strategy, it was noted that the IJB's strategic plan and strategic commissioning plan would help inform decisions around prioritisation of resources, new models of service delivery and disinvestment decisions, all of which would be necessary in the medium term financial planning process. As part of the 2016/17 Scottish Budget there was a requirement for NHS Boards to undertake three year financial planning. In addition, the council had approved a priority based approach medium term financial planning as part of the 2017/18 budget approved on 20 February 2017.

It was recommended that the Board requested partners to work with the IJB Director and Chief Finance Officer on preparation of a financial plan for IJB delegated functions over a minimum three year period. It was further proposed that this would be reflected in Directions issued to partners and that a further update on the proposed approach to the IJB's medium term financial strategy would be brought to the Board on 27 June 2017.

It was recommended that the IJB:

1. Note the financial assurance work undertaken to date;

2. Agree the allocation of additional 2017/18 Health and Social care Fund resources, taking account of Scottish Government requirements;

3. Agree that council and NHS Lothian 2017/18 budget contributions were allocated back to Partners, via Directions, to operationally deliver and financially manage IJB delegated functions from 1 April 2017;

4. Agree that the Directions attached in Appendix 3 to the report be issued to West Lothian Council and NHS Lothian respectively;

5. Agree that, in accordance with Scottish Government requirements, Audit Scotland and CIPFA Best Practice, the IJB would request that Partners work in conjunction with the Director and Chief Finance Officer to prepare a medium term financial strategy for IJB delegated functions;

6. Agree the updated IJB Annual Financial Statement attached in Appendix 4 to the report.

A number of questions raised by Board members were then dealt with by the Chief Finance Officer and the Director.

In response to a question raised, the Director of Finance (NHS Lothian) undertook to provide additional information relating to the budget figure under 'GMS' (Appendix 2) as the figure reflected a reduction for 2017/18.

Decision

1. To note the terms of the report and

2. To approve the recommendations by the Chief Finance Officer.

5. STRATEGIC PLAN ANNUAL REVIEW, HEALTH AND SOCIAL CARE DELIVERY PLAN AND DIRECTIONS

The Board considered a report (copies of which had been circulated) by the Director outlining the Draft First Annual Review of the IJB Strategic Plan 2016/26, the draft Health and Social care Delivery Plan and the proposed approach to Directions for 2017/18.

The report recalled that the Strategic Plan 2016-26 was developed during the course of 2015/16 with engagement of stakeholders through the Strategic Planning Group. It had been approved by the IJB at its meeting on 31 March 2016.

There was provision for review of the Strategic Plan periodically within the lifetime of the plan and in consultation with the Strategic Planning Group. The review should include the effectiveness of the plan in delivering integrated functions and whether a replace plan was required.

The Strategic Plan had been reviewed on the basis of consistency with the policy, economic and social context and ongoing accordance with values, resources, appropriateness, feasibility and desirability. The visions and values set out in the plan remained relevant and had a good fit with NHS Lothian and West Lothian Council encapsulating the purpose of the partnership. It was noted that the values required continuous reinforcement and promotion to support their practical demonstration.

The priorities and programmes outlined in the strategic Plan were considered to be consistent with the refreshed needs assessment. Taking these priorities into delivery within localities (including emerging arrangements for Primary Care Clusters) was a developmental requirement and was aligned with ensuring explicit connection with the Community Planning Partnership regeneration plans.

The Director considered that the first annual review preserved stability in the plan and did not require a replacement plan. It also confirmed progress and reiterated and reinforced the direction set by the 2016-26 plan. The review updated and refreshed the policy drivers for the plan.

The report went on to advise that, under Scottish Government guidance, the Strategic Plan should incorporate a medium term financial plan for the resources within its scope. The IJB should set out the total resources included in each year of the plan. This would be undertaken to ensure that there was appropriate resourcing and devolution of responsibility to deliver in line with the outcomes and priorities set out in the plan. In keeping with the guidance, NHS Lothian and West Lothian Council were expected to provide indicative three year allocations to the IJB which should be in line with the Strategic Plan. The rolling indicative allocation was subject to annual approval through the respective budget setting processes. A revised detailed integrated budget would be presented to the IJB following the conclusion of the budget setting process of the parent bodies.

The report then went on to provide commentary on the Health and Social care Delivery Plan which had been published on 19 December 2016. Appendix 2 to the report outlined the draft West Lothian Health and Social care Delivery Plan which took account of the Strategic Plan review and the Scottish Government's Health and Social Care Delivery Plan. It was intended to hold an IJB development session in June 2017 which would focus on the Health and Social Care Delivery Plan and transformational change required to support this.

Finally, the report examined the approach to directions. It was noted that the high level Directions for 2017/18 would be included within the IJB Financial Report to the Board. Regular review of performance against the West Lothian Health and Social Care Delivery Plan would be undertaken

with Partner bodies and reported to the Board as part of the quarterly performance updates.

The Integration Joint Board was recommended to:

1. Receive the report;

2. Discuss the contents of the report;

3. Approve the Draft First Annual Review of the Strategic Plan, the Draft Health and Social Care Delivery Plan and the approach to Directions for 2017/18.

4. Agree an IJB development session to be held in June 2017 which would focus on the Health and Social Care Delivery Plan and transformational change required to support this.

Decision

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

6. PRIMARY CARE PREMISES REPORT

The Board considered a report (copies of which had been circulated) by the Director setting out the Primary Care premises priorities for West Lothian and recommending actions to adjust the existing Infrastructure to support the needs of the steadily growing West Lothian population.

The Board was informed that West Lothian Council was at an advanced stage in replacing the West Lothian Local Plan with a new Local Development Plan (LDP).

The scale of housing development proposed in the LDP was set by the approved South East Scotland Strategic Development Plan and its associated Supplementary Guidance for Housing. The housing land requirement for West Lothian was identified as providing for a minimum of 18,010 houses for the period 2009 to 2024. This was well above the NRS projections and, if completed, would lead to potential population growth by 2024 of 39,081 – equivalent to 7 new GP practices.

It was noted that, to date, Primary Care Infrastructure development had been driven by a response to the poor state of existing premises, the capacity of individual practices to raise awareness of their particular issues and the opportunities created by sites becoming available.

The Scottish Government review of Primary Care Premises was due to report and it was anticipated that this might give a strengthened role in premises provision and management to the NHS/IJBs.

The Board was informed that the former CHCP had agreed a list of priorities and actions. The Primary Care Premises Plan (Appendix 1 to the report) had been refreshed to update progress against these.

The Board was asked to:-

1. Note the contents of the report.

2. Note the progress made in developing new premises and refurbishing existing premises to increase physical capacity for primary care and community service provision.

3. Approve the Primary Care premises priorities for West Lothian and actions required to match Primary Care infrastructure to population growth including:

   a. Development of new Heath Centre premises in East Calder

   b. Development of an additional GP practice in new building in Armadale

   c. Refurbishment of Whitburn Health Centre

   d. Progress the established development of Blackburn Partnership Centre to implementation in September 2017.

4. Recognise that premises, GMS income and associated funding stream were only part of the community service capacity which needed to be developed. The work needed to come together with the workforce planning for all associated disciplines.

Decision

1. To note the terms of the report; and

2. To approve the recommendations by the Director as set out in Section B of the report.

7. MEMBERSHIP REVIEW

The Board considered a report (copies of which had been circulated) by the Director concerning the membership of the Board, the Strategic Planning Group (SPG) and the Audit Risk and Governance Committee.

The report recalled that the Board and the SPG had previously asked for their membership to be brought back for review at a future Board meeting. The Audit Risk and Governance Committee had asked officers to consider what steps could be taken to widen participation at that committee.

The report contained a proposal to strengthen representation of the third sector by inviting the West Lothian Voluntary Sector Gateway to provide a non-voting member to sit on the Board and also to provide an additional members of the SPG.

The current membership of the Board, the SPG and the Audit Risk and

Governance Committee was shown in Appendix 1 to the report, together with the relevant categories of membership for each.

It was recommended that the IJB:-

1. Note the current membership of the Board, the SPG and the committee

2. Note the statutory guidance in relation to the role of the third sector interface (West Lothian Voluntary Sector Gateway) in the integration of health and social care.

3. Agree to one representative of the West Lothian Voluntary Sector Gateway, to be chosen by it, becoming a non-voting member of the Board.

4. Agree to one representative of the West Lothian Voluntary Sector Gateway, to be chosen by it, becoming a member of the SPG.

5. Otherwise note that there were places in the membership of the SPG to be filled and to consider how to do so.

6. Agree in principle, despite the statutory barrier to committee membership for non-Board members, that wider participation and involvement at the Audit Risk and Governance Committee was desirable.

7. Instruct officers to explore ways in which that might be achieved and to report back to the Board accordingly.

8. Consider if there were other changes that should be explored in relation to membership of the Board, the SPG and the Board's committees.

Decision

1. To note the terms of the report.

2. To agree that West Lothian Voluntary Sector Gateway be represented on the West Lothian IJB and SPG and to note that the organisation had chosen Bridget Meisak as its representative.

3. To note that officers would explore options for filling places in the membership of the SPG and the Board's Audit Risk and Governance Committee as recommended in the report, and that suggestions brought would be brought back to the Board in due course.

8. RISK MANAGEMENT POLICY AND STRATEGY

The Board considered a report (copies of which had been circulated) by the Director concerning the Risk Management Policy and Risk Management Strategy.

The Board was informed that a risk management policy was an essential element of an effective system for managing risks. The proposed IJB Risk Management Policy was attached as an appendix to the report.

The IJB's stated policy was to effectively mitigate risks to the achievement of its objectives by implementing robust risk management strategies, policies and procedures.

The Risk Management Strategy set out how the IJB would implement the Risk Management Policy and was attached as an appendix to the report. The Strategy included provision for the approval of policy strategy and procedures, and for the review of the risk register by the IJB and the Audit Risks and Governance Committee at regular intervals.

The IJB was asked to:-

Approve the Risk Management Policy.

Approve the Risk Management Strategy.

Decision

To approve the Risk Management Policy and;

To approve the Risk Management Strategy.

9. WEST LOTHIAN TECHNOLOGY ENABLED CARE PROGRAMME (WL TEC)

The Board considered a report (copies of which had been circulated) by the Director providing a six-monthly progress report on the West Lothian Technology Enabled Care (TEC) Programme.

The report recalled that West Lothian had been awarded funding by Scottish Government to participate in the 2 year national programme, to build on the original investment in telecare technology and accelerate commitment in line with emerging national and local priorities and technological developments.

The report went on to advise that work was progressing on all deliverables, with most projects currently at the implementation phase. The report contained a summary of achievements to date.

The Board was asked to note the progress on the West Lothian Technology Enabled Care (TEC) Programme and the contribution the programme was making to the IJB Strategic Plan.

Decision

To note the terms of the report.

10. CALLS FOR VIEWS ON DESTITUTION AND ASYLUM IN SCOTLAND

The Board considered a report (copies of which had been circulated) by the Director seeking approval of a response to the Equalities and Human Rights Committee in respect of their call for views on destitution and asylum in Scotland.

The report advised that the Scottish Parliament's Equalities and Human Rights Committee was intending to examine the issue of destitution and asylum in Scotland. The Committee had identified three questions that it would like input on, and these were outlined in the report.

The report contained a suggested response on behalf of the IJB. For question two, it was noted that West Lothian Council had a "No Recourse to Public Funds Procedure" and this was attached as Appendix 1 to the report.

The Board was asked to approve the response to the Equalities and Human Rights Committee in respect of their call for views on destitution and asylum in Scotland.

Decision

1. To note the terms of the report; and

2. To agree that the suggested response be submitted on behalf of the West Lothian IJB.

11. NATIONAL HEALTH AND SOCIAL CARE WORKFORCE PLANNING

The Board considered a report (copies of which had been circulated) by the Director providing a draft response to the Scottish Government's discussion paper in relation to workforce planning.

The Head of Health Services presented the report, highlighting that IJBs were required to complete integrated workforce development plans and they were tasked with managing integrated budgets to deliver or commission integrated health and community care services. This required a planned approach to the workforce which provided these services.

The draft response to the consultation contained the following key points:-

- that a national workforce development framework should be developed that also allowed for local variances.

- that IJBs would and should be responsible for local workforce planning and contributing to both regional and national workforce plans.

- that further consultation regarding the representation of the group who would design the framework.

- recognised the need for workforce planning in key areas as per the attached response.

- that all Organisational Development and Learning and Development resources across the IJB work collectively to plan and deliver on workforce plans.

The Board was asked to approve the draft response in appendix 1 for submission to the Scottish Government by the deadline of 28 March 2017.

Decision

1. To note the terms of the report and the draft response in Appendix 1.

2. To agree that, rather than submitting the full response as recommended, officers should write to the Scottish Government reflecting the IJB's view that workforce planning required a flexible approach that recognised that the two partners had two different structures.

12. CONSULTATION - ORGAN AND TISSUE DONATION AND TRANSPLANTATION

The Board considered a report (copies of which had been circulated) by the Director providing a response to the Scottish Government in respect of their consultation on organ and tissue donation and transplantation.

The Board was informed that the Scottish Government was consulting on a range of matters relating to two key approaches to inreasing numbers of deceased organ and tissue donors. A draft response on behalf of the IJB was provided in Appendix 2 to the report. The Board was invited to approve the submission of the response to the Scottish Government.

There followed a discussion around aspects of the consultation and a range of views were expressed, including the view that members may not have the level of expertise required to respond fully to the consultation.

Decision

1. To note the terms of the report and the draft response to the Scottish Government in respect of their consultation on organ and tissue donation and transplantation.

2. To agree that, rather than submitting the full response as recommended, officers should submit the suggested response to Question 1 on behalf of the IJB and that individual IJB members wishing to respond fully, could do so separately.

15. WOKRPLAN

A copy of the Workplan had been circulated for information.

Decision

1. To note the workplan; and

2. To agree that the item 'NMC Revalidation' (scheduled for the April 2017) be removed from the Workplan.

14. PROPOSED MEETING DATES 2017/18

The Board considered a list of proposed meeting dates for 2017/18 (copies of which had been circulated).

Decision

To approve the proposed meeting dates for 2017/18 as undernoted:-

Tues 26 September at 2.00 pm
Tues 31 October 2017 at 2.00 pm
Tues 5 December 2017 at 2.00 pm
Tues 23 January 2018 at 2.00 pm
Tues 13 March 2018 at 2.00 pm
Tues 1 May 2018 at 2.00 pm
Tues 26 June 2018 at 2.00 pm

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 20 APRIL 2017.

Present

Voting Members - Danny Logue (Chair), John McGinty, Anne McMillan, Martin Hill, Alex Joyce, Lynsay Williams.

Non-Voting Members – Ian Buchanan (Stakeholder Representative), Jim Forrest (Director), Mairead Hughes (Professional Advisor), Jane Houston (Staff Representative), Jane Kellock (Chief Social Work Officer), James McCallum, Patrick Welsh (Chief Finance Officer), Bridget Meisak (WL Vol Sector Gateway).

Apologies – Elaine Duncan, Mary-Denise McKernan, Martin Murray.

In Attendance – Alan Bell (Senior Manager, Communities and Information, WLC), Carol Mitchell (NHS Lothian), Marion Barton (Head of Health Services), Bridget Meisak (WL Voluntary Sector Gateway), Kenneth Ribbons (IJB Internal Auditor), Carol Bebbington (Senior Manager Primary Care and Business Support).

1. DECLARATIONS OF INTEREST

Danny Logue declared a non-financial interest as an employee of NHS Lothian.

2. MINUTES -

(a) The West Lothian Integration Joint Board approved the minute of its meeting held on 14 March 2017.

(b) The West Lothian Integration Joint Board noted the minute of the meeting of the Audit Risk and Governance Committee held on 6 January 2017.

(c) The West Lothian Integration Joint Board noted the minute of the meeting of the Strategic Planning Group held on 19 January 2017.

3. IJB ANNUAL ACCOUNTS COMPLIANCE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer setting out final accounts requirements and timescales for the IJB and proposed reporting arrangements to meet compliance with the Local Authority Accounts (Scotland) Regulations 2014.

The Chief Finance Officer advised that he was responsible for preparing the financial statements in accordance with relevant legislation and the

Code of Practice on Local Authority Accounting. This required the maintenance of proper accounting records and the preparation of financial statements which gave a true and fair view of the state of affairs of the IJB at 31 March 2017.

The EY Annual Audit Plan outlined requirements and timescales for the annual accounts process. The Local Authority Accounts (Scotland) Regulations 2014 required that the unaudited annual accounts, including the governance statement, were submitted to the appointed external auditor no later than 30 June each year. The regulations included a number of provisions in relation to the unaudited accounts including a requirement for the accounts to be considered by the Board, or a committee who remit included audit or governance, prior to submission to the external auditor.

The 2014 regulations required the audited accounts to be approved by 30 September. Following approval, and by 31 October at the latest, the audited annual accounts required to be signed and dated by the IJB Chair, Director and Chief Finance Officer, and then provided to the auditor.

It was therefore proposed that the annual audited accounts along with Audit Scotland's audit report be presented to the IJB for consideration and approval at its scheduled meeting on 26 September 2017.

It was recommended that the Board:-

1. Note the requirements set out in the report.

2. Note that the unaudited annual accounts would be considered by the IJB on 27 June 2017.

3. Note that the audited annual accounts would be considered for approval by the IJB at its meeting on 26 September 2017, allowing the deadline of 30 September to be met.

Decision

To note the terms of the report.

4. EXTERNAL AUDIT PLAN 2016/17

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer attaching a copy of Ernst and Young Annual Audit Plan 2016/17

The Chief Finance Officer advised that, as set out in the EY audit plan, auditors in the public sector gave an independent opinion on the 'truth and fairness' of the financial statements. Section three of the plan outlined EY's approach to the audit of the financial statements and significant risks identified.

Section 6 of the plan set out EY's audit team, timeline and deliverables. The

auditors would aim to certify the annual accounts by 30 September 2017. In terms of the audit fee, it was noted that due to the nature of the IJB, with this being the first full year of operation, no expected fee had been set centrally yet. Subsequent to this, a fee had been proposed by EY but this was still subject to agreement and further discussion with EY. Appendices to the plan set out audit independence and objectivity requirements and communications that would be provided to the IJB.

It was recommended that the Board note the external auditors' 2016/17 annual audit plan.

Decision

To note the external auditor's 2016/17 annual audit plan and that it had been approved by the Audit, Risk and Governance Committee subject to completion of the audit fee setting process and acceptance of the fee proposed by EY.

5. INTERNAL AUDIT ANNUAL REPORT

The Board considered a report (copies of which had been circulated) by the Internal Auditor advising the IJB of the Internal Audit Annual Report for 2016/17.

The Internal Auditor informed the Board that he was required to submit an annual report timed to support the annual governance statement. This would include:

- An annual internal audit opinion on the overall adequacy and effectiveness of the IJB's governance, risk and control framework;
- a summary of the audit work from which the opinion was derived;
- A statement on conformance with the PSIAS and the results of the internal audit quality assurance and improvement process.

The annual report, a copy of which was attached the report, fulfilled the requirement.

The IJB was required to conduct, at least once in each financial year, a review of the effectiveness of its system of internal control. This requirement had been discharged firstly, by the risk based audit work undertaken during 2016/17 as set out in the annual report and secondly, by the report on annual accounts compliance prepared by the Chief Finance Officer.

It was recommended that the Board:

- consider the contents of the annual report, in particular the internal audit opinion on the framework of governance, risk management and control.
- refer the annual report to the Audit, Risk and Governance

Committee for further consideration.

Decision

1. To note the terms of the annual report; and

2. To refer the annual report to the Audit, Risk and Governance Committee for further consideration.

6. ADDITIONAL ONE-OFF INVESTMENT FOR SOCIAL CARE/HEALTH PRIORITIES

The Board considered a report (copies of which had been circulated) by the Director providing details of one off funding agreed by West Lothian Council for Alcohol and Drug Partnership (ADP) Technology Enabled Care (TEC) investment.

The Board was informed that additional one off funding of £296,000 had been approved by the Council for social care/health initiatives. The use of the funding had subsequently been agreed by Council Executive on 28 March 2017 as relating to IJB functions and as an additional budget contribution to the IJB.

Health and Social Care officers had taken account of how this additional £296,000 should be utilised to support health and social care investment priorities, including taking account of the one off nature of the funding. Based on this, the following two measures had been agreed by Council Executive on 28 March 2017:-

1. Additional investment to commissioned addiction services to partially offset reduced specific Scottish Government funding for Alcohol and Drug Partnerships (ADPs).

2. Additional investment to support the Technology Enhanced Care programme (TEC)

The report recalled that Scottish Government funding for ADPs had been reduced by 23% in 2016/17. Part of the additional one off funding had been allocated to partially offset reductions to commissioned addictions services. A number of the service delivery activities had just been tendered with revised service specifications and reduced overall contract sums. It was not possible to make any change in these contracts without contravening European Procurement rules.

It was proposed that the restoration of funding be applied to the following two commissioned services for 2017/18:-

Therapeutic Support Service - £111,533

Recovery Service - £42,426

The outcomes achieved through this investment would be closely reviewed during 2017/18 and the ongoing sustainability of this investment would be

assessed as part of the overall 2018/19 budget planning process for social care and health services.

The report went on to advise that West Lothian had been innovative in exploring options to enhance investment in assistive care technologies and this was a key investment priority that would help meet future care demands and enable elderly clients to stay in their own homes. It was felt that the programme would benefit significantly if additional funding of £142,041 was added to the programme for 2017/18. This was likely to see a range of planned initiatives come on-stream at a much earlier state than would otherwise have been possible.

Both addiction services and the Technology Enhance Care programme were services which the IJB provided already under the Strategic Plan and it was proposed that the funding of £296,000 be made available to the IJB by Council for the purposes as outlined in the report with the IJB, through the Chief Officer, giving a supplementary Direction to Council to proceed on this basis.

It was recommended that the IJB agree that a further Direction be issued to West Lothian Council in respect of additional one off funding of £296,000 for ADP and TEC related investment.

Decision

1. To agree the recommendation by the Director that a further Direction be issued to West Lothian Council in respect of additional one off funding of £296,000 for ADP and TEC related investment.

2. To recognise that future proposals relating to the allocation of funding would be subject to a planning process that would take account of the entire budget and would be supported by the priorities outlined in the Strategic Plan.

7. STATUTORY ANNUAL PERFORMANCE REPORT

The Board considered a report (copies of which had been circulated) by the Director presenting the outline for the Annual Report 2016/17 and how this would be developed for publication by 31 July 2017.

The Senior Manager Primary Care and Business Support presented the report, advising that the Annual Performance Report 2016/17 as outlined in Appendix 1 to the report was structured according to the national health and well being outcomes and would include key performance measures, a performance assessment and practice examples for the reporting period.

Performance measures would be drawn from the Core Suite of Integration Indicators. Where appropriate the performance measures would be 'RAG-rated' using a traffic light system for illustrating progress against expected performance.

The Board was informed that the annual Performance Report 2016/17 would include sections on governance and decision making, financial

performance, Best Value, inspection findings, the annual review of the Strategic Plan and locality arrangements.

It provided the opportunity to reflect on the year and to celebrate the achievements delivered by employees and partners. It was also a chance to highlight new ways of working within services which focused on maximising choice and control for individuals, families and carers, tackling inequalities, long term conditions and working alongside employees, partners, professionals, third sector and communities to bring about change.

For each section the report would provide an assessment of performance and highlight examples of good practice. To this end the members of the Strategic Planning Group and Integration Joint Board were invited to submit examples for inclusion in the report.

Finally, it was noted that the Draft Annual Performance Report would be brought to the Board for comment and approval prior to publication in July 2017.

The Integration Joint Board was asked to:

1. Note the contents of the report.

2. Comment on the proposed Annual Performance Report outline

3. Consider examples of good practice for inclusion in the report.

Decision

To note the terms of the report and to note that examples of good practice were invited from Board members.

8. ARRANGEMENTS TO LIAISE AND CO-OPERATE WITH PARTNER ORGANISATIONS

The Board considered a report (copies of which had been circulated) outlining the arrangements in place to co-operate with Partner bodies to help achieve IJB objectives and outcomes.

The Board was informed of the requirements of Section 22 of the Public Bodies (Joint Working) (Scotland) Act 2014, and the West Lothian Integration Scheme in relation to collaboration, co-operation and sharing of relevant information.

The Director advised that there were a number of forums in place currently which were meeting the need for co-operation and collaboration, and these were listed in the report.

In addition to those listed, it was worth noting that there were the following national groups in place in relation to IJBs:

- Chief Officer's Health and Social Care Scotland. This group ensured

there was collaboration and a sharing of information at a national level between IJB chief officers and other partner organisations including the Scottish Government.

- Chief Finance Officers Network. This group met regularly to ensure that was collaboration and a sharing of information at a national level between IJB Chief Finance officers and other partner organisations including the Scottish Government.

The Board was asked to note the contents of the report.

In response to questions raised, the Director undertook to ascertain (i) whether a group (chaired by Carol Harris) was still in operation and (ii) the appointed staff side representative on the Primary Care Investment and Redesign Board.

Decision

To note the terms of the report.

9. EQUALITIES MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2017 - 2021

The Board considered a report (copies of which had been circulated) by the Director attaching a copy of the Integration Joint Board's Equality Mainstreaming Report and Equality Outcomes 2017-2021.

Under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, public bodies were required to develop and publish an equality mainstreaming report and a set of equality outcomes and to report on progress against those every two years.

The Board was informed of what West Lothian IJB was doing and what it planned to do to mainstream equality. It also set out four equality outcomes for the IJB to work towards over the coming four years. If agreed, the mainstreaming report and equality outcomes would be published ahead of the deadline of 30 April 2017 and progress against this would be published in April 2019.

It was explained that equality outcomes were results intended to achieve specific and identifiable improvements in people's life chances. The IJB's Equality Outcomes for the four year period 2017-2021 were set out in the final section of Appendix 1 to the report. The outcomes had been developed through evidence gathering and engagement work as part of the development of the strategic plan. Each outcome had been designated to a responsible officer or group.

It was recommended that the Board note the report and agree the Equality Outcomes for 2017 – 2021.

During discussion, the Board heard a suggestion by Jane Houston relating to Appendix 1 to the report at page 10. It was suggested that "policies" should read "governance". In response, officers undertook to

amend the document as suggested.

Decision

1. To note the terms of the report.

2. To agree the Equality Outcomes for 2017-2021, but subject to amending “policies” to “governance” as suggested.

10. COMMUNITY PLANNING PARTNERSHIP

The Board considered a report (copies of which had been circulated) by the Director providing an overview of the IJB relationship with the West Lothian Community Planning Partnership and the various groups and work streams associated with the Partnership.

The Board was informed that the West Lothian Community Planning Partnership (CPP) was structured to deliver the Single Outcome Agreement through a number of partnership groupings. These were:

The Community Planning Partnership Board
The Community Planning Steering Group
Four thematic Forums

1. Community Safety
2. Health and Well Being
3. Economic
4. Environment

Each grouping of the partnership had relevant representation from partner organisations based on the business of that group. This included the SOA enabler groups and related development work streams.

The IJB was represented by the Chief Officer and Senior Managers on the CPP Board; CPP Steering Group, Community Safety Strategic Steering Group and the Anti Poverty Strategy Board. In addition, members of the senior management team were involved in the CPP work streams focussed on resource aligning; resources, data and information; and enabling collaborative leadership.

Finally, it was noted that the CPP received regular reports on the health and well being outcomes and had received presentations on our approach to health and social care integration and the IJB Strategic Plan. Through the various Boards and groups representatives of the IJB ensured the CPP were actively engaged in the work of the IJB and could contribute fully to the development of plans and approaches to ensure alignment with the SOA and the National Health and Well Being Outcomes.

It was recommended that the IJB:-

1. Receive the report;

2. Note that the IJB was a member of the Community Planning Partnership

3. Note that the Chief Officer and Senior Managers represented the IJB across the activities of the Community Planning Partnership

4. Note the joint working with the Community Planning Partnership in terms of Strategic Planning and Locality Planning

Decision

To note the terms of the report.

11. WORKPLAN

A copy of the Workplan had been circulated for information.

Decision

To note the Workplan.

Chair's Closing Remarks

Referring to the forthcoming local government elections in May 2017, the Chair thanked officers and IJB members for their support and co-operation during the current term of administration.

East Lothian Integration Joint Board

1.16

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 23 FEBRUARY 2017
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:
Mr A Ash
Councillor S Akhtar
Councillor J Gillies (*substitute)
Councillor D Grant
Ms F Ireland
Mr A Joyce
Mr P Murray

Non-voting Members Present:
Dr R Fairclough
Dr A Flapan
Mr D Harvie
Mr D King
Mrs M McKay
Ms M McNeill
Ms S Saunders (Items 4 – 8)
Mr D Small
Mr A Wilson

ELC/NHS Officers Present:
Mr B Davies
Mr P Currie

Clerk:
Ms F Currie

Apologies:
Councillor S Currie
Councillor Goodfellow
Ms F Duncan
Ms A MacDonald
Mr T Miller

Declarations of Interest:
None

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 26 JANUARY 2017

The minutes of the East Lothian Integration Joint Board meeting of 26 January 2017 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 26 JANUARY 2017

The following matters arising from the minutes of the meeting held on 26 January were discussed:

Delayed Discharges – David Small updated members on the census figures for February 2017 which had exceeded the target for that month. He confirmed that good progress continued to be made and he was hopeful of meeting the target set for March 2017.

3. CHAIR'S REPORT

The Chair reported that East Lothian Council had agreed their budget on 21 February 2017 and that further details of the Adult Wellbeing element would be discussed under agenda item 7.

He also advised members that Mike Ash had been appointed to the Edinburgh IJB and that he would be standing down as a member of the East Lothian IJB with effect from 31 March 2017.

4. NHS HEALTHCARE GOVERNANCE COMMITTEE

Fiona Ireland reported that although the NHS Healthcare Governance Committee had not met since the last IJB, she had attended a meeting of the Acute Hospitals Committee (AHC) earlier that week. She advised that there had been an extensive presentation from the outpatient board (Joan Donnelly). The outpatient modernisation was particularly pertinent to IJB Strategic Planning Groups and the paper referred to the governance being through the Acute SMT and each of the IJB Strategic Planning Groups. Ms Ireland suggested that this may be a topic for a presentation to future meetings of the Strategic Planning Group and the East Lothian IJB to help facilitate the IJB's involvement in shaping the future of outpatient services for the community. In the meantime, if members agreed, she would circulate a copy of the paper presented to the Committee.

Dr Andrew Flapan provided additional background to the outpatient modernisation programme which, he said, centred on a shift from acute to outpatient care through greater use of primary care services and community-based care. He said that this programme offered the IJB the opportunity to influence how these services would look in the future.

Members discussed the risks associated with such a shift in care and the implications for GP services and home-based care packages. They agreed that the IJB should be closely involved in developments.

Ms Ireland advised that the AHC had also considered a report on the Edinburgh IJB Flow Programme. This had included the "Whole System Flow Dashboard" which was being developed not just for Edinburgh but for all Lothian IJBs and this single collection of data would allow the IJB to consider the impact of actions in one part of the system on the other parts, and where efforts needed to be focussed to make a difference.

Mr Small said that this was more of an operational management tool rather than a strategic tool but he acknowledged the value of keeping the IJB informed of its development. He advised that there was no proposal for the IJB to become involved in the Flow Board and day-to-day issues would continue to be managed from the Hub at Roodlands.

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

The Chair advised members that there had been no meetings of the Policy & Performance Review Committee and the Audit & Governance Committee in February.

Mr Small advised that both Committees would be meeting in March and that Councillor Goodfellow would provide an update at the next IJB on 30 March.

David King indicated that the issue of information sharing between NHS Lothian and IJB audit committees had been discussed at the Audit & Risk Committee meeting on 21 February and a dialogue was ongoing. Mr Small added that a revised proposal on information sharing between the Council's Internal Audit team and the IJB Audit & Risk Committee would be presented to a future meeting of the Council's Audit & Governance Committee. However, the timing of this had yet to be confirmed.

6. HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT UPDATE

The Chief Officer had submitted a report updating the IJB on performance against an agreed suite of indicators which were last reported on in August 2016 and informing the IJB of the introduction of new performance measures which will need to be incorporated into local performance monitoring processes.

Paul Currie presented the report. He provided a summary and analysis of the data contained in the performance report and how this compared with the results of last year's report. He also referred to the recent guidance on additional performance indicators issued by the Scottish Government and COSLA.

The Chair advised that Sir Harry Burns was working on a review of health and social care targets and indicators and that the Scottish Government's Ministerial Strategic Group would take account of these in their development of future performance indicators.

Mr Ash observed that the six indicators on the Scottish Government's list were not exhaustive but were considered crucial and on which there was data available. The wider development of performance monitoring was a matter for individual IJBs and could include any number of additional indicators.

Danny Harvie raised the question of Care Inspectorate (CI) visits and the measures in place to identify the services which were struggling. He asked about services in East

Lothian and whether the CI had a view on their performance. He also commented that there may be a process issue in that high performing services tended to be inspected less than those who were struggling and that this may impact on overall performance results.

Mr Small said he was not aware of any current issues from the local CI team. He advised that two care homes and two care providers had experienced problems during 2014/15 and 2015/16 but that work had been undertaken to bring them back up to standard.

Peter Murray expressed concern about the frequency of reporting and on the rating for National Performance Indicator No. 8. He asked how it could be rated 'green' when it was only 47.7% and just above the Scottish average. He stated that local priorities were crucial to ensure that performance was measured in a way that was meaningful to the local population of East Lothian.

Margaret McKay agreed with Mr Murray's remarks and questioned how the IJB could take comfort from these results. She added that the time was long overdue for the IJB to develop its understanding of the needs of carers, many of which were already well-documented, and to take a comprehensive look at the current provision for carers in East Lothian with a view to developing a cohesive action plan.

Dr Richard Fairclough stated that while strategy and policy were important there needed to be more work done on the ground. This was of particular urgency given the proposals for the transfer of care to community-based services. He said that the IJB must make sure that the key components were in place to support carers and address their needs.

Bryan Davies responded to these points outlining plans to engage with stakeholders to develop a Carers' Strategy and to look at improvements to current governance arrangements. He acknowledged the importance of action on the ground but emphasised the need to begin with a clear strategy to drive this work forward.

Mr Small suggested that this may be a good topic for a development session for IJB members, possibly in place of the April business meeting. Mrs McKay agreed that this would be very helpful.

In response to a question from Councillor Shamin Akhtar, Mr Davies advised that the work on the Carers' Strategy would begin very soon.

Mr Small advised members that a further report would be presented later in the year and, in the meantime, their comments would be taken into account when drafting the Directions to make them more focussed and measurable.

The Chair thanked members for their input and observed that issues relating to carers were nationwide and not restricted to East Lothian. However, he acknowledged Mrs McKay's point that further work needed to be done.

Decision

The IJB agreed to:

(i) Note the second Performance Report and to note progress made against the indicators between August 2016 and February 2017;

(ii) Discuss the implications of the second Performance Report and its consequences for the development of further performance measures and monitoring; and

(iii) Note the additional measures being developed by the Scottish Government and COSLA.

7. FINANCIAL PLANNING 2017/18

The Chief Finance Officer had submitted a report laying out the Scottish Government's budget settlement for East Lothian Council and NHS Lothian for 2017/18; the Scottish Government's indications for the IJB's budget settlement for 2017/18; the outline offer from NHS Lothian and a reflection of East Lothian Council's budgetary proposals for the IJB; the financial pressures identified by the current position; and the proposed approach to this settlement.

Mr King presented the report. He outlined the key points relating to the settlement from the Scottish Government for 2017/18, including Health Boards, Councils and the Social Care Fund (SCF). He also informed members of the budget offer from East Lothian Council and provided an update on the discussions with NHS Lothian. He confirmed that a formal budget offer would be made to the IJB by NHS Lothian before 31 March 2017.

Mr King also drew members' attention to the potential financial pressures for 2017/18 that had been identified by the Partners, warning that these would be significantly greater than the pressures experienced in 2016/17. Finally, he invited the members to consider the proposed approach to this settlement as set out in the report.

Mr Murray observed that the current budget information did not seem to reflect the IJB's aspirations around movement of resources from hospital services to community-based services. He wanted to know if this was a timing issue or if it would be reflected in the Directions for 2017/18. He referred to Dr Flapan's earlier point about the power of the IJB to influence change and wanted to know at what point the IJB would begin to address this.

Mr King advised that disinvestment and reinvestment of this kind would take time and would require the closure of some services before the funds could be transferred elsewhere. However, he acknowledged that these were the aspirations of the IJB and would need to be reflected in the Directions.

Dr Fairclough expressed concern that the transfer of services from Acute to Primary Care could happen ahead of the resource transfer. He said that this could cause significant challenges which may result in the IJB not being able to achieve its aims. He emphasised the need to work on remodelling care and community provision as a matter of urgency and to ensure necessary resources were available.

Mr Ash referred to the delay in receiving financial information in 2016/17 and recommended that the IJB be much tougher on its Partners this year. He suggested that addressing the potential financial pressures should be the first priority but also commended the use of the Integrated Care Fund (ICF). He reminded members that the ICF had been set up to support innovative ideas and its use would ensure that, no matter how severe the financial pressures might be, there would always be the opportunity for innovation.

Dr Flapan said that there needed to be clarification on the difference between someone needing complex hospital care and simply needing care. Money currently spent on hospital beds could achieve much in the community but there needed to be a change in mindset.

Mrs McKay observed that the IJB needed to find a way not only to bridge the gap between the old and new system of care but also a way to bridge the funding gap.

Mr Murray gave the example of the Fire & Rescue Service which had required additional money to fund the initial stages of its transformation programme. He acknowledged the need to bridge the gap and that the IJB would have to consider how best to achieve this.

Mr Small referred to the Scottish Government's Transformation Fund which was set up for this purpose. He suggested that the IJB may wish to consider bidding for a share of this money. He also thanked members for providing a clear steer in terms of what they expected to see in the Directions for 2017/18. These would be presented to the IJB at its meeting on 30 March.

Decision

The IJB agreed to:

(i) Note the report;
(ii) Note the issues surrounding the 2017/18 budget settlement;
(iii) Note the magnitude of the financial challenge facing the IJB in 2017/18; and
(iv) Consider the approach to the 2017/18 financial settlement.

8. POSITION STATEMENT ON SECTION 10 GRANT FUNDED SERVICES – ADULT SERVICES

The Chief Officer had submitted a report informing the IJB of the current position with regard to Section 10 grant awards within Adult Services and the proposed way forward for 2017/18.

Bryan Davies presented the report. He outlined the background to the grant awards, the ongoing review and how these related to the projects on remodelling specialist support and care at home services which would be in place by April 2017. He explained that the review of Section 10 grant funding would consider how existing services could fit into the future framework and whether they may be alternative funding options for services such as independent advocacy and lunch clubs.

At the request of the Chair, Mr Davies provided additional information on the remit and membership of the Health & Social Care Procurement Board.

Responding to further questions from members, Mr Davies advised that most grant awards were historic but that this would be looked at as part of the review. He also said that the recent internal audit had identified the need for more robust arrangements for procurement and review and that these were now in place.

Sharon Saunders stated that a number of the arrangements currently in place, both Service Level Agreements and contractual arrangements, were of several years standing and she was aware from earlier discussions that the IJB was supportive of a

number of these services. The review would help to identify where improvements could be made to procedures for awarding and reviewing the value received from grant funding. She added that, going forward, it would be important to evidence how these grant awards were supporting the IJB's strategic priorities for adult and older people's services.

Decision

The IJB agreed to:

(i) Approve continuation of current Section 10 Grants for the 12 months from April 2017 to March 2018 noting the commitment to complete the review of all grant funding within that year;

(ii) Note that a number of reviews have taken place and further reviews on the remaining services will continue beyond April 2017 in order to have a complete picture of community provision in preparation for the development of a new community framework to be in place by April 2018;

(iii) Note that a proportion of Section 10 funding has been made available and a decision will be made on the use of this funding once the budget position for 2017/18 is confirmed; and

(iv) Note the progress made against the key recommendations from the internal audit of Section 10 Grant funded services.

Signed .....
Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 30 MARCH 2017
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:
Mr A Ash
Councillor S Akhtar
Councillor S Currie (items 1 – 10)
Councillor Goodfellow (items 1 – 11)
Councillor D Grant
Ms F Ireland
Mr P Murray

Non-voting Members Present:
Ms F Duncan (items 6 – 15)
Dr R Fairclough
Dr A Flapan (items 5 – 15)
Mr D King
Ms A MacDonald
Mrs M McKay (items 1 – 9)
Mr T Miller
Ms S Saunders
Mr D Small

ELC/NHS Officers Present:
Mr M Bonnar
Mr P Currie
Mr B Davies
Ms J Ogden-Smith

Clerk:
Ms F Currie

Apologies:
Mr A Joyce
Mr D Harvie
Ms M McNeill
Mr A Wilson

Declarations of Interest:
Mr E Stark declared an interest in relation to Item 7 – Integrated Care Fund.

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 23 FEBRUARY 2017

The minutes of the East Lothian Integration Joint Board meeting of 23 February 2017 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 23 FEBRUARY 2017

The following matters arising from the minutes of the meeting held on 23 February were discussed:

Carer's Strategy - Councillor Shamin Akhtar asked when work would begin on the Strategy. Bryan Davies advised that a Strategy Officer was now in post and would shortly begin working with partners and stakeholders.

Cost of Care at Home – In response to a question from Councillor Jim Goodfellow, David Small circulated a briefing note to members regarding an article in the East Lothian Courier on 23 March 2017. The article focused on the average hourly rate for care at home for older people for East Lothian Council compared to other councils. Mr Small summarised the response contained in the briefing note which detailed the factors affecting the average rate and why direct comparisons between councils were not always helpful.

A brief discussion followed regarding the costs of care, the conditions of service for care providers, the expectations of service users in relation to reliability, continuity and quality of care provision, and whether a lower cost per hour suggested that the Council was getting better value for money than other local authorities who charged more. Mr Davies explained some of the measures in place to improve the relationship with care providers and the level of service. He also confirmed that regular surveys were undertaken to assess the views of service users on the type and quality of care they receive.

Mr Small added that while the IJB had overall responsibility for delivery of the Strategic Plan it was for the Council to determine the details of care contracts. He acknowledged that there may come a point where this might impact on the IJB's ability to deliver its priorities but matters had yet to reach that stage.

Ministerial Steering Group – Mike Ash provided an update to members on the work of the Group in reviewing health and social care targets and indicators. He reported that the Group had taken on board comments and would provide a revised list which may contain more than the current six performance indicators.

3. CHAIR'S REPORT

The Chair said he would reserve his remarks to the end of the meeting.

Valedictory
On behalf of all of the members of the IJB, Mr Small expressed his sincere thanks and appreciation to Donald Grant and Mike Ash, both of whom would shortly step down from the East Lothian IJB. He praised their commitment and drive which he said had been instrumental in advancing change over the past 5 years through the Community

Health Partnership, the Shadow Board and culminating in the establishment of the IJB. Mr Small concluded that these partnerships had been stronger as a result of their efforts and would be diminished by their departure. He wished them both well for the future.

4. NHS HEALTHCARE GOVERNANCE COMMITTEE

Fiona Ireland reported that she had not been able to attend the last meeting of the NHS Healthcare Governance Committee. However, she had received feedback on the discussion and confirmation that District Nursing across the Lothian area and wider primary care priorities would be included as standing items on the agenda for future meetings.

Mr Small also advised members that there would be a 'Second Summit on Primary Care' taking place on 4 May 2017. While he understood that many of the Councillors would be occupied by the local government elections, he encouraged other members to attend. Further details would be circulated to members via e-mail.

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

Councillor Goodfellow advised members that there had been no items of significance to the IJB on the agendas of the most recent meetings of the Policy & Performance Review Committee and the Audit & Governance Committee.

6. DELAYED DISCHARGES

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

Alison MacDonald presented the report. She outlined the key points of the report and provided additional context to each of the 15 delayed discharges. She acknowledged that there was a personal story behind each number and assured members that the focus was on addressing each person's individual needs. She added that a lot of good work had gone into reducing the delayed discharge figure from 61 to 15 and she hoped that this would continue to decrease over the coming months.

Ms MacDonald responded to questions from members providing further information on multi-disciplinary assessments to identify the most suitable care packages and the involvement of non-professional carers. She also confirmed that she was aware of the 72 hour target indicator but not of any date having been set for its achievement.

Mr Ash commented that the report from the Scottish Government Working Group, due out later in the year, may provide more clarity on this matter.

Councillor Stuart Currie commented that if someone is assessed as being ready for discharge it was unacceptable that they should be kept in hospital. Referring to the regular fluctuations in the figures he said that he would like to see a more consistent improvement. He did not question the level of commitment shown by staff but he pointed out that the target was 0.

Dr Richard Fairclough agreed that in an ideal world the aim would be to reach 0. However, as a community GP, he would prefer to see people discharged with an appropriate care package in place rather than discharged too early and risk a failure in care resulting in readmission to hospital. In his view, it was worthwhile spending a few more days to get things right.

Mr Davies and Ms MacDonald referred to new procedures in place to try to avoid some delayed discharges, such as leaving open existing care packages for those people on short-term admissions and developing care packages at a much earlier stage.

Dr Jon Turvill added that avoiding unnecessary hospital admissions in the first place would also help matters.

Mr Small agreed that consistency was important but reminded members that the figures were influenced by a range of factors including seasonal fluctuations.

The Chair welcomed members' comments and noted the work ongoing to continue reducing the delayed discharge figure.

Decision

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

7. DELAYED DISCHARGE FUND AND INTEGRATED CARE FUND

The Chief Officer had submitted a report updating the IJB on utilisation of the Delayed Discharge Fund and the Integrated Care Fund in 2016/17 and presenting propositions for their use in 2017/18.

Paul Currie presented the report. He outlined the main points of the report, summarising some of the key projects and proposals for the development of future initiatives. He reminded members of the importance of early intervention in the acute care process to avoid delayed discharges and the need to further develop out of hours services, and improve engagement with family and support networks to avoid unscheduled admissions.

Mr Murray asked about the overlap between some services and the possibility of a review and restructuring to avoid duplication.

Ms MacDonald advised that many of the services had been set up in response to demand but acknowledged that there was overlap and that this would be looked at as part of a broader review aimed at developing more flexible community-based services.

Mr Ash noted that the Delayed Discharge Fund was now part of the base budget and asked why the same had not been done for the Social Care Fund, given that the Scottish Government had made provision for this to happen.

Mr Small reminded him that there may be a potential change to the money coming from the Government. Mr King said that holding it separately gave the opportunity to use it for transformation; however, it could be brought into the baseline if members preferred this option.

Ms Ireland supported Mr Ash's comments stating that the only way to transform district nursing and community provision was to bring it in as part of the core budget. She said that the impact of keeping these services separate needed to be fully considered.

Margaret McKay welcomed the report as a useful synopsis. She noted that the amount of money for carers was small and that the emphasis had been placed on care packages. Mr King advised that the there was also a modest amount for the Carers' Strategy which had been missed out of the report in error. This would be reinstated.

In response to further questions on funding, Mr Small advised members that there was limited money available and choices would have to be made on what was possible. He added that it would be very important for the IJB to meet its commitments in relation to dementia suffers and their families, as they were not doing so at present.

Councillor Currie said that baseline budgets and tracking outcomes were both important. He also supported the funding of the Carers' Strategy but questioned whether the agreed budget would be sufficient.

Mr Murray was concerned that IJB should concentrate its own priorities rather than those imposed by others.

Mr Ash said that his understanding was that the Scottish Government was trying hard to make money available in the baseline budget. He agreed with the idea of a transformation fund but it should not be limited to the Social Care Fund.

Decision

The IJB agreed to:

(i) Note the range of initiatives made possible by the Delayed Discharge Fund and the Integrated Care Fund which have improved the way care is provided across East Lothian through a focus on community based support and care delivery at home or in a homely setting;
(ii) Support the continuing development of the initiatives into the next financial year;
(iii) Support the incorporation of the Delayed Discharge funding into the baseline operational budget to continue the services it supports.

8. PRIMARY CARE PRIORITIES IN EAST LOTHIAN

The Chief Officer had submitted a report informing the IJB of the intended focus of work in 2017-18 to support, stabilise and develop General Practitioner (GP) primary care services across East Lothian. This follows on from a range of actions taken during 2016-17 to support GPs and their teams.

Mr Currie presented the report. He outlined the background and key proposals for primary care development.

The members raised questions around the lack of developer's contribution for healthcare services in the new Blindwells settlement and the proposals for GP services.

Mr Currie said it was his understanding that Phase 1 of the development fell outside of the scope for section 75 contributions but that this may be an option for Phase 2.

Mr Small added that while the new Local Development Plan (LDP) included a clear framework for section 75 contributions for healthcare, the Blindwells planning application was dealt with under the 2008 LDP which did not include this provision. However, he had been assured that the phases of the development which come forward under the new LDP will be subject to section 75 agreements.

Dr Turvill declared an interest as a member of one of the GP practices involved in discussions over the provision of a small 'seed' practice which would eventually migrate to Blindwells. He said that the Cockenzie practice was close enough geographically to the Blindwells site although public transport links may have to be reviewed.

Mr Murray commented that this report pointed the IJB in the right direction and offered a model which may be able to meet future demand across the county. He agreed with proposals for a multi-disciplinary approach but was concerned that the message was not being relayed strongly enough internally or externally. He said that the IJB needed to ensure that whatever primary care model was put in place it supported a reduction in acute beds.

Councillor Currie observed that the Blindwells development would progress over the coming years but he would have preferred to see a section 75 contribution for healthcare. In terms of access to primary care services in Musselburgh, he supported the idea of a roll-out of the new model which would allow time to build community confidence. He emphasised the importance of continued dialogue with the community to promote the new services and demonstrate how these could benefit local people.

Ms Ireland supported the 8 priorities set out in the report but had concerns about the funding for these services. She said it would be helpful to see figures for each of the priorities.

Mr Small advised that further money would be available and a follow-up report would be presented to the IJB when these sums were known. In the meantime, he said it was important that the IJB saw these proposals as they would be reflected in the Directions for 2017/18.

Dr Fairclough welcomed a report which prioritised GP services and said that the focus should be on a multi-disciplinary approach. He agreed with other members that funding remained a concern and urged the IJB to consider carefully how it spent money across the county and not to perpetuate existing health inequalities. He acknowledged the need to be realistic about the challenges of delivering these services and the importance of getting the message across that a change to services did not necessarily mean a reduction in services.

Decision

The IJB agreed to:

(i) Note that general practitioner managed services across East Lothian remain under pressure as a result of a number of local and national factors;

(ii) Approve plans to focus primary care development input and available funding on the following priority areas:

- Musselburgh Primary Care Access Service
- East Lothian Care Home Team

- Primary care nursing training
- Practice-based pharmacists
- LEGup support for list size growth
- Provision of IT hardware
- Future planning for a new practice at Blindwells
- Diabetes LES

9. SET ASIDE INVESTMENT PROPOSALS FOR 2017-18

The Chief Officer had submitted a report presenting to the IJB the NHS Lothian and acute hospitals Set Aside investment proposals for 2017-18 and seeking approval to secure outcomes from planned developments which are of benefit to East Lothian residents and which shift the balance of care.

Dr Turvill presented the report outlining in detail the background to and reasons for the recommendations.

Dr Fairclough welcomed the shift towards community-based care but expressed his concern that the necessary resources would not follow and that this would create an increased risk of failure.

Mr Ash said that the IJB should continue its dialogue and make it clear to NHS Lothian that it cannot support its proposals as they stand and that money not invested in acute beds must be passed on to the IJB.

Mr Murray urged caution noting that it would be a significant challenge to get to 85% bed capacity. However, he accepted that a community-based solution was needed.

Dr Andrew Flapan said that he appreciated the views of members however NHS Lothian had a requirement to deliver medical care and to meet waiting time targets. Acute medical units were not long stay units and moving patients elsewhere in the hospital could result in the cancellation of admissions for routine operations.

Mr Small accepted these arguments but reminded members that the report was asking them to consider exploring alternatives and not to agree movement in budgets.

Councillor Currie observed that there were consequences to every decision and that the whole point of integration was to make different choices to improve outcomes. He referred to concerns expressed by constituents about the distance they were required to travel to hospital and the difference it would make if services were delivered in East Lothian. He accepted that part of the IJB's role was to assess the risks but he urged members not to delay too long in making their decision.

Dr Fairclough reiterated his concerns about funding and additional pressures on primary care services. Dr Turvill supported this view and reminded members that it was not simply resources but also manpower and putting in place the mix of staff to deal with demands in a different way.

Decision

The IJB agreed:

(i) To note the intention of NHS Lothian (articulated in its financial plan) to establish additional beds in the Acute Medical Unit (AMU);
(ii) To note NHS Lothian's intention to fund the continuing expansion of insulin pump provision and its inclusion in the NHS Lothian financial plan;
(iii) That further discussion is needed with NHS Lothian to look at acute and community alternatives to the AMU expansion and to examine the merits of the NHS Lothian plans for continuing expansion of insulin pump provision and that therefore these developments should not be supported at this time;
(iv) to support plans for the HSCP to engage with NHS Lothian on work to deliver the principles of the Modern Outpatients report, particularly to reduce unnecessary outpatient activity.

10. DRUG AND ALCOHOL FUNDING IN EAST LOTHIAN 2016/17 AND 17/18

The Chief Officer had submitted a report providing an update to the IJB in relation to the work being undertaken to deliver a redesign of drug and alcohol services driven by the 23% reduction in the financial year 2016/17 and the shift in the responsibility for alcohol and drugs to be a fully delegated function of the IJB.

Sharon Saunders reminded members that a report had been submitted to a previous meeting of the IJB regarding the reduction in funding. Since then further work had been undertaken and this most recent report connected to the proposed Directions for 2017/18 which would be discussed later in the meeting.

Martin Bonnar presented the report. He outlined the main points drawing members' attention to the operational transfer of the East Lothian element of the pan-Lothian substance misuse service and the savings agreed by the MELDAP Strategic Group in January 2017.

Mr Small and Mr King responded to questions from members regarding the implications of the budget allocations from the Scottish Government and NHS Lothian outlining the reasons for seeking to maintain the 12% share of the budgets.

Councillor Akhtar asked several questions relating to prevention, additional budgets and the proposals for a recovery Hub. Ms Saunders provided further detail on the service model and how this would link in with other services in the Esk Centre and the Brunton Hall. She recognised the need to look further at services in the east of the county and said that proposals would be developed and brought back to the IJB.

Dr Turvill reported that as a GP he had already noticed a knock on effect of the anticipated budget cuts in local services, particularly in staffing levels and increased waiting times. He noted that any further deterioration in services would impact not only GP services but other primary and secondary care services too.

Mr Bonnar acknowledged these anxieties and reiterated that securing a 12% allocation would allow the IJB to mitigate the anticipated cuts to a much greater extent.

Mr Small advised that there would be a meeting of IJB Chief Officers in the coming week and with members agreement he would take these proposals to that meeting.

Decision

The IJB agreed to:

(i) note the process agreed by the Midlothian and East Lothian Drugs and Alcohol Partnership [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 budgetary changes and service developments for financial year 2017-18;

(iii) support the redesign process by directing NHS Lothian to:

- Make available East Lothian's full 12% share of the drug and alcohol funding available to the IJB from Scottish Government and 12% of NHSL Core monies spent in the East Lothian IJB area. This would mitigate some of the impact of the removal of 23% of Scottish Government funding and will minimise the impact on service provision. Previously, East Lothian received only 10% of drugs and alcohol from these sources.

- Ask MELDAP to initiate a redesigned drug and alcohol service for East Lothian within the available financial envelope designed on a community based, recovery based model for future IJB agreement

Sederunt: Councillor Currie left the meeting.

11. INITIAL POSITION STATEMENT ON THE USE OF SOCIAL CARE FUND TO SUPPORT ADDITIONALITY IN SOCIAL CARE PROVISION

The Chief Finance Officer had submitted a report informing the IJB of the interim position with regard to the use of the Social Care Fund in 2016/17 to support additionality of service provision in the delivery of social care with plans to have a final position update to be provided by June 2017 once year end budget processes have been completed.

Mr Davies presented the report. He summarised the background to the use of the Social Care Fund and drew members' attention to some of the examples of additionality achieved during 2016-17. Further work was required on tracking how the money was being spent and this would form part of the follow up report in June. He also said that there would be the opportunity, after the year end, to produce a financial analysis and comparison between 2015/16 and 2016/17.

In response to questions Mr Davies provided clarification of some of the terms in the report.

Ms Ireland asked if it would be possible to have a more detailed analysis of the figures and outcomes and Mr Davies said he would aim to include this in the June report.

Peter Murray commented that, in his view, additionality was about doing things differently and not simply doing more of the same. Mr Small reminded him that the IJB had previously agreed that additionality could include doing more of the same.

Councillor Goodfellow observed that this could be the case where a component of the population was increasing, for example the elderly, and this required an increase in existing services.

Decision

The IJB agreed to:

(i) Note the interim position statement on the use of the Social Care Fund;
(ii) Note that a full update will be forthcoming in June 2017 once all the financial information is available on completion of year end processing of accounts for 2016/17.

Sederunt: Councillor Goodfellow left the meeting.

12. BUDGET SETTING 2017/18

The Chief Finance Officer had submitted a report setting out for the IJB the 2017/18 budget propositions from East Lothian Council and NHS Lothian. The report also examined the projected financial pressures for 2017/18 which had been developed by East Lothian Council, NHS Lothian and the IJB.

Mr King presented the report. He referred to the report presented to the IJB on 23 February 2017 and the progress made since that meeting. He outlined in detail the budget propositions from East Lothian Council and NHS Lothian, the Social Care Fund and the key financial pressures identified for 2017/18. He also referred to the Scottish Government's recent guidance stating that IJBs should have in place a 3 year financial plan and he said he hoped to provide a draft outline to the members at the June meeting.

The Chair welcomed the proposal to formulate a 3 year financial plan.

Mr Ash asked whether Mr King considered that the money offered in the set aside budget was an equitable share of the pressures overall and whether he was asking the IJB to accept the budget on that basis. Mr King confirmed that his recommendation was that the IJB accept the proposals and that he was confident this represented an equitable share of the pressures.

Mr Murray said that it would be helpful to see figures showing the savings and the impacts of these budget proposals. Mr King replied that further information would become available later in the year but in the meantime the process needed to move forward.

Mr Small acknowledged members' concerns about gaps in the information but reminded them that the financial seminar held in January had considered these matters.

Ms Ireland reiterated that the IJB must have information on high level plans to address these pressures.

Mr Ash said that Mr King's role as section 75 officer was to examine the information and give advice. He took assurance from the information provided and Mr King's recommendation. He agreed that it was up to the members to decide whether to accept

the advice given but his understanding was that the purpose of this paper was to allow the IJB to move forward and issue Directions for 2017/18.

Mr Murray accepted Mr Ash's point but agreed with Ms Ireland that information was missing and this was the time to have these discussions.

Mr Small stated that the Directions were drafted on the basis that there would be a balanced budget and although the IJB did not have all of the information on the Set Aside budget yet, Mr Ash's point about the section 75 officer was valid.

Decision

The IJB agreed to:

(i) Accept the formal budget proposition from East Lothian Council;
(ii) Accept the indicative budget proposition from NHS Lothian;
(iii) Receive a further report at the June IJB meeting further detailing the financial management propositions for 2017/18.

13. PROPOSED DIRECTIONS FOR 2017-18

The Chief Officer had submitted a report presenting to the IJB a proposed set of Directions to be issued to NHS Lothian and East Lothian Council in March 2017.

Mr Currie presented the report. He advised members that the Directions for 2017/18 were an amalgamation of those that were new and those carried forward from 2016/17. He said that information had been given to the partners and discussions had taken place to ensure that they understood what the IJB was asking them to do. He referred to the list of Directions contained in the report, the related budgets and the process for performance monitoring. He reminded members that further Directions may come forward during the year and that these would be presented to the IJB for approval.

Mr Murray said that it would be helpful to have further information about where the savings were being drawn from and what benefits were expected from additionality.

Mr Small agreed that this could be looked at and in the meantime, he reminded members that it was up to the IJB to decide which Directions to approve and that, following further discussions on efficiencies at the June meeting, the IJB could decide to issue further Directions.

Mr Ash noted that these Directions were based on the information provided in the report for the previous agenda item. He said he hoped that as performance monitoring information came forward the efficiencies would become clearer allowing the IJB the opportunity to issue revised Directions, should that be necessary. He suggested that this should be discussed with the partners so that they understand their requirement to provide information to allow the IJB to do what it needs to do.

Decision

The IJB agreed to:

(i) Note end of year progress against the 2016-17 Directions and the decision taken to either end, continue or replace each of these individual Directions.

(ii) Approve the proposed 2017-18 Directions which require NHS Lothian and East Lothian Council to take action with partners across a range of priority services; and
(iii) Note that each partner responsible for delivering a Direction is required to report on progress with these quarterly, or as frequently as required by the IJB for the purposes of monitoring achievement.

14. CHANGES TO THE VOTING MEMBERSHIP AND CHAIR OF EAST LOTHIAN INTEGRATION JOINT BOARD AND NHS MEMBERSHIP OF THE AUDIT AND RISK COMMITTEE

The Chief Officer had submitted a report asking the IJB to note the changes to NHS Lothian membership, to agree appointment of a Chair and to agree transitional arrangements for the approval of minutes.

Mr Small confirmed that Mr Ash would be moving on to Edinburgh IJB from 1 April and would be replaced by Professor Moira White. He also reminded members that the Chairmanship of the IJB would switch from East Lothian Council to NHS Lothian as of 1 April and he sought a nomination from the NHS Lothian voting members.

Mr Ash advised that the NHS Lothian nominee was Peter Murray. His nomination as Chair was approved by the IJB members.

Mr Small then sought approval for Fiona Ireland to replace Mr Murray on the Audit and Risk Committee. This was also approved.

The Clerk also outlined the proposals for transitional arrangements for the approval of minutes as a result of the impending local government elections and likely change in voting membership.

Decision

The IJB agreed to:

(i) Note that Mr Mike Ash is to be replaced by Professor Moira White an an NHS Lothian voting member from 1 April 2017;
(ii) The appointment of Peter Murray as the Chair of the IJB for two years from April 2017;
(iii) Fiona Ireland replacing Peter Murray as an NHS member of the Audit and Risk Committee; and
(iv) That the minutes of the most recent meetings, which could not be approved by the IJB or the Audit and Risk Committee before the change in membership, be submitted to the current Chairs for verification and signing.

15. RESERVES POLICY

The Chief Finance Officer had submitted a report providing the IJB with a draft Reserves Policy for consideration and approval.

Mr King presented the report. He briefed members on the requirement for the IJB to have in place a Reserves Policy and sought their approval of the draft provided.

Decision

The IJB agreed to:

(i) Note the contents of the report; and
(ii) Approve and adopt the draft reserves policy as laid out in the annex to the report.

VALEDICTORIES

Councillor Grant reflected on his involvement in health and social care, from the initial discussions around integration of services in 2012 to the establishment of the East Lothian IJB in 2015. He said he was confident that the IJB would continue to go from strength to strength. He offered his sincere thanks to Mike Ash, to members of the IJB and to colleagues in the Council and NHS Lothian for their support and wished them well for the future.

Mr Ash offered a formal vote of thanks to the Chair for his leadership which he said had exemplified how the partnership should work on both a personal and professional level. He also acknowledged the contributions of the staff within the Council and NHS Lothian.

Signed .....
Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

Item 4.1 Minutes

Edinburgh Integration Joint Board

1.17

9.30 am, Friday 24 March 2017
Waverley Gate, Edinburgh

Present:

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

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

Apologies: Mike Ash.

1. Minutes

Decision

1) To approve the minute of the Edinburgh Integration Joint Board of 20 January 2017 as a correct record.

2) To approve the minute of the Edinburgh Integration Joint Board of 17 February 2017 as a correct record.

2. Sub-Group Minutes

Decision

To note the Sub-Group minutes.

3. Rolling Actions Log

The Rolling Actions Log for 24 March 2017 was presented.

Decision

1) To approve the closure of actions 2, 4, 10 and 12.

2) To otherwise note the outstanding actions.

(Reference – Rolling Actions Log – 24 March 2017, submitted.)

4. Annual Review of the Strategic Plan - Presentation

Wendy Dale provided a presentation on the annual review of the Joint Board's Strategic Plan. The presentation covered the following areas:

- The scope of the review.
- Legislative requirements.
- Why an annual review was required.
- Timeline and dependencies.
- Proposed approach to conducting the review.
- Directions related to the Strategic Plan.

Decision

1) To note the proposed approach to updating the strategic plan.

2) To agree to consider the updated plan at the Joint Board Development Session in April 2017 before formal approval at the Joint Board in June 2017.

3) That actions to improve undelivered elements be included in the Annual Performance Report.

(References – minute of the Integration Joint Board 16 September 2016 (item 10); report by the IJB Chief Officer, submitted.)

5. 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 the target to reduce the number of individuals awaiting discharge to 50 by the April 2017 census was unlikely to be achieved. A review of the Flow Programme, put in place in March 2016 to deliver a number of specific actions to address the high levels of delayed discharge in Edinburgh, would take place at the end of March 2017 and be overseen by the Flow Programme Board.

Decision

1) To note the current performance in respect of delayed discharge.

2) To note the progress made in reducing the length and number of delayed discharges from hospital.

3) To note the proposed future actions to further improve performance.

4) To note that the Flow Programme Board would be undertaking a review of the Flow Programme at the end of March 2017, following which a revised set of indicators and trajectories would be recommended to the Integration Joint Board.

5) To note the following changes to the report by the Chief Officer:

   5.1) To update paragraph 21 to note that partner providers had increased their capacity by 6.5% across the city.

5.2) To update paragraph 26 to note that the approach would utilise 60 beds rather than 45.

6) That future strategy including actions be presented to the Joint Board at the next formal meeting for approval.

(References – minute of the Integration Joint Board 20 January 2017 (item 6); report by the IJB Chief Officer, submitted.)

6. Funding for Alcohol and Drug Services 2017/18

In 2016/17 the Scottish Government reduced the allocation to Alcohol and Drugs Partnerships (ADPs) by 23% nationally. This resulted in a reduction of £1,550,000 for the Edinburgh Alcohol and Drug Partnership. A balanced budget was achieved for 2016/17 utilising carry forward and through financial support from the Joint Board.

A total of £1,155,00 revenue savings had been identified through service redesign. There were significant risks to identifying further savings. Financial support of £395,000 was sought from the Joint Board on a recurring basis to mitigate against risks.

Decision

1) To continue the report by the IJB Chief Officer to a special meeting of the Joint Board on 28 April 2017 where revised proposals, including detailed risk and impact assessment and alternative funding options, would be presented.

2) That the membership of the Professional Advisory Group be consulted on proposals in advance of consideration by the Joint Board.

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

Declaration of Interests

Christine Farquhar declared a non-financial interest in the above item as a Trustee Director of a Care Provider and a Guardian of a recipient of a direct payment.

Ella Simpson declared a non-financial interest in the above item as EVOC provided support for the Substance Users Network.

7. Review of Integrated Care Fund Projects

Details were provided of the evaluation and review of a number of initiatives funded by the Integrated Care Fund. Approval was sought for the allocation of ongoing funding for projects from the Social Care Fund, based upon recommendations from the Strategic Planning Group.

Decision

1) To note the contribution made to the delivery of better outcomes for citizens through the work carried out by the eight projects reviewed by the Strategic Planning Group.

2) The agree to the recommendations for further funding of the eight projects from the Social Care Fund as set out in the table in paragraph 14.

3) To agree to delegate authority to the Chief Officer and Vice-Chair of the Joint Board in respect of recommendations to be made by the Strategic Planning Group on 31 March 2017 regarding the Step Forward Project.

(References – minute of the Strategic Planning Group 10 March 2017 (item 2); report by the IJB Chief Officer, submitted.)

Declaration of Interests

Christine Farquhar declared a non-financial interest in the above item as a Trustee Director of a Care Provider and a Guardian of a recipient of a direct payment.

Ella Simpson declared a non-financial interest in the above item as EVOC provided support for the Substance Users Network.

8. Financial Position to February 2017

The forecast year end position for the Joint Board and an overview of the financial position for the 11 months to February 2017 was detailed. This showed an 11 month overspend at £6.2m with, equivalent to a year-end overspend of £9.2m.

Decision

To note that a break even position would be delivered through a combination of social care fund monies identified by the Joint Board; provisions made by the City of Edinburgh Council; and the underwriting by NHS Lothian of the projected overspend in the health element of the Joint Board's budgets. These factors amounted to the £6.2m required to enable full closure of the 2016/17 budget.

(References – minute of the Integration Joint Board 20 January 2017 (item 8); report by the IJB Chief Officer, submitted.)

9. Financial Plan Update and Financial Assurance

The level of 2017/18 resources delegated by the City of Edinburgh Council and NHS Lothian and resultant 2017/18 financial plan was presented for approval.

Decision

1) To note the financial assurance work undertaken to date;

2) To agree that budgets delegated from the Council and NHS Lothian be allocated back to partners to operationally deliver and financially manage Joint Board delegated functions;

3) To agree the draft financial plan for 2017/18, including the proposed investments in projects previously funded through the Integrated Care Fund.

4) To remit the Strategic Planning Group to scrutinise the savings proposals to ensure alignment with the strategic plan on behalf of the Joint Board.

5) To request that partners work in conjunction with the Chief Officer and Interim Chief Finance Officer to prepare a medium term financial strategy for Joint Board delegated functions.

6) To agree to receive the annual financial statement following the review of the Strategic Plan.

7) To thank the Interim Chief Finance Officer for her work on the 2017/18 Financial plan.

(References – minute of the Integration Joint Board 20 January 2017 (item 7); report by the IJB Chief Officer, submitted.)

10. Royal Edinburgh Hospital Update

An update on the move from the Royal Edinburgh Hospital to the new Royal Edinburgh Building, including details of measures to prevent admissions, reduce length of stay and facilitate discharge, was provided.

Decision

1) To note the general progress made to address the reduction in beds necessary for people over 65, which had a general RAG status of Green.

2) To note the general progress made to address the reduction in beds necessary for people under 65, which had a current RAG status of Amber/Green.

3) To note the detail and progress surrounding the various work streams that were being developed to reduce further the necessary bed capacity for those under 65.

4) To agree to accept further reports which would be necessary to implement future plans to reduce the number of hospital beds and to support people at home and in the community.

5) To note that mental health facilities for adults over and under 65 were projected to open at the end of June 2017.

6) To request an update to a future meeting of the Joint Board on the impact on patient care.

(References – minute of the Integration Joint Board 20 January 2017 (item 11); report by the IJB Chief Officer, submitted.)

11. Southside Medical Practice Update

An update was provided on efforts to secure alternative GP premises for the 5,000 patients of the Southside Medical Practice in advance of premises becoming unavailable on 30 June 2017. A move to the Conan Doyle Medical Centre had been identified as a solution and an agreement had been reached with the practice on 21 February 2017.

Decision

1) To note the outcome of negotiations which agreed that the practice would move to Conan Doyle Medical Centre in May or June 2017.

2) To note the assurances given in regard to Section 17C funding available to the Conan Doyle practice for a five year period from 1 April 2017.

(References – minute of the Integration Joint Board 17 February 2017 (item 3); report by the IJB Chief Officer, submitted.)

12. Niddrie/ Durham Road Craigmillar Medical Practice Leases

A joint lease existed for Craigmillar Medical Centre, the Craigmillar Medical Practice and the Durham Road Medical Practice with NHS Lothian. Revised responsibilities for each practice to reflect the creation of the Niddrie Medical Practice were submitted for approval.

Decision

1) To agree that the whole lease for the building would be held by NHS Lothian. That two mirror leases for the Craigmillar Medical Practice and the Niddrie Medical Practice be established to reflect their constituent parts of the building.

2) To note that the GP partners of both practices were released from their current liabilities to cover the risk of the neighbouring practice, should that neighbouring partnership fail or cease to exist.

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

Declaration of Interests

George Walker declared a non-financial interest in the above item as the relative of a partner in the Durham Road GP Practice.

13. Parkgrove Medical Centre

In 2016 due to operational difficulties encountered by the East Craigs and Parkgrove Medical Practice it had become necessary for the Joint Board and NHS Lothian to provide support including taking over responsibility for the lease of one of the premises utilised by the practice at 22B Parkgrove Terrace. A view was sought on whether the lease should be extended past its current expiry of 2019.

Decision

1) To advise NHS Lothian to enter into discussions with the landlord about a further 10 year lease to 2029.

2) To ask NHS Lothian to support investment to help develop the building as referred to in paragraph 7 of the report by the IJB Chief Officer.

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

14. Development of a New Practice in the North West Edinburgh Partnership Centre

Details were provided regarding the requirement identified in the North West Edinburgh Partnership Centre Business Case to establish a new medical practice in the North West Partnership Centre building and the associated General Medical Services (GMS) costs.

Decision

1) To agree to the proposal from Muirhouse Medical Group to establish the new practice as a branch and agree the required General Medical Services (GMS) costs to enable this.

2) To note that on 14 March 2017, the Muirhouse Partnership agreed to take 1,318 patients from the Inverleith Medical Practice which would close on 30 June 2017.

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

15. Programme of Development Sessions and Visits

A summary of feedback received from Joint Board members on the programme of development sessions and visits and proposals regarding the frequency of development sessions were submitted.

Decision

1) To note the summary of feedback received on the programme of development sessions and visits that took place during 2016/17.

2) To agree the proposal that the frequency of development sessions should move from bi-monthly to quarterly from June 2017.

3) To agree to receive a programme of development sessions and visits for 2017/18 at the June 2017 meeting of the Joint Board.

4) To note that an induction programme would be developed for new members joining the Joint Board.

(References – minute of the Integration Joint Board 16 September 2016 (item 4); report by the IJB Chief Officer, submitted.)

Item 4.1 Minutes

Edinburgh Integration Joint Board (Special Meeting)

9.30 am, Friday 28 April 2017
City Chambers, Edinburgh

Present:

Board Members: Councillor Ricky Henderson (in the Chair), Councillor Elaine Aitken, Colin Beck, Carl Bickler, Sandra Blake, Wanda Fairgrieve, Christine Farquhar, Councillor Joan Griffiths, Kirsten Hey, Councillor Sandy Howat, Carolyn Hirst, Alex Joyce, Angus McCann, Rob McCulloch-Graham, Ian McKay, Alex McMahon (substitute for Shulah Allen), Michelle Miller, Peter Murray (substitute for Michael Ash) and Moira Pringle.

Officers: Wendy Dale, Ann Duff, Gavin King, Karen Lloyd, Allan McCartney, Ross Murray, Nick Smith and Julie Tickle.

1. Welcome

As it was the last meeting of the Joint Board before the Local Government Election Councillor Ricky Henderson paid tribute to Councillor Elaine Aitken who would be standing down as an elected member. He thanked her for her contribution to the work of the Joint Board.

2. Funding for Drug and Alcohol Services 2017/18

In 2016/17 the Scottish Government reduced the allocation to Alcohol and Drugs Partnerships (ADPs) by 23% nationally. This resulted in a reduction of £1,550,000 for the Edinburgh Alcohol and Drug Partnership. A balanced budget was achieved for 2016/17 utilising carry forward and through financial support from the Joint Board.

On 24 March 2017 the Joint Board continued consideration of a report which identified savings of £702,000 and sought financial support of £395,000 from the Joint Board on a recurring basis to mitigate against risks.

Revised proposals including risk and impact assessments of proposed changes and savings, as well as alternative funding option for services, was submitted.

Decision

1) To agree the allocation of £420,000 to maintain existing levels of service delivery. This included £395,000 to support treatment and recovery services and £25,000 to Regional Infectious Diseases Unit (RIDU) and sexual health services to enable a review to be completed by 30 June 2017. These allocations had been set aside within the Social Care Fund.

2) To note the approach, impact and risks of identifying £600,000 revenue savings in adult treatment and recovery services and £102,000 in RIDU and sexual health services, and that a delay to a decision about these savings would incur costs of £50,000 per month.

3) To approve the alternative funding options set out in paragraph 19 of the Chief Officer's report as an opportunity to offset the reductions in drug/alcohol funding.

4) To keep under review the implementation of detailed service changes and monitor the impact.

(References – minute of the Integration Joint Board 24 March 2017 (item 6); report by the IJB Chief Officer, submitted.)

Declaration of Interests

Carl Bickler declared a non-financial interest in the foregoing item as a General Practitioner who worked with drug users.

Christine Farquhar declared a non-financial interest in the foregoing item as a Director of VOCAL.

Minute of Meeting

1.18

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 9 February 2017	2pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

Present (voting members):

Cllr Bob Constable	Peter Johnston (Vice Chair)
Cllr Bryan Pottinger	John Oates

Present (non voting members):

Eibhlin McHugh (Chief Officer)	Alison White (Chief Social Work Officer)
David King (Chief Finance Officer)	Dave Caesar (Medical Practitioner)
Patsy Eccles (Staff side representative)	Margaret Kane (User/Carer)
Keith Chapman (User/Carer)	Ruth McCabe (Third Sector)

In attendance:

Ewan Aitken (Cyrenians)	Suzanne McShane (Chief Officers Network)
Chris Lawson (Risk Manager)	Mike Broadway (Clerk)

Apologies:

Cllr Catherine Johnstone (Chair)	Cllr Derek Milligan
Cllr Andrew Coventry (substitute for Cllr Catherine Johnstone)	Alex Joyce
Alison McCallum	Hamish Reid (GP/Clinical Director)
Caroline Myles (Chief Nurse)	Aileen Currie (Staff side representative)

Midlothian Integration Joint Board

Thursday 9 February 2017

1. Welcome and introductions

The Vice-Chair, Peter Johnston, welcomed everyone to this meeting of the Midlothian Integration Joint Board, in particular Ewan Aitken (Cyrenians) and Suzanne McShane (Chief Officers Network).

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 Thursday 1 December 2016 was submitted and approved as a correct record.

4.2 The Minutes of Meeting of the Midlothian Integration Joint Board Audit and Risk Committee held on Thursday 8 September 2016 was submitted and noted.

5. Public Reports

Report No.	Report Title	Presented by:
5.1	Appointment of Standards Officer for the Midlothian Integration Joint Board	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to confirm the recommendation to the Standards Commission for Scotland in relation to the appointment of the Standards Officer to the Midlothian Integration Joint Board.

The report summarised the Standards Officer's key responsibilities and recommended that the Council's Legal Manager, Alan Turpie (who was also the Council's Monitoring Officer) be nominated to the Standards Commission as the Standards Officer for the Midlothian Integration Joint Board.

Decision

The Board agreed:

- **To approve the remit of the Standards Officer as outlined in the report;**
- **To approve that Alan Turpie be recommended for the position of Standards Officer to the Midlothian Integration Joint Board to the Standards Commission for Scotland; and**
- **To instruct the Chief Officer to communicate the same to the Standards Commission for Scotland.**

Midlothian Integration Joint Board

Thursday 9 February 2017

Action
Chief Officer

Report No.	Report Title	Presented by:
5.2	Budget Setting, Financial Planning and Financial Management 2017/18 – Outline and Approach	David King

Executive Summary of Report

This report provided a preparatory briefing for the finance paper that would be presented to the Special IJB Meeting on 16th March 2017, when agreement would be sought on the 2017/18 Budget and Directions.

On 15th December 2016, the Scottish Government had announced its proposed budget settlements for both Local Authorities and the NHS in Scotland for 2017/18. The announcement had also contained further details about the social care fund and laid out the Government's clear ambitions for IJBs.

In summary the Council's budget had been reduced and NHS Lothian had a net uplift of 0.4%.

Both the Council and NHS Lothian had provided the IJB with estimates of expenditure in 2017/18, these forecasts based on current models of service delivery were considerably in excess of the budgetary resources that would be available.

Summary of discussion

The Chief Finance Officer in presenting the report emphasised that it was clear from the experience of 2016/17 that the IJB required a detailed financial management agreement with its partners to ensure that financial pressures and the proposed actions to resolve them were reported timeously to the Board. He also updated the Board on the position reached with regards the budgetary offers from the Council and NHS Lothian.

The Board, in considering the current financial position and likely financial pressures, discussed the importance of affecting a positive shift in the models of service delivery.

Decision

The Board noted:

- **the projected out-turn position for 2016/17;**
- **the magnitude of the financial challenge facing the IJB in 2017/18; and**
- **the issues surrounding the 2017/18 budget settlement and in particular the implications of Scottish Government's clear ambitions for IJBs which would require to be achieved within the financial resources available.**

Midlothian Integration Joint Board

Thursday 9 February 2017

Action
Chief Finance Officer

Report No.	Report Title	Presented by:
5.3	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 provided an update on the progress made by the Council in addressing the new Direction issued by the Board at its meeting on 18th August 2016 requiring a review of the current design of care at home services and to develop proposals which address the current risks facing the service.

Summary of discussion

The Board, in considering the Chief Officer's Report, discussed the potential impacts arising from the service pressures and how these were being addressed.

Decision

The Board:

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

Report No.	Report Title	Presented by:
5.4	Risk Register	Chris Lawson

Executive Summary of Report

The purpose of this report was to invite comments on the risks and controls contained in the MIJB Risk Register and to seek formal approval of the Register. It also sought agreement that the Register be routinely monitored by the IJB Audit and Risk Committee.

The report explained that the development of the MIJB Risk Register followed on from the approval of initial proposals by the IJB on 20th August 2015 and built upon the consideration and approval of the formal Risk Management Policy at the IJB meeting on 11th February 2016. It also incorporated the high level risks identified at the Risk Management Workshop held on 14th January 2016, which had been further developed and considered initially by the IJB on 14th April 2016 and subsequently by the IJB Audit and Risk Committee on 9th June 2016.

Summary of discussion

The Board, having heard from the Risk Manager, discussed the Risk Register; a copy of which was appended to the report.

Midlothian Integration Joint Board

Thursday 9 February 2017

Decision
The Board: • **Approved the Risk Register;** • **Agree to remit the responsibility for monitoring the Risk Register to the IJB Audit and Risk Committee;** • **Agree to receive regular reports on the risks facing the IJB to support informed and effective decision making; and** • **Confirmed that the risks presented in this report reflect the current risks/opportunities facing the IJB.**

Report No.	Report Title	Presented by:
5.5	MAPPA Annual Report 2015/2016	Alison White

Executive Summary of Report
The purpose of this report was to bring to the IJB's attention the MAPPA Annual Report for 2015 – 2016; the final report of the national MAPPA Joint Thematic Review which had been published in November 2015; and the Lothian and Borders response to the areas for development identified in the Joint Thematic Review report. Copies of which were appended to the report.

Summary of discussion
The Board, having heard from the Chief Social Work Officer discussed the excellent work undertaken by MAPPA in Midlothian.

Decision
The Board: • **Noted the content of this report and background papers.**

Report No.	Report Title	Presented by:
5.6	East Lothian and Midlothian Public Protection Committee Biennial Report 2014/16	Alison White

Executive Summary of Report
The purpose of this report was to explain the requirement that the Convener of East Lothian and Midlothian Public Protection Committee submit a Biennial Report to Scottish Government on the exercise of the Committee's functions under Section 42 of the Adult Support and Protection (Scotland) Act 2007. The Biennial Report, a copy of which was appended to the report, reflected the work undertaken by the East Lothian and Midlothian Public Protection Committee during the period 2014 to 2016 thereby informing the IJB of its progress during that period.

Midlothian Integration Joint Board

Thursday 9 February 2017

Summary of discussion
Having heard from the Chief Social Work Officer, the Board discussed the excellent work undertaken by the East Lothian and Midlothian Public Protection Committee.

Decision
The Board: • **Noted the contents of the report; and** • **Noted the progress made by the East and Midlothian Public Protection Committee during 2014/16.**

Report No.	Report Title	Presented by:
5.7	Reserves Policy	David King

Executive Summary of Report
The purpose of this report was to provide the IJB for consideration and approval, a draft Reserves Policy, which laid out what reserves would be held and how these would be reported. The report explained that because governance of the IJB was under the local authority regulations, the IJB was permitted to hold a reserve. Put simply a reserve was a mechanism to carry forward from one financial year to another a balance of unused funds. These funds may be specifically earmarked for a particular purpose(s) or just held as a general financial buffer against unforeseen in year events or as part of a longer term financial plan. As the IJB had not the current capacity to build up a reserve there would not be any reserves in the current financial year.

Summary of discussion
The Board, having heard from the Chief Finance Officer discussed the draft Reserves Policy; a copy of which was appended to the report.

Decision
The Board: • **Noted the content of this report; and** • **Approved and agreed to adopt the reserves strategy.**

Report No.	Report Title	Presented by:
5.8	Development of IJB Strategic Indicators	Eibhlin McHugh

Executive Summary of Report
The purpose of this report was to make the IJB aware of national and local developments that would change the performance information received by the IJB.

Midlothian Integration Joint Board

Thursday 9 February 2017

The report advised that as a result of these developments a more detailed paper would be presented to the IJB meeting in March along with details of the new performance indicators and proposed improvement trajectories.

Summary of discussion

The Board, having heard from the Chief Officer, discussed the shift in the expectation on IJBs to improve system-performance.

Decision

The Board:

- **Noted the national and local developments that would change the performance information received by the IJB;**
- **Noted the plan to update the performance information that the IJB received to reflect the new directions and recent correspondence from Scottish Government; and**
- **Noted that a more detailed report would be presented to the IJB in March.**

Report No.	Report Title	Presented by:
5.9	Proposed Meeting Schedule and Workshop Dates 2017/18	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to set the dates for the Board meetings and Development Workshops for the Midlothian Integration Joint Board for 2017/18 as prescribed by Midlothian Integration Joint Board Standing Orders 5.2.

Summary of discussion

Having heard from the Chief Officer, the Board considered the proposed dates for 2017/18 it being noted that some fine tuning was required particularly with regards the Development Workshops dates for the latter part of 2017.

Decision

The Board agreed that subject to resolution of the above, to:

- **Approved the schedule of meetings of the Midlothian Integration Joint Board as outlined in the report;**
- **Approved the schedule of meetings of the Midlothian Integration Joint Board Audit and Risk Committee as outlined in the report;**
- **Approved the schedule of Development Workshops for the Midlothian Integration Joint Board as outlined in the report; and**
- **Noted the approach for service visits for the Midlothian Integration Joint Board.**

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

No additional business had been notified to the Chair in advance

8. Date of next meeting

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

• Thursday 16th March 2017 *	2pm	**Special Midlothian Integration Joint Board**
• Thursday 20th April 2017	2pm	**Midlothian Integration Joint Board**
• Thursday 25th May 2017	2pm	Development Session

* Please note carefully that this date will now be a formal Board meeting.

The meeting terminated at 3.28 pm.

Appendix

(relative to paragraph 5.9)

Midlothian Integration Joint Board
Meeting Schedule and Development Workshops
Dates 2017-18

MIJB Meetings

- Thursday 16th March 2017, 2pm - Special
- Thursday 20th April 2017, 2pm
- Thursday 15th June 2017, 2pm
- Thursday 24th August 2017, 2 pm
- Thursday 5th October 2017, 2pm
- Thursday 7th December 2017, 2pm
- Thursday 11th January 2018, 2pm
- Thursday 1st March 2018, 2pm
- Thursday 3rd May 2018, 2pm

Development Workshops

- *Thursday 25th May 2017, 2pm
- *Thursday 14th September 2017, 2pm
- *Thursday 16th November 2017, 2pm
- Thursday 8th February 2018, 2pm
- Thursday 5th April 2018, 2pm
- Thursday 7th June 2018, 2pm

*** Please note that the three dates marked with an asterisk have been adjusted as agreed by the Board meeting (paragraph 5.9 refers).**

Service Visits

Further service visits will be scheduled as required or at the request of members of the Midlothian Integration Joint Board.

MIJB Audit and Risk Committee Meetings

- Thursday 9th March 2017, 2pm
- Thursday 8th June 2017, 2pm
- Thursday 7th September 2017, 2pm
- Thursday 14th December 2017, 2pm

Thursday 22nd March 2018, 2pm

Minute of Special Meeting

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 16th March 2016	2pm	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 Bob Constable	Alex Joyce
Cllr Bryan Pottinger	Alison McCallum
	John Oates

Present (non voting members):

Eibhlin McHugh (Chief Officer)	David King (Chief Finance Officer)
Hamish Reid (GP/Clinical Director)	Patsy Eccles (Staff side representative)
Aileen Currie (Staff side representative)	Keith Chapman (User/Carer)
Margaret Kane (User/Carer)	Ewan Aitken (Third Sector) (substitute for Ruth McCabe)
Fiona Huffer (substitute for Caroline Myles (Chief Nurse))	

In attendance:

Gary Fairley (Head of Finance and Integrated Service Support, Midlothian Council)	Allister Short (Head of Healthcare, Midlothian Council)
Jamie Megaw (Strategic Programme Manager)	Mike Broadway (Clerk)

Apologies:

Cllr Derek Milligan	Ruth McCabe (Third Sector)
Alison White (Chief Social Work Officer)	Dave Caesar (Medical Practitioner)
Caroline Myles (Chief Nurse)	

Midlothian Integration Joint Board

Thursday 16 March 2017

1. Welcome and introductions

The Chair, Catherine Johnstone, welcomed everyone to this Special Meeting of the Midlothian Integration Joint Board in particular Ewan Aitken, who was substituting for Ruth McCabe (Third Sector) and Fiona Huffer, who was substituting for Caroline Myles (Chief Nurse).

2. Order of Business

The Chair advised the meeting that –

(a) the follow paper - "Budget Setting 2017/18" which relating to Agenda Item 4.1 Finance Paper had been circulated electronically under separate cover;

(b) an additional item of business had been tabled, namely a report by the Chief Officer, entitled "Midlothian Integration Joint Board – Publication Scheme" which would be considered as Agenda Item 4.6; and

(c) Agenda Item 4.4 would be taken as the second item of business immediately after the Finance Paper.

3. Declarations of interest

No declarations of interest were received.

4. Reports

Report No.	Report Title	Presented by:
4.1	Budget Setting 2017/18	David King

Executive Summary of Report

The purpose of this report was to set out the 2017/18 budget propositions from Midlothian Council and NHS Lothian to the IJB, and to examine the projected financial pressures for 2017/18 which had been developed by Midlothian Council, NHS Lothian and the IJB.

The report explained that the IJB required financial resources to allow it to deliver its Strategic Plan. These resources were provided by the IJB's partners – Midlothian Council and NHS Lothian. Midlothian Council had set its 2017/18 budget and made a proposition to the IJB and NHS Lothian had provided an indicative position which would be formally agreed by the NHS Lothian Board at its meeting in April 2017.These two propositions represented the total of the financial resources available to the IJB in 2017/18.

Both NHS Lothian and Midlothian Council in collaboration with the IJB had also considered the potential financial pressures inherent in these budgetary offers and it was clear that without a significant change to the current model of the delivery of services there would be a significant gap between the resources available and the projected expenditure.

Midlothian Integration Joint Board

Thursday 16 March 2017

The paper then discussed two issues :-

a) Whether the budget proposals from the Partners were a fair share of the resources available to them; and

b) The risks inherent in the delivery of a balanced financial position given that the forecasts suggest a significant overspend and thus a significant financial recovery plan would have to be delivered.

Summary of discussion

The Chief Finance Officer advised that a great deal of work had already been carried out by both partners, individually and collectively, in developing the financial propositions put forward to the IJB and that whilst it was acknowledged that there were significant challenges ahead, it was nonetheless considered extremely important that the process be allowed to continue, in order that the changes that needed to be made were allowed to take place.

The Board, in discussing some of the key challenges likely to be faced in the coming year(s), acknowledged that although the current position was not entirely satisfactory, it was extremely important that the process of change was allowed to continue.

Decision

After further discussion, the Board agreed to:-

- **Accept the formal budget proposition from Midlothian Council.**
- **Accept the indicative budget proposition from NHS Lothian.**
- **Receive a further report at the April IJB meeting laying out the financial risk mitigating propositions.**

Action

Chief Finance Officer

Report No.	Report Title	Presented by:
4.4	Measuring Performance under Integration – Agreeing the IJB's Performance Measurements	Jamie Megaw

Executive Summary of Report

The purpose of this report was to present to the Board the emerging draft objectives for the IJB to monitor progress against the indicators agreed by the Ministerial Strategic Group for Health and Community Care, namely:- unplanned admissions; occupied bed days for unscheduled care; A&E performance; delayed discharges; end of life care; and the balance of spend across institutional and community services.

Midlothian Integration Joint Board

Thursday 16 March 2017

The report explained that all IJB's had been asked to set local objectives for each indicator and to describe expected performance per quarter during 2017/18. Details of the proposed objectives for the Midlothian IJB were appended to the report.

Summary of discussion

The Board, heard from the Strategic Programme Manager, who advised that the IJB needed to consider its ambitions for change across the system and ensure that these were reflected in its objective for each target. An un-ambitious objective may fail to keep up with increasing demand on services from an ageing population but an over-ambitious objective may be impossible to deliver within system constraints. It was also important to consider the ownership of the objectives because system-level change would require all parts of the system to be working towards each goal and share ownership of it.

Members of the IJB, in considering the emerging local objectives, discussed the means by which appropriate targets could best be set. The view being that whatever targets were finally agreed upon needed to reflect the IJB's aspirations as set out in both the Strategic and Delivery Plans. There also needed to be a clear understanding of established baselines and also the potential impact of any interventions.

Decision

The Board:

- **Noted the emerging objectives for the Midlothian IJB to monitor progress using the indicators agreed by the Ministerial Strategic Group for Health and Community Care;**
- **Noted that discussions regarding the emerging objectives with the Joint Management Team were ongoing; and**
- **Agreed to receive a further report updating the emerging objectives as a result of these and other discussions.**

Action

Chief Officer

Report No.	Report Title	Presented by:
4.2	2017-18 Delivery Plan for Health and Social Care	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to introduces and seek approval of the 2017-18 Delivery Plan; a copy of which was appended to the report.

Midlothian Integration Joint Board

Thursday 16 March 2017

The report summarised the development of the 2017-18 Delivery Plan, which was based upon the Strategic Plan 2016-19, providing an update on the progress made in implementing the 2016-19 Strategic Plan and summarising the key actions planned for 2017-18.

Summary of discussion

The Board, having heard from the Chief Officer, who responded to questions from Members of the IJB, considered the key issues addressed in the Delivery Plan, namely: increasing the capacity and managing the demands upon Primary Care; Reducing the use of acute hospitals particularly in relation to delayed discharge and preventable admissions; Improving mental health wellbeing given the high levels of prescribed medication and the links to offending and substance misuse; Reducing the cost of Learning Disability services and Strengthening the multi-agency approach to Health Inequalities.

Decision

The Board:

- **Approved the 2017-18 Delivery Plan; and**
- **Agreed to the preparation of a summary version.**

Action

Chief Officer

Report No.	Report Title	Presented by:
4.3	IJB Directions 2017/18	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to introduce a draft version of the 2017-18 Directions to be issued by the IJB to Midlothian Council and NHS Lothian.

The report explained 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 should be considered alongside the Strategic Plan 2016-19 and the Delivery Plan 2017-18.

Summary of discussion

The Board, having heard from the Chief Officer, who responded to Members questions, discussed the topics covered in the Directions in particular, the involvement of the third sector, the provision of pan-lothian services and health inequalities.

Midlothian Integration Joint Board

Thursday 16 March 2017

Decision
The Board: • **Noted the current position on the development of the IJB's Directions;** • **Noted that the Directions would flow from the IJB's agreed Strategic Plan;** • **Agreed to delegate the authority to (i) finalise the detail in terms of financial information and performance data related to each Direction; and (ii) issue the Directions for 1st April 2017 to the IJB's Chief Officer;** • **Agreed to receive a further report detailing the Directions issued by the Chief Officer; and** • **Agreed that a summary paper be provided to ensure there is no dubiety about the key changes which need to be made**

Action
Chief Officer

Report No.	Report Title	Presented by:
4.5	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 and forthcoming key service developments.

Summary of discussion
Having heard from the Chief Officer and the Head of Healthcare, Midlothian Council, the Board acknowledged that the development that from 1 April 2017, no further Midlothian patients would be admitted to Liberton Hospital for post-acute rehabilitative care, marked an important milestone in achieving the IJB's stated aim of rebalancing care from acute to community settings.

Decision
After further discussion, the Board: • **Noted the issues outlined in the report.**

Report No.	Report Title	Presented by:
4.6	Midlothian Integration Joint Board – Publication Scheme	Eibhlin McHugh

Midlothian Integration Joint Board

Thursday 16 March 2017

Executive Summary of Report
The purpose of this report is to confirm the requirement of the Midlothian Integration Joint Board to adopt and maintain a publication scheme under the Freedom of Information (Scotland) Act 2002 which has the approval of the Scottish Information Commissioner and further to publish information in accordance with the scheme.

Decision
The Board, having heard from the Chief Officer, agreed: • **To note the requirement to adopt and maintain a publication scheme under the Freedom of Information (Scotland) Act 2002;** • **To delegate and instruct the Chief Officer to prepare the Midlothian Integration Joint Board publication scheme in line with the Model Publication Scheme prescribed by the Information Commissioner for Scotland;** • **To delegate and instruct the Chief Officer to submit this scheme to the Information Commissioner for Scotland for formal approval; and** • **To delegate and instruct the Chief Officer to submit information to the Information Commissioner in line with the requirements under Freedom of Information commencing in April 2017.**

Action
Chief Officer

5. Date of next meeting

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

• Thursday 20th April 2017	2pm	**Midlothian Integration Joint Board**
• Thursday 25th May 2017	2pm	Development Workshop
• Thursday 15th June 2017	2pm	**Midlothian Integration Joint Board**

The meeting terminated at 3.42pm.

NHS LOTHIAN

Board Meeting
21 June 2017

2.2

Executive Director, Nursing, Midwifery and Allied Healthcare Professionals
Executive Lead, REAS and Prison Healthcare

2017-18 LOCAL DELIVERY PLAN (LDP) FEEDBACK AND ARRANGEMENTS FOR NHS LOTHIAN 2017 ANNUAL REVIEW

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the contents and requirements to undertake further actions outlined in the Scottish Government feedback letter relating to the 2017-18 LDP (Appendix 1) and arrangements for the 2017 Annual Review scheduled to take place on 29 September 2017 (Appendix 2).

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

2 Recommendations

2.1 The Board note NHS Lothian Executive Leads will undertake further actions outlined in the Scottish Government 2017-18 LDP feedback communication as summarised in Section 3.2.

2.2 Note and discuss the comments relating to 'risk' as set out below and what actions in addition to those that are set out are required.

2.3 Note progress against the 2017-18 LDP should be reported to Lothian NHS Board and will be reviewed by the Scottish Government at the 2017 Annual Review and In-Year Reviews.

2.4 Note NHS Lothian's 2017 Annual Review is scheduled to take place on Friday 29 September 2017 and will be undertaken by Maureen Watt, Minister for Mental Health

2.5 Discuss the need for any regional in put to the annual review given the comments relating to the regional planning work which will be submitted at the time of the annual review.

3 Discussion of Key Issues

3.1 The draft 2017-18 LDP was discussed at NHS Lothian Board meeting on 5 April 2017. Following discussion at the Board meeting, the LDP was updated to include a summary of key measures and submitted to the Scottish Government on 11 April 2017 (Appendices 3 and 4).

3.2 Further key actions outlined in the Scottish Government feedback letter are outlined in the Table 1.

Table 1 2017-18 LDP Further Key Actions

Action	Deadline
Draft Regional Delivery Plan to be submitted to Scottish Government. Further Scottish Government guidance relating to the regional plan will be developed over the summer.	30 Sept 2017 and 31 March 2017
2017-18 Draft LDP to be updated and resubmitted depending on impact of regional plan	30 Sept 2017
Following Quarter 1 2017, prepare a revised financial plan forecast detailing steps in place to address forecast deficit. This will be followed up through an in-year review in September / October 2017	31 July 2017
Waiting Times template on activity, finance and performance circulated on 12 May 2017 to be completed. Funding to be announced May / June 2017 and second tranche September 2017 against receipt of regional plans.	31 May 2017
Initial regional sign off of elective centres plans with next stage approval via Regional Delivery Planning process.	June 2017
Ensure patients are discharged as soon as fit and support avoidance of unnecessary admissions and address poorer rate of discharge at weekends.	On-going
Better resourcing and flexibility in primary care through new ways of working and the potential created through establishment of GP clusters. Create robust plans to ensure GP practices at risk are supported.	On-going
Scottish Government will contact NHS Boards to discuss Board visits and local priorities relating to Patient Centeredness and Patient Safety Programme	Scottish Government -To Be Confirmed
Review actions relating to 21 February 2017 Scottish Government letter relating to cyber security resilience.	On-going
Publish NHS Lothian Workforce Plan during 2017	Dec 2017
Support implementation of the Scottish Government Mental Health Strategy Published in March 2017 over the next 10 years.	March 2027

3.3 NHS Lothian is commended for continuing to meet and expecting to meet the LDP Standard in 2017-18 relating to Alcohol Brief Interventions (ABIs).

3.4 NHS Boards are expected to report on progress against the 2017-18 LDP to their Boards. The Scottish Government will review progress associated with the LDP at the NHS Board Annual and In-Year Reviews.

3.5 NHS Lothian has received guidance for the 2017 Annual Review scheduled for 29 September 2017 (Appendix 2) which require a number of documents to be prepared and submitted to the Scottish Government in advance of the Annual Review as outlined below.

Annual Review Document	Submission Deadline
NHS Lothian 2017 Annual Review Self-Assessment	8 September 2017
At A Glance Handout (Data Outcome Materials)	8 September 2017
Chairman's Presentation / Speech	8 September 2017
Area Clinical Forum Briefing	15 September 2017
Lothian Partnership Forum Briefing	15 September 2017
'Hot Topic' Briefings	15 September 2017
Questions submitted in advance by members of the public	15 September 2017

3.6 Arrangements and associated briefings for the 2017 Annual Review will be discussed at the Board Development Session scheduled to take place on 6 September 2017.

4 Key Risks

4.1 The key risks highlighted in the 2017-18 LDP 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 and will be required to support the preparation of briefing materials for the 2017 Annual Review.

8 Resource Implications

8.1 At the time of submitting the 2017-18 LDP on 11 April 2017, the financial plan shows that following the deployment of all available resources and uplifts to income, there remained a need to identify a further £22.4m of savings over and above those already delivered.

8.2 There are several "ring-fences" of national priority areas such as mental health.

8.3 Following Quarter 1 2017-18, a revised financial plan requires to be submitted to the Scottish Government by 31 July 2017 detailing steps in place to address any forecast deficit to deliver financial balance. The plan should also include an update relating to the sustainability and value programme.

Alyson Cumming
Strategic Programme Manager
14 June 2016
alyson.cumming@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Scottish Government 2017-18 LDP Feedback
Appendix 2: Scottish Government 2017 Annual Review Guidance
Appendix 3: 2017-18 Draft LDP (Submitted on 11 April 2017)
Appendix 4: 2017-18 Draft LDP Letter from Chief Executive

Health Performance and Delivery Directorate
NHSScotland Chief Operating Officer
John Connaghan CBE

Scottish Government
Riaghaltas na h-Alba
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T: 0131-244 3480
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Tim Davison
Chief Executive
NHS Lothian

17 May 2017

Dear Tim

NHS LOTHIAN: LOCAL DELIVERY PLAN

1. The challenges that NHSScotland face mean that we need to deliver fundamental reform and change to the way that the NHS delivers care. The Health and Social Care Delivery Plan sets out the actions required to reform and further enhance health and social care services. Through the triple aim approach we must prioritise the actions which will have the greatest impact on delivery on better care, better health and better value.

2. We acknowledge the planning that you have already carried out and that further planning is underway in your Board and Region.

3. It is vital that work now moves at pace in collaboration with Integration Authorities, acknowledging their statutory planning remit, to ensure the transformational change needed can be effectively delivered. Only by adopting a whole system approach can assurance be given that any potential financial and delivery risks have been identified and mitigated.

4. Regional planning and delivery is a key component of the Delivery Plan, and over the coming months I expect Boards to work collaboratively to develop Regional Delivery Plans (RDPs), setting out broad actions and priorities. Initial plans should be submitted through your Regional Implementation leads by the end of September 2017. Finalised plans should be submitted by the end of March 2018. You should consider whether aspects of the RDP will impact on your current (2017-18) LDP and update this accordingly by the end of September. Regional Planning Guidance will be developed over the summer to support these plans including the submission process.

5. As Accountable Officer, you have a responsibility for ensuring that the resources of your Board are used economically, efficiently and effectively. Your LDP financial plan forecast an outturn deficit for 2017-18. As a result, I would ask that following the first quarter of this financial year, you submit a revised plan to the Scottish Government detailing the steps in place to address this forecast deficit and for the Board to deliver financial balance this year. This should be submitted no later than 31 July 2017 and will be followed up formally as part of an in-year review meeting to happen in either September or October. The revised plan should include an update on the progress made by the Board in relation to the sustainability and value programme.

6. Further specific feedback is set out in the accompanying annex.

7. If you have any questions about this letter, please contact Jim May in the East Performance Management Team or Dan House in the West Performance Management Team. May I take this opportunity to offer my thanks to you and your team for all of your hard work in 2016-17.

Yours sincerely

JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer

ANNEX

1. Regional Planning

Regional Planning Guidance will be developed over the summer and we expect outline Regional Delivery Plans, setting out broad actions and priorities, to be submitted by the end of September 2017. Finalised plans should be submitted by the end of March 2018. NHS Boards will also want to consider whether this will impact on their current (17/18) LDPs and update these accordingly. We will continue to engage with NHS Boards around the development of the LDP process and its relationship to regional planning over the coming months.

2. Integration

The Health and Social Care Delivery Plan includes a focus on reducing inappropriate use of hospital services, improving links between Acute Hospital and Primary Care teams to improve patient care by appropriately shifting resources to primary and community care and supporting the capacity of community care. This demands a more coherent whole system strategic planning approach than that which currently exists. Moving forward and building on the improvement plans shared by Integration Authorities and LDPs submitted to Scottish Government, it is imperative that work now moves at pace in collaboration with Integration Authorities, acknowledging their statutory planning remit, to ensure the transformational change needed can be effectively delivered. Only by adopting a whole system approach can assurance be given that any potential financial and delivery risks have been identified and mitigated.

3. Waiting Times

You will be aware that additional funding is being identified for elective services for 2017/18 and should be announced shortly. The Scottish Government Access Support Team are engaging with your executives on elective plans and trajectories for 2017/18. We expect that regional capacity will be a key consideration in local planning so as to minimise activity being carried out in the independent sector. NHS Boards must ensure that clinical priority is given to patients – including cancer and patients referred with urgent status.

We expect that the template on activity, finance and performance circulated by the Access Support Team on 12 May 2017 will be completed by the end of May 2017 in accordance with the agreed timescale set out in the letter. Following receipt we will release additional funding on sign-off. We anticipate the release of funds will occur no later than mid-June.

Please be advised that we will be holding a second tranche investment for release in September 2017 against receipt of Regional Plans.

Steps are also being taken to strengthen improvement capability to improve elective services, particularly around the modern outpatient programme and MSK waiting times. These steps, alongside the capital investment in elective centres, will transform elective services in Scotland. There is also a requirement for initial

regional sign off of elective centres plans by June 2017 with next stage approval as part of the Regional Delivery Planning process.

4. Alcohol Brief Interventions (ABI)

The Board should be commended for continuing to meet the current target and it is expected that ABI delivery will continue to be built in to future planning throughout 2017-18.

5. Drug and Alcohol Waiting Times

The Board are facing challenges in delivering current Drug and Alcohol waiting times and the Scottish Government is assisting Alcohol and Drug Partnerships (ADPs) to identify local challenges and solutions to improve waiting times.

6. Unscheduled Care

Through the 6 Essential Actions programme objectives and funding for unscheduled care in 2017/18 have been agreed on the basis that further improvements will be delivered. This will build on Scotland's good performance in comparison to other countries. A greater focus this year will be placed on joint working across Integration Authorities to further improve processes to:

- Ensure that patients are discharged as soon as they are fit and ready, given the negative impact delay has on patient outcomes and service efficiency, and where appropriate, maintain patient care in a community/homely setting.

- Supporting the avoidance of unnecessary admissions.

NHS Boards and their partners must also ensure that they address the patient care delay evidenced by the poorer rate of discharge at the weekend compared to midweek rates. This requires a whole system response, but the benefits to patients and optimal use of resources will be material. The national 4 day public holiday review will help NHS Boards and Integration Authorities tackle this key issue. Boards should not await the outcome of this group, given the potential whole system performance and financial benefits improving performance in this area will deliver.

7. Primary Care

We expect NHS Boards to be working with their Integration Authorities in developing the delivery of primary care services (General Practices, Dentistry, Optometry, Pharmacy). The Health and Social Care Delivery Plan makes it clear that primary care services need to be better resourced and more flexible to deliver a service that is fit for patients and work "hand in glove" across the sectors. We expect your Board, with strategic guidance and support from Integration Authorities, to consider how to deliver new ways of working within primary care for both in and out of hours services linked effectively to acute services. It will be particularly important to consider the development of GP clusters in line with the National GP Cluster Framework, and the creation of robust plans to ensure GP practices at risk of becoming unsustainable are identified and supported.

As the primary care transformation programme moves into a maturity phase, we will expect to see a focus on sharing and spreading the impact of tests of change, and mainstreaming activities and processes that are working well. Existing programmes of monitoring and evaluation should also continue.

We expect progress to continue to be made on the recommendations made in the National Review of Primary Care Out of Hours Services.

As you develop your regional plans, we would expect a continued focus on transforming primary care, with a particular focus on the recruitment and retention of the primary care workforce, as well as ensuring a joined-up approach with the Scottish Ambulance Service and NHS 24.

As you develop your regional plans, we would ask for a continued focus on transforming primary care, particularly in progressing the priorities for primary care following the Primary Care Summit(s) and ensuring that these are reflected within Integration Authority strategic plans. We would also expect you to focus on the recruitment and retention of the primary care workforce, as well as ensuring a joined up approach with the Scottish Ambulance Service and NHS 24. You should also focus on developing innovative solutions to address the significant number of general practices that are restricting their patient lists due to pressures caused by population growth.

8. Person-Centeredness and Patient Safety Programme

In January the Scottish Government wrote to NHS Boards' Quality and Safety Leads, Safety Programme Managers and Person-Centred Programme Managers, to provide further advice on setting this year's improvement aims for safety and person-centeredness. The Scottish Government will be in touch with Boards over the coming weeks to arrange a series of visits and conversations to discuss local priorities.

9. Healthcare Associated Infection

Reducing Healthcare Associated Infection remains a key priority for the Scottish Government and we would ask you to continue working towards reductions in healthcare associated infections and appropriate antimicrobial prescribing.

10. Digital Health & Care

Work is underway to develop a new approach to how we use digital technology, this will position our NHS as a digital first organisation that will support a digitally-active population, a digitally-enabled workforce, health and social care integration, whole-system intelligence and sustainable care delivery. We will continue to consult with Boards on this development. In preparation for this change, Boards are asked to consider how digital can support all service changes and will wish to consider how digital technology can further support the actions outlined in their LDPs above and beyond their existing work on technology enabled care and eHealth, including supporting their workforce.

I would also ask that you review the action that you took in relation to my letter of 21 February 2017 on cyber security resilience.

11. Workforce

As part of the implementation of Everyone Matters: 2020 Workforce Vision Implementation Plan 2017-18, we expect continued progress against the 5 priorities: healthy organisational culture, sustainable workforce, capable workforce, a workforce to deliver integrated services and effective leadership and management.

A National Health and Social care Workforce Plan is planned for publication in Spring 2017. NHS Boards are expected to publish their workforce plan during 2017.

Strengthening the approach to Nursing and Midwifery Workforce planning will be a focus this year. We expect to see evidence that the Nursing and Midwifery Workload and Workforce Planning Tools have been applied to all clinical areas where validated tools are available and that a triangulated approach has been taken.

12. Mental Health

The Scottish Government's Mental Health Strategy, published in March 2017, set out its ambition to deliver "parity of mental and physical health" over the next 10 years. This is the first national strategy since the integration of health and social care and Health Boards and Integration Authorities should continue to work collaboratively to ensure its successful implementation through widening access to services and supporting earlier intervention.

13. Maternity, Neonatal and Early Years

The Scottish Government will continue to provide support to Boards and their partners to deliver additional Health Visitor numbers, alongside delivering the Universal Health Visiting Pathway and Family Nurse Partnership expansion. The progress made to date is welcome and should be maintained. The emphasis on prevention and early intervention to improve the lives of all children should feature strongly as part of any future decision making and planning.

14. Reduce Unscheduled Bed-days in Hospital Care

The Health & Social Care Delivery plan sets out the intention to reduce unscheduled bed-days in hospital care by 400,000 bed days by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. NHS Boards will be working in partnership with their Integration Authorities towards delivery through the work on "Health and Social Care Integration - Local Improvement Objectives" and "6 Essential Actions programme" to ensure all relevant programmes of work are joined up, not least through respective Board and Integration Authority planning processes. Annex 1 provides some relevant statistics to support this work to reduce unscheduled bed-days in hospital care.

15. Next Steps

We expect NHS Boards to report on progress against the LDP to their Boards. The Scottish Government will also consider progress against LDPs at the NHS Board Annual and In-Year Reviews.

Annex 1:

This annex provides some relevant statistics to support work around reducing unscheduled bed-days in hospital care.

Bed Days Occupied by Delayed Discharges in February 2017

NHS Board	Number of bed days for all delays for 18+	Number of bed days for all delays for 75+	Rates per 100,000 population over 75+
Scotland	**40,246**	**28,298**	**6,464.9**
Ayrshire & Arran	**2,938**	**2,562**	**7,435.1**
Borders	**693**	**528**	**4,529.5**
Dumfries & Galloway	**760**	**517**	**3,207.0**
Fife	**1,699**	**1,069**	**3,424.1**
Forth Valley	**2,628**	**1,819**	**7,613.7**
Grampian	**3,806**	**2,637**	**5,933.0**
Greater Glasgow & Clyde	**4,863**	**2,586**	**2,957.9**
Highland	**3,821**	**3,256**	**10,688.4**
Lanarkshire	**5,928**	**4,198**	**8,501.2**
Lothian	**9,049**	**6,498**	**10,431.2**
Orkney	**64**	**50**	**2,384.4**
Shetland	**70**	**62**	**3,395.4**
Tayside	**3,271**	**2,074**	**5,258.1**
Western Isles	**656**	**442**	**14,777.7**

Average Length of Stay for Emergency Admissions (All Specialties)

NHS Board	Average Length of Stay in FY 2015/16[p]	Average Length of Stay in CY 2016[p]
Scotland	**6.9**	**6.9**
Ayrshire & Arran	**6.5**	**6.5**
Borders	**5.1**	**5.3**
Dumfries & Galloway	**8.8**	**8.2**
Fife	**6.6**	**6.5**
Forth Valley	**7.3**	**7.4**
Grampian	**7.5**	**7.5**
Greater Glasgow & Clyde	**6.6**	**6.7**
Highland	**7.8**	**7.7**
Lanarkshire	**5.8**	**5.6**
Lothian	**7.4**	**7.9**
Orkney	**7.2**	**7.6**
Shetland	**5.8**	**6.0**
Tayside	**7.7**	**7.2**
Western Isles	**10.5**	**9.4**

[p] - provisional

Number of Emergency Admissions in 2015/16[p]

NHS Board	Number of Emergency Admissions	Rate of Emergency Admissions per 100,000 population
Scotland	**565,344**	**10,571.9**
Ayrshire & Arran	**50,313**	**13,557.4**
Borders	**14,241**	**12,488.8**
Dumfries & Galloway	**14,759**	**9,843.3**
Fife	**37,526**	**10,217.8**
Forth Valley	**28,546**	**9,502.3**
Grampian	**49,272**	**8,433.5**
Greater Glasgow & Clyde	**138,833**	**12,150.8**
Highland	**28,301**	**8,823.1**
Lanarkshire	**77,543**	**11,869.3**
Lothian	**70,437**	**8,208.6**
Orkney	**1,851**	**8,573.4**
Shetland	**2,048**	**8,816.2**
Tayside	**42,635**	**10,303.3**
Western Isles	**2,817**	**10,337.6**

[p] - provisional

Number of Emergency Bed Days in 2015/16[p]

NHS Board	Number of Emergency Bed days	Rate of Emergency Bed days per 100,000 population
Scotland	**3,914,991**	**73,210.2**
Ayrshire & Arran	**332,450**	**89,582.6**
Borders	**75,935**	**66,592.1**
Dumfries & Galloway	**131,674**	**87,817.8**
Fife	**260,444**	**70,915.4**
Forth Valley	**208,807**	**69,507.3**
Grampian	**372,528**	**63,762.8**
Greater Glasgow & Clyde	**904,908**	**79,198.7**
Highland	**227,248**	**70,846.7**
Lanarkshire	**466,930**	**71,471.4**
Lothian	**528,493**	**61,589.5**
Orkney	**13,459**	**62,339.0**
Shetland	**13,205**	**56,844.6**
Tayside	**325,279**	**78,607.8**
Western Isles	**30,236**	**110,957.8**

[p] - provisional

7 and 28 day Readmissions, July to September 2016

	Surgical Readmissions within 7 Days[1]	Surgical Readmissions within 28 Days[2]	Medical Readmissions within 7 Days[3]	Medical Readmissions within 28 Days[4]
	Standardised Rate[5] per 1,000 admissions	Standardised Rate[5] per 1,000 admissions	Standardised Rate[5] per 1,000 admissions	Standardised Rate[5] per 1,000 admissions
	Jul - Sep 16	Jul - Sep 16	Jul - Sep 16	Jul - Sep 16
Scotland	25.34	45.55	53.42	116.45
Ayrshire & Arran	21.27	41.15	49.46	110.05
Borders	38.02	63.72	50.56	111.41
Dumfries & Galloway	17.25	33.60	44.36	112.37
Fife	42.53	68.43	55.10	127.42
Forth Valley	39.12	61.97	54.76	136.23
Grampian	21.89	42.72	40.69	88.28
Greater Glasgow & Clyde	22.34	41.62	53.61	114.47
Highland	21.19	33.75	49.89	106.73
Lanarkshire	28.02	51.98	64.56	135.05
Lothian	31.54	52.88	55.92	119.93
Orkney Islands	30.89	44.40	40.35	92.75
Shetland Islands	14.86	29.85	30.03	85.63
Tayside	26.83	49.49	59.66	132.58
Western Isles	15.12	24.89	64.58	128.25

Notes:

1 - Numerator = The number of emergency readmissions to any surgical specialty within 7 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a surgical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

2 - Numerator = The number of emergency readmissions to any surgical specialty within 28 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a surgical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

3 - Numerator = The number of emergency readmissions to any medical specialty within 7 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a medical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

4 - Numerator = The number of emergency readmissions to any medical specialty within 28 days of discharge, for patients initially admitted between 1 July 2016 - 30 September 2016. Data derived from SMR01.
Denominator = The number of hospital discharges, for patients admitted to a medical specialty between 1 July 2016 - 30 September 2016. Data derived from SMR01.

5 - This measure has been standardised by age, sex and deprivation (SIMD 2009).

Source: ISD Hospital Scorecard

The numbers below show the additional weekend discharges required to bring the proportion of patients who were admitted on a Wed / Thu / or Fri with and had a LOS of 2 or 3 days, up to the average proportion of the rest of the week.

Potential Additional Weekend Discharges*

SCOTLAND	290.1
ABERDEEN ROYAL INFIRMARY	14.5
BELFORD HOSPITAL	0.9
BORDERS GENERAL HOSPITAL	7.7
CAITHNESS GENERAL HOSPITAL	2.3
DUMFRIES & GALLOWAY ROYAL INFIRMARY	10.7
FORTH VALLEY ROYAL HOSPITAL	16.2
GLASGOW ROYAL INFIRMARY	16.1
HAIRMYRES HOSPITAL	9.3
INVERCLYDE ROYALHOSPITAL	8.2
LORN & ISLANDS HOSPITAL	1.3
MONKLANDS DISTRICT GENERAL HOSPITAL	14.7
NINEWELLS HOSPITAL	21.5
PERTH ROYAL INFIRMARY	8.6
QUEEN ELIZABETH UNIVERSITY HOSPITAL	30.3
RAIGMORE HOSPITAL	10.9
ROYAL ALEXANDRA HOSPITAL	11.0
ROYAL HOSPITAL FORCHILDREN	1.8
ROYAL HOSPITAL FOR SICK CHILDREN (EDINBURGH)	1.5
ROYAL INFIRMARY OF EDINBURGH AT LITTLE FRANCE	12.9
UNIVERSITY HOSPITAL AYR	11.3
UNIVERSITY HOSPITAL CROSSHOUSE	21.0
VALE OF LEVEN GENERAL HOSPITAL	1.4
VICTORIA HOSPITAL	10.8
WESTERN GENERAL HOSPITAL	8.4
WESTERN ISLES HOSPITAL	1.8
WISHAW GENERAL HOSPITAL	15.9
WOODEND GENERAL HOSPITAL	0.6

Almost every hospital in Scotland has the potential to increase the number of discharges that they are making at weekends. Analysis suggests that an additional 290 patients who had been admitted in the previous week as an emergency could be discharged every weekend.

These are typically patients admitted on an Wednesday, Thursday or Friday who would normally have a length of stay of two to three days, but who have their length of stay extended to over the weekend. These additional discharges are broadly equivalent to improving acute bed occupancy on a Monday morning by 2%. This is a significant change that would dramatically reduce the levels of boarding, reduce long delays at the front door experienced by patients waiting for admission to an inpatient bed and contribute to safely and appropriately reducing length of stay.

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ANNUAL REVIEWS: NHS BOARDS: GUIDANCE NOTE: 2017

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ANNUAL REVIEWS 2017: NHS BOARDS: GUIDANCE

Introduction

1. This note covers the arrangements for, and content of, this year's Annual Review meeting for each NHS Board, and also provides specific guidance on the other meetings and activities that will take place on the day of the Ministerial Reviews. This guidance is primarily aimed at the Territorial Boards, but should also be used as the basis for taking forward the Special Health Board Reviews.

2. The detailed arrangements for the Special Health Boards will be the subject of further discussion between these Boards and the appropriate policy lead in the Scottish Government Health and Social Care Directorates (SGHSCD). The guidance is being issued to NHS Boards and within SGHSCD.

3. Ministers have agreed that there will continue to be a split between Boards that receive a Ministerial Review (with some chaired by Ms Robison, some by Ms Watt and some by Ms Campbell as confirmed at Annex A), and those that conduct a non-Ministerial Review. Ministerial attendance at Annual Reviews will be prioritised on the basis of local issues and performance, whilst Ministers will ensure that they chair a Review in each Board area at least once per Parliamentary Session.

Ministerial Reviews

4. We have continued to receive very positive feedback on the changes that were made to the Ministerial Reviews in recent years. As such, Ministers have agreed that they are content that Ministerial Reviews continue in the same format in 2017. We will continue to have separate meetings with the ACF, APF and local patients on the mornings of Ministerial Reviews. As before, please ensure that there are at least 4 spare chairs around the edge of the room for each of these meetings for the SGHSCD officials supporting Ministers. Further detail on the handling of the ACF, APF and local patients' meetings are provided at Annexes F, G and H, respectively.

Ministerial Reviews: Lunch

5. As with last year, we would ask that lunch is provided for the Minister and their Team as part of the 30 minute SGHSCD pre-meeting. This will afford Ministers the chance to have a proper break and catch up with business in a private setting ahead of the main Review meetings. Please note: as well as for the lunch, it would be most helpful to have a small, private room available for the Minister and their staff throughout the day.

Formal Annual Review Meeting (including Q&A Session)

6. For Ministerial Reviews, the process will again be split into two separate sessions. Session one will be held in public and will begin with a brief introduction

from the Minister before the Board Chairperson delivers a presentation on the Board's key achievements/challenges in 2016/17 (including an update on action points from the 2016 Review) and looking forward (15 minutes total). This should be structured around the 3 Quality Ambitions. The final aspect of the public session will be the Q&A session which will last around 30 minutes, dependent on attendance and level of interest. Flexibility will be applied in areas where more time is required. A further 30 minutes will then be taken for Ministers to fulfil any media commitments.

7. The second session will consist of a private meeting chaired by the Minister and involving the full NHS Board. **Please note: every effort should be made to have the Chief Officer for each IJB in the Board area present at this meeting**. The central engagement will remain between the Minister and the Chairperson of the Health Board, more closely mirroring the approach to the formal Review in previous years. As with last year, the discussion at this meeting will be based on the key local achievements/challenges and performance against national standards; as informed by the Board's self-assessment and the Minister's experience during the Review day. Whilst principally concentrating on performance in 2016/17, Boards should be prepared for discussion around current and future priorities and issues, as informed by the Board's draft LDP.

8. There remains flexibility for Boards who are undertaking non-Ministerial Reviews to shape the session to best fit local circumstances. We would encourage Boards to carefully consider a similar, more focussed approach to the public sessions, as with the Reviews in 2016; they should continue to appropriately cover the key local achievements/challenges, in line with national guidelines and frameworks; and allow a proper opportunity for local people to ask questions/interact. Further guidance is at Annex I.

9. The core purpose of the Annual Review continues to be for Boards to be held to account for their performance. Boards will continue to receive detailed Annual Review letters with action points, and these should be published on Board websites.

Arrangements/Logistics

10. The dates for each 2017 Ministerial Review and the division of responsibility between Ministers for chairing the meetings have now been agreed and should be in Boards' diaries (see Annex A).

11. The 'At a Glance' outcomes and performance hand-out (see Annex E) will again serve to illustrate key aspects of local performance. Boards will be expected to produce self-assessments for submission to SGHSCD, as in previous years. As with last year, we would ask that Boards provide only a copy of the Chairperson's presentation and the 'At a Glance' material for attendees. Boards should make clear that their self-assessment and any supporting information, as well as the formal Annual Review letter, will be published on their website.

12. As in previous years, the run-up to each Review will typically be as follows in the matrix detailed on the following page:

Weeks Before / After Review	Event
6-8	Request to Board to prepare self-assessment and 'at a glance' material
3	Boards submit their self-assessment, 'at a glance' material and Chair's presentation
2	Final briefings of Chair and Minister, as appropriate
0	Annual Review
+4-6	Formal Annual Review letter issued by Minister

13. The day will typically take the form set out in Annex B, with adaptations where required to take account of local circumstances. Please discuss the proposal for your Annual Review venue with your SGHSCD contact before finalising arrangements. Boards should ensure that the venue (and publicity material) is fully accessible and that the participants are clearly visible and audible (including hearing loops) to the attending public. PA equipment should be used where necessary.

Official Attendance

14. For Ministerial Reviews, the Minister will be accompanied by DG Health & Social Care or one of his Directors for each meeting. At the public session of the formal Review meeting, the expectation is that the meeting (including the Q&A session) will be fronted by the Minister and DG Health & Social Care/Director for the Scottish Government, and by the Chairperson and Chief Executive on behalf of the Board.

15. PowerPoint slides used for the Chairperson's presentation should be clearly visible to all attendees. Boards should discuss and agree seating arrangements for officials with their relevant SGHSCD contact but please note that Board Team and SG Team should be seated at different tables. As in previous years, a support team (drawn from SGHSCD and the Board) will deal with note-taking and domestic arrangements.

Public Attendance and Participation

16. It is essential that the Reviews should continue to be as accessible to as many people as possible. Boards should encourage members of the public to attend and facilitate their attendance. This means advertising the meetings in a way that reaches as wide an audience as possible and that gives adequate notice, within reasonable cost.

17. The Annual Review should be advertised on the Board's website. Advertising should indicate that there will be a public question and answer session during which the Minister or Chairperson will invite questions from the audience. Boards

should also give some thought to widening access to meetings by using technology.

Further Information

18. For any clarification or further information required please contact the following members of the relevant team in SGHSCD:

NHS Board – Territorial	Performance Team Contacts	Phone
Ayrshire & Arran	Catriona.bateman@gov.scot	0131 244 2868
Borders	ruth.winkler@gov.scot	0131 244 6919
Dumfries & Galloway	Catriona.bateman@gov.scot	0131 244 2868
Fife	ruth.winkler@gov.scot	0131 244 6919
Forth Valley	ruth.winkler@gov.scot	0131 244 6919
Grampian	ruth.winkler@gov.scot	0131 244 6919
Greater Glasgow & Clyde	Catriona.bateman@gov.scot	0131 244 2868
Highland	Catriona.bateman@gov.scot	0131 244 2868
Lanarkshire	Catriona.bateman@gov.scot	0131 244 2868
Lothian	ruth.winkler@gov.scot	0131 244 6919
Orkney	ruth.winkler@gov.scot	0131 244 6919
Shetland	ruth.winkler@gov.scot	0131 244 6919
Tayside	ruth.winkler@gov.scot	0131 244 6919
Western Isles	Catriona.bateman@gov.scot	0131 244 2868

Health Performance & Delivery
Scottish Government
May 2017

ANNUAL REVIEWS: NHS BOARDS: GUIDANCE NOTE 2017: LIST OF ANNEXES

ANNEX A

DATES FOR TERRITORIAL BOARDS REVIEWS IN 2017

Territorial Boards Ministerial Annual Reviews

1. Chaired by either Shona Robison, the Cabinet Secretary for Health & Sport; Maureen Watt, the Minster for Mental Health; or Aileen Campbell, the Minister for Public Health & Sport.

Date	Territorial Board	Chairperson
3 July	NHS Ayrshire & Arran	Martin Cheyne
6 July	NHS Fife	Tricia Marwick
16 August	NHS Tayside	Professor John Connell
21 August	NHS Shetland	Ian Kinniburgh
31 August	NHS Highland	David Alston
8 September	NHS Lanarkshire	Neena Mahal
29 September	NHS Lothian	Brian Houston
2 October	NHS Greater Glasgow & Clyde	John Brown

Territorial Boards Non-Ministerial Annual Reviews

2. Please contact your SG contact (page 4) to agree approach and date (please note: must not clash with Ministerial Reviews).

Territorial Board
NHS Borders
NHS Dumfries & Galloway
NHS Forth Valley
NHS Grampian
NHS Orkney
NHS Western Isles

ANNEX B

TYPICAL MINISTERIAL ANNUAL REVIEW DAY: TERRITORIAL NHS BOARDS

To be agreed in light of local circumstances – timings shown are indicative only:

Time	Issue
10:00hrs	Minister meets Area Clinical Forum
11:00hrs	Short break
11:15hrs	Minister meets Area Partnership Forum
12:15hrs	Short break
12:30hrs	Minister meets Patient Groups
13:30hrs	Pre-meeting with SG officials (private room required and lunch provided)
14:00hrs	Annual Review Public Session: Chairpersons Presentation followed by a 30-minute Q&A session
15:00hrs	Media interviews
15:30hrs	Annual Review Private Session: Minister meets full NHS Board with relevant Integrated Joint Board representation
16:30hrs	Minister departs

ANNEX C

ANNUAL REVIEW FOR TERRITORIAL BOARDS – CORE AGENDA

1. The core purpose of the Annual Review continues to be for Boards to be held to account for their performance. The primary focus is on performance during 2016/17 but Boards should be prepared to discuss the in-year position, as well as looking ahead. There will continue to be a focus on the impact that Boards are making in delivering outcomes as set out in their LDPs, e.g. through the Quality Ambitions and LDP Standards.

Agenda for Each Session

2. Given the time constraints and the need to focus on key local achievements and challenges, **the Chairperson's presentation in the public session should be structured around the 3 Quality Ambitions: Person-Centred, Safe and Effective**. Boards will agree the content and approach to the presentation in advance with their SGHSCD contact. Non-Ministerial Reviews should also follow this approach, as appropriate, in line with local circumstances.

3. The private session at Ministerial Reviews provide an opportunity for Ministers to question full Boards (and Health and Social Care Partnership Chief Officers and Integrated Joint Board representatives, where appropriate) on local performance and issues. The focus may differ depending on the relevant Board area; however, key topics areas may include:

    a) health improvement and reducing inequalities;
    b) clinical governance, patient safety and infection control;
    c) improving access including waiting times performance;
    d) the integration of health and social care with a focus upon prevention, anticipation and supported self-management;
    e) the best use of resources, including workforce planning, financial management, including forward sustainability, as well as service redesign;
    f) establishing strong and effective population based regional planning in partnership with fellow Health Boards.

Introductions and Approach

4. In the public session, the Minister will begin by welcoming attendees; they will briefly set the scene before handing over to the Chairperson for their presentation.

5. The private session will more closely mirror the previous formal Review with the Minister and DG Health & Social Care/Lead Director asking the Board (through the Chairperson) questions on local performance.

ANNEX D

PUBLIC INVOLVEMENT INCLUDING. Q&A SESSION

Public Involvement

1. Boards should continue to try and maximise public attendance on the day: through effective and accessible advertising, within reasonable cost; by using venues appropriate to expected attendance; and should discuss options with the Scottish Health Council well in advance. The appropriate Minister's office will invite local MSPs to attend.

2. Boards will also wish to consider other ways of increasing participation in the Reviews and access to a record of them afterwards; for example, through webcasts or through audio recording of proceedings for subsequent posting on their websites. If Boards choose to broadcast or record meetings in this way, it will be important for them to make clear in advance publicity that this will happen.

Public Question and Answer Session

3. As in previous years, the session will last for approximately 30 minutes at the end of each main Review meeting. All questions will be taken from the floor on the day. Boards should make this clear in their advance publicity, and should also be clear that it will not be possible to answer questions about patient-specific issues. For Non-Ministerial Reviews, Boards should continue to facilitate questions from the public, with Boards given flexibility on which format would work best for their local circumstances.

4. For Ministerial Reviews, the Minister will chair the sessions and he/she or DG Health & Social Care/Director will answer questions, where appropriate. However, where questions are clearly directed at the Board, he/she will hand over to the Chairperson and Chief Executive to respond. The Minister/Chairperson will reiterate at the outset that questions about patient-specific issues will not be answered in public.

5. Any follow-up action will largely depend on the nature of the questions asked and whether it has been possible to answer them fully on the day. In some cases, it may be necessary to ask questioners to leave contact details to allow the Board or the Minister as appropriate to provide a written response. It is not necessary for Boards to publish details of questions and answers on their websites after the Reviews.

ANNEX E

'AT A GLANCE' MATERIAL & BOARD SELF-ASSESSMENTS

'At a Glance' Material

1. Boards should continue to produce an 'at a glance' hand-out consisting of two parts: outcome indicators and performance against Local Deliver Plan (LDP) Standards. These should be available on the day of the Annual Review for the public. At Ministerial Reviews, a copy of the Chairperson's presentation slides on key achievements and challenges should also be made available. The purpose of these hand-outs is to provide the participants with easy access to key information during the Reviews. This information should also be provided on Board websites alongside any supporting material, including Board self-assessments.

2. Boards should use the latest published data in the hand-outs.

Outcome Indicators

3. Boards should decide the content, taking account of national outcomes.

4. The hand-outs should be written in a way that is accessible to the interested lay person. Boards may wish to liaise with key stakeholders in the development of the hand-out. The hand-out itself should clearly show which outcomes are improving/worsening.

5. To assist in the production, the NHS Scotland Resilience and Business Management Team has provided Boards with an information data pack pulling together a range of nationally published information – this should not be seen as exhaustive.

Performance Against LDP Standards

6. The second part relates to how the Boards are progressing towards their LDP Standards.

7. Any questions about the 'at a glance' material should be directed to Sandra Campbell and her Team on (0131) 244 2402.

Self-Assessment

8. The 'At a Glance' material described above should essentially cover headline aspects of progress and performance.

9. Whilst the more detailed Board self-assessments will no longer be provided to attendees on the day of Reviews, these will still be required to be submitted to the Scottish Government to the timescale indicated earlier in this guidance, and should be published on Board websites.

10. Self-assessments should succinctly set out the Board key achievements and challenges in the context of the outcomes being pursued. Boards should keep their self-assessment material as short as possible, aiming for no more than 15 pages of A4, excluding the 'At a Glance' hand-out. It should cover the following:

    a) a short report on the action points agreed at the 2016 Annual Review indicating which actions have been completed and which are outstanding (together with the expected completion date in the case of the latter);
    b) using the 3 Quality Ambitions as headings, list succinctly under each the Board's main achievements and the main challenges that it faces. The focus should be clearly on **key local achievements and challenges**;
    c) as the self-assessments will be published on Board websites, please use plain language and provide illustrative data wherever possible. In this respect there will be some crossover between the self-assessment, the Chair's presentation, and the 'at a glance' document. **It will be important to use published data and other information (or data/information that is otherwise in the public domain) in relation to both past performance and future plans.** Data should be consistent with Scotland Performs, but Boards may also use other output, activity and input data, where relevant; and
    d) type in the simplest format possible using Arial 12 pt with any included tables in Word format rather than Excel.

11. Scotland Performs provides published statistics on LDP standards via link: http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance

ANNEX F

MINISTERIAL MEETING WITH AREA CLINICAL FORUM (ACF)

1. The Minister will meet representatives of the Area Clinical Forum. Patient safety and effective clinical governance will likely be the key focus of this meeting.

2. The Annual Review day runs to a tight timetable and therefore it is important that the meeting does not overrun the allocated time, especially given the additional time allocated to the morning meetings this year. As such, Boards are asked to brief ACF Chairpersons in advance making clear their key role in ensuring that this section of the agenda runs to time.

3. To provide the Minister with context for this meeting, **Boards are asked to provide a short overview briefing** to summarise the work and impact of the ACF in the previous 12 months.

4. As with the meetings with Partnership Forums, the core agenda will provide a focus for discussion of key matters of national interest at these meetings. The emphasis on the various elements of the agenda may again differ from Board to Board, depending on local issues and priorities. There will still be room for some discussion of purely local topics, but generic issues need to be central.

Outline Agenda

5. The Minister will wish to explore the Forum's contribution to the delivery of the 2020 Vision which may include the following key topics:

   a) CMO's commitment to 'Realistic Medicine' and National Clinical Strategy;
   b) Person-centred;
   c) Safe Care;
   d) Primary Care;
   e) Unscheduled & Emergency Care;
   f) Integrated Care;
   g) Care for Multiple and Chronic Illnesses;
   h) Early Years;
   i) Health Inequalities;
   j) Prevention;
   k) Workforce;
   l) Innovation;
   m) Efficiency & Productivity; and
   n) Everyone Matters 2020 Workforce Vision implementation.

ANNEX G

MINISTERIAL MEETING WITH AREA PARTNERSHIP FORUM (APF)

1. The Minister will meet representatives of the Area Partnership Forum. Boards should arrange a suitable venue and for a representative group of members of their APF (or equivalent) to attend the meeting. A member of the Scottish Partnership Forum will normally attend this meeting.

2. Though workforce planning may factor in the main Review meetings, this meeting will be the primary opportunity for the Minister to reflect on how the Board is placed in relation to the implementation of *Everyone Matters: 2020 Workforce Vision*.

3. In implementing *Everyone Matters* we would expect to see continuing progress across all 5 priorities: healthy organisational culture, sustainable workforce, capable workforce, and a workforce to deliver integrated services, effective leadership and management to deliver against the 2016-17 actions and in planning delivery of the 2017-18 actions.

Outline Agenda

4. We may look at progress being made by Boards regarding:

   a) staff engagement and development, and by looking at local staff governance;
   b) workforce planning and management of workforce risks, including progress in reducing levels of sickness absence;
   c) progress in promoting dignity at work, reducing levels of bullying and harassment and how the Board is raising awareness of local whistleblowing policies and issues; and
   d) progress in implementing PIN Policies.

5. The Annual Review day runs to a tight timetable and therefore it is important that the meeting **does not overrun the allocated time**.

6. To provide the Minister with context for this meeting, **Boards are asked to provide a short overview briefing** to summarise the work and impact of the APF in the previous 12 months.

ANNEX H

MEETING WITH PATIENTS/CARERS

1. The Minister will then meet with a representative group of patients/carers. A local Scottish Health Council (SHC) representative and PFPI staff member from the Board should be available to provide support during the meeting, if required.

2. As it is important that patients and members of the public have ownership of this meeting, there is no set agenda. As in the past, **it would be useful to know in advance if any particular issues have been identified for discussion – please advise your SGHSCD contact**. The main purpose of the meeting remains to give people the opportunity to air their views based on their experience of their local NHS.

3. Boards should arrange a suitable and accessible venue, and work with the SHC representative to identify a group of around six patients/carers or other members of the public who can give Ministers a perspective from local service users. Wherever possible Boards should aim to include in the group:

    a) people who have used local NHS services within the last six months;
    b) a person who can reflect the Board's work on equality and diversity; and
    c) people representative of the diversity of the population.

4. Boards will be responsible for providing the chosen participants with any support and advice they require to play their full part in the discussions. This will include issuing invitations, greeting on arrival, provision of refreshments, payment of expenses etc.

5. Boards should ensure that their staff are available to meet attendees and brief them on the purpose of the meeting. The selected attendees should be asked to attend a pre-meeting at which the arrangements can be explained to them and any questions/concerns they may have addressed.

6. Attendance at the main meeting should be restricted to the Minister's Team, and the selected patients/carers/members of the public, although a local SHC representative should be available to attend the meeting, if required (this will depend on the size and composition of the group that will meet the Minister and the support they may need).

ANNEX I

NON-MINISTERIAL REVIEWS

1. In 2011, Scottish Ministers introduced Non-Ministerial Reviews. In order to encourage further direct dialogue whilst preserving accountability, NHS Boards not having a Ministerial Review are still required to conduct public Annual Reviews meetings. For these Reviews, the Chairperson of the Board conducts the meeting, calling on the Senior Board Team to support, as necessary.

2. Boards have the freedom to determine the most appropriate format and structure to cover the material in the most meaningful way – this could involve the Board Chairperson directing specific questions to the Board, or a presentation covering the themes identified in the agenda. We would encourage Boards to carefully consider a focussed approach to the public sessions, they should continue to appropriately cover the key local achievements/challenges, in line with national guidelines and frameworks; and allow a proper opportunity for local people to ask questions/interact.

3. Please contact your SGHSCD contact at an early stage to discuss the intended format and content of your Review and discuss what worked well and what didn't with Boards who have had or are in the process of planning a Non-Ministerial Review for this year.

4. For those Boards who do not have Ministerial Reviews (and therefore no Ministerial morning meetings) the key is to ensure Staff and Patient Groups continue to have an opportunity to feed into the Annual Review process. One option would be for Boards to commission brief reports from their ACF, APF and relevant local patients' body and reflect on these in their self-assessment material; as well as using them to inform the main Review meeting conducted by the Board Senior Team. Boards could alternatively continue the practice of holding meetings with Staff and Patient Groups and reflect on some of these discussions during the public session of the review. It is for Boards to decide how best to involve staff and patient groups in the process in light of local circumstances.

5. Boards will, as with Ministerial Reviews, produce a self-assessment and 'at a glance' performance material to inform the Review. This material should be sent to the Scottish Government ahead of the Review and an official will attend the Reviews in an observing role.

6. Officials will then prepare a written response which should be made available on the Board's website, alongside the self-assessment and any other supporting information.

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
Status: DRAFT	Version 5 Final Draft 110417
Date Authorised: To be authorised by Scottish Government	Review Dates: 15 March 2017 Corporate Management Team 5 April 2017 NHS Lothian Board 10 April 2017 Corporate Management Team

CONTENTS Page

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 not increased in recent years as outlined in the table below. An update is expected during 2017-18.

Lothian Healthy Life Expectancy (years)

	2009-2013 Male	**2009-2013 Female**
Lothian	64.8	67.2
Scotland	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

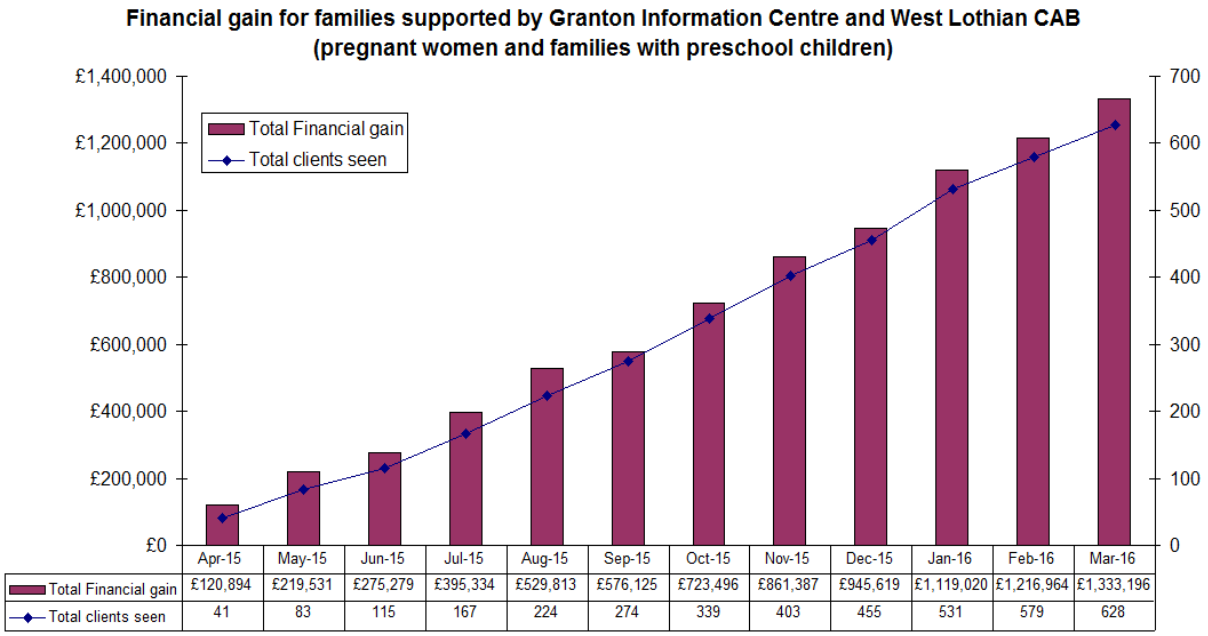
pregnancy and childhood. In Lothian we used quality improvement methods to boost family incomes during pregnancy. We started off with Healthy Start, a UK-wide food and vitamin voucher programme for low income families promoting healthy choices, but ended up also addressing unclaimed entitlements more 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.



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

Increasing Healthy Life Expectancy - Summary of Key Measures
➢ Develop and implement actions to increase the number and quality of community benefits achieved through NHS Lothian contracts
➢ Continue to implement the Socially Responsible Recruitment Programme
➢ In partnership with Local Authorities and the Voluntary Sector increase the reach of Welfare Advice
➢ Use health inequality indicators to raise awareness of determinants of health inequalities and monitor progress to address these
➢ Continue to disseminate our strategic approach and provide training in health inequalities
➢ Implement the Health Equality Framework too across Learning Disability nurses and evaluate the impact at an individual patient level
➢ Commence the new child 13-15 month Scottish development assessment in May 2017
➢ Continue to reduce the number of babies born with a birth weight of less than 2.5kgs
➢ Continue to reduce the percentage of women who are obese (BMI >=35) at ante-natal booking

3. NHS SCOTLAND HEALTH AND SOCIAL CARE DELIVERY PLAN

The NHS Scotland Health and Social Care Delivery Plan[1] 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.

[1] http://www.gov.scot/Resource/0051/00511950.pdf

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.
- 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 realise 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 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
Edin	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 eFraility 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.

Health and Social Care Integration – Summary of Key Measures
➢ Lothian Health and Social Care Partnerships to deliver their range of actions to support a reduction in the delayed discharge position across Lothian
➢ Lothian Health and Social Care Partnerships to deliver a reduction of unscheduled bed days by 10% (179 bed days)
➢ Edinburgh Health and Social Care Partnership to continue to implement their integration structure and develop an integrated workforce strategy to deliver sustainable and affordable services

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

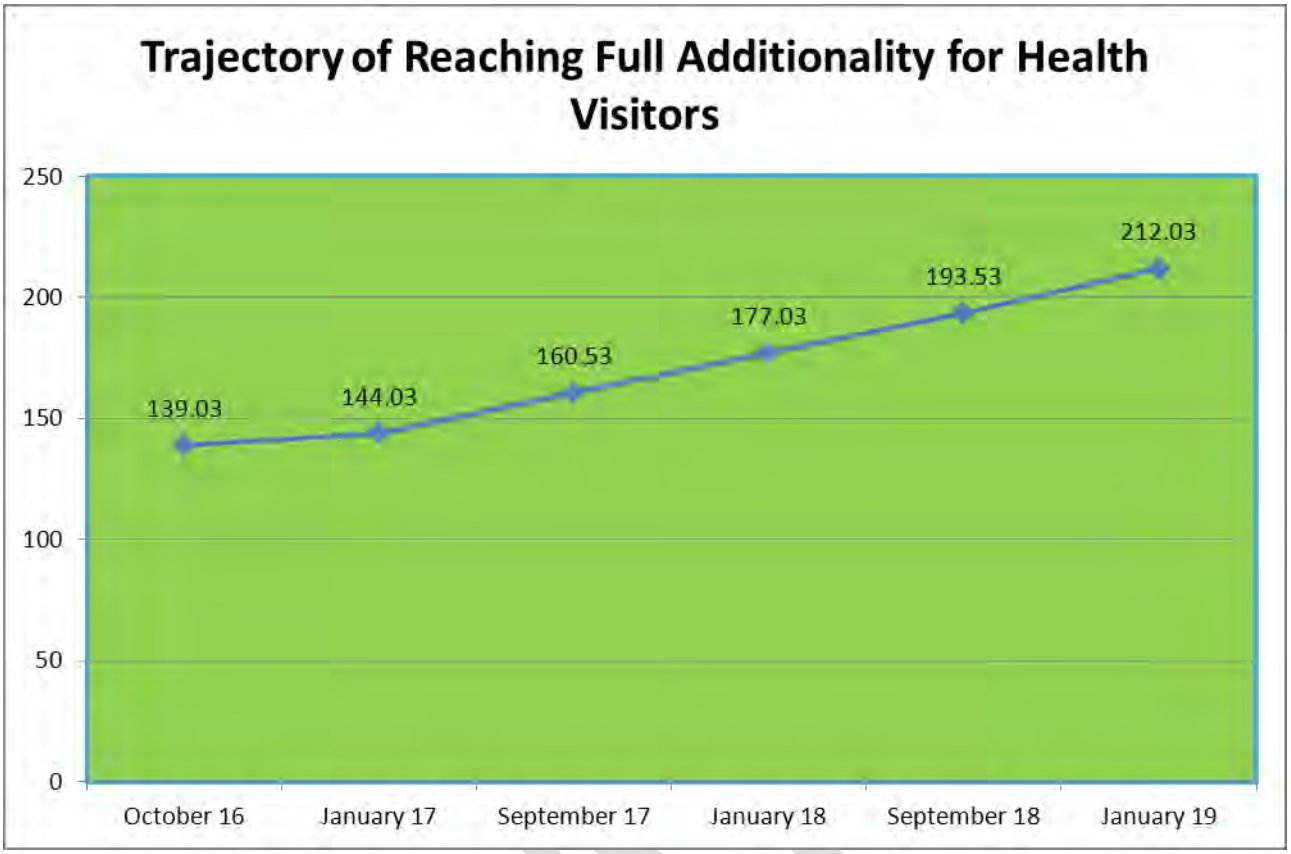
Scottish Government issued CEL 13 (2013): Public Health Nursing, Future Focus, which stated that the role of the HV should focus on prevention and early intervention to improve outcomes for the 0-5 year's population. A national Children and Young People's Nursing Advisory Board was established and a 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 under gone 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 additionalityadd 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.



UNIVERSAL PATHWAY

OCT 2016:
1st Trimester Pregnant Women start Pathway

Women who booked as pregnant prior to October 2016 (and their future child) will not be on new model of first year home visits and incremental delivery of Child health programme (as described below)

APRIL/MAY 2017 onwards: Babies born will be on new pathway model of visits*

APRIL/MAY onwards 2017:
The new model of 12 home visits in the 0-5 years will be delivered by the full HV team: HV's, Staff Nurses and Nursery Nurses (with the HV responsible for allocation of visits)

MAY 2017 onwards: New 13-15 month developmental and wellbeing assessment commences for babies of this age (ASQ, ASQ-SE, new CHSP form)

MAY 2017 onwards:
New 13-15 month assessment introduced
This is a home visit assessment, and will be delivered by the full HV team

2018-2020 ONWARDS

FROM 2018 - 2021 AND ONWARDS:
The Pathway will gradually move to specialist Health Visitor delivery, with additional support to families and early years work from the wider Health Visiting team

2020/2021
4-5 year old preschool assessment start for the babies born from May 2017 that will be school intake Aug 2021

Pathway fully implemented

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 case 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.

Children and Young People – Summary of Key Measures
➢ Lothian Community Planning Partnerships to submit a new services plan to the Scottish Government by the end of April 2017
➢ Continue to implement the Universal Pre-Birth and Pre-school Pathway across Lothian
➢ Commence a new suite of visits and development and wellbeing assessment for babies born from April / May 2017
➢ Commence a further 40 health visitor training places
➢ Achieve the trajectory of 177 health visitors by January 2018
➢ Delivery the 2017-18 priorities associated with the Lothian Children and Young People Strategy 2014-2020
➢ Commence work to create a new Lothian Maternity and Neonatal Care Strategy 2017-2022
➢ Support implementation of the Children and Young People Allied Health Professional Programme for 2017-18
➢ Clinical services to the new Children's Hospital to go live in February 2018

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 NHSL 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 Review[2]. 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.

This document outlines the range of initiatives that will be tested by LUCS and partners. The proposed initiatives are listed below.

[2] http://www.gov.scot/Topics/Health/Services/Primary-Care/nrpcooh

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.

Primary Care – Summary of Key Measures
➢ Undertake a survey to support improvement in GP recruitment and retention
➢ Deliver the 2017-18 premises projects and plan for future premises developments
➢ Complete the appointment of cluster quality leads across Lothian
➢ Continue to manage challenges associated with the district nursing workforce
➢ Develop a plan to support training of additional Advance Nurse Practitioners to support primary care sustainability
➢ Integration of day and evening district nursing services in Edinburgh
➢ In Edinburgh, complete the process of implementing an integrated multi-disciplinary team structure based around two GP clusters in each locality
➢ In East Lothian, change delivery of primary care services in Musselburgh to support joint working to manage same day demand
➢ In West Lothian, deliver the identified primary care capacity actions
➢ In Midlothian, support improvement in primary care services through identified actions
➢ Continue to develop proposed Out of Hours work stream initiatives and recruit a programme manager to support implementation

➢ Review the delivery of Independent Prescribing Clinics delivered through community pharmacists
➢ Primary care pharmacy team will continue to build on support provided to general practices
➢ Implement 2017-18 key actions outlined in the Lothian Prescribing Plan 2016-18
➢ Develop a local action plan to implement recommendations associated with National Dental Action Plan due to be published in 2017
➢ In collaboration with the Lothian Health and Social Care Partnerships, take forward recommendations associated with oral health care in care homes and long stay hospitals

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:

Social Prescribing	Meaningful activities	Support
Improving access and supporting people to get help and support as early as possible	Supporting people to access activities, interests, education, which are meaningful to them	Specific supports and treatment for people experiencing mental ill health
Information and Advice	Volunteering	Psychological support including counselling
Peer workers	Employment	Support in Crisis
	Arts	Supporting early discharge and

Link workers Community facilitators	Ecotherapy	providing an alternative to admission
Delivered in places where people feel safe and secure		

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 pace 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.

Mental Health – Summary of Key Measures
➢ Develop a comprehensive and effective mental health quality improvement programme by April 2018 to ensure safe, effective and person centred care
➢ Increase availability of computerised cognitive behavioural therapy (CCBT) for those with anxiety and depression from 1 April 2017
➢ Continue to develop effective and sustainable models of supporting mental health in primary care
➢ Recruit to new clinical psychology posts to - support needs of older people who have mental health and physical health conditions to avoid hospital admission and support hospital discharge - provide more primary care based delivery of psychological treatments
➢ During May / June 2017, open operational services to support adults with acute mental illness, old age mental health and intensive psychiatric care needs at the new Royal Edinburgh Hospital
➢ Progress with the development of the Outline Business Care for Phase 2 of the Royal Edinburgh Hospital re-provision

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.

Palliative Care – Summary of Key Measures
➢ Complete the evaluation of the palliative care redesign programme by May 2017
➢ Edinburgh Health and Social Care Partnership will host the arrangements on behalf of the four Lothian partnerships for the St. Columba's Hospital and Marie Curie Service Level Agreements and the Lothian Palliative Care Managed Clinical Network from 1 April 2017 and engage with all stakeholders to outline the nature of these new arrangements

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 demanded 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 finance section of our LDP characterises our sustainability pressures. NHS Lothian will be unable to provide additional revenue funding in 2017/18 for Independent Sector Capacity. This additional external capacity has been central to supporting previous years performance.

The impact of this capacity loss in 2017-18 should be well understood. The loss of this was demonstrated in 2016/17; where our predicted deterioration in Out Patient and In Patient/ Day case patients waiting was realised.

Our modelling of Demand & Capacity for 2017-18 is being finalised and whilst we are already deploying significant programmes of work both clinical and administrative, building on our experience and expertise in this area, to mitigate elements of performance deterioration, NHS Lothian must explicitly emphasise that our access performance achieved in March 2017 will significantly deteriorate in 2017-18.

NHS Lothian will submit our definitive performance trajectories formally to Scottish Government.

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 31st 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 31st March 2016	Estimated position as at March 2017
Outpatient 12-week standard	7,036	Approx 17,000
12-week treatment time guarantee	289	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 advice 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 he 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.

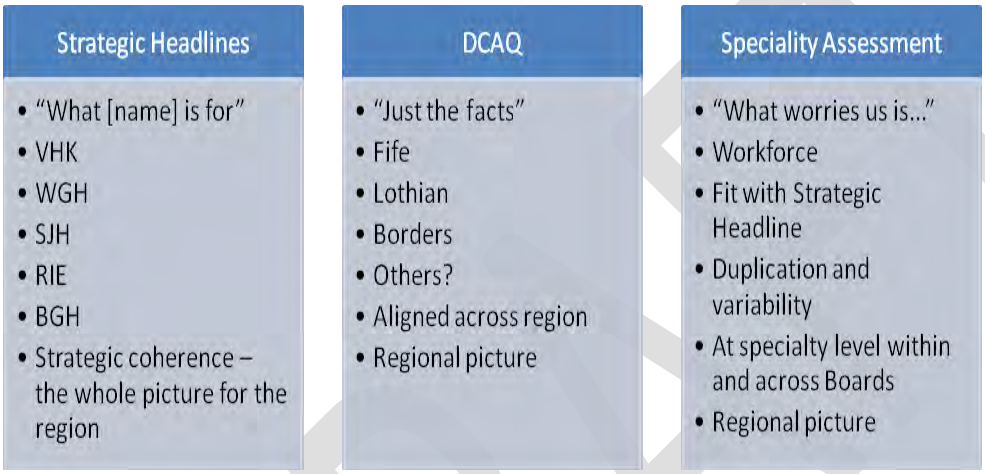
The South-East and Tayside (SEAT) regional planning group has begun to reframe itself as the East of Scotland Health and Social Care Delivery Plan. Arrangements are on-going to identify Chief Executive leadership for this Board and to ensure delivery of an east of Scotland plan for end September 2017. 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;



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.

Secondary and Acute Care – Summary of Key Measures
➢ Roll out Daily Dynamic Discharge Methodology to enhance and optimise discharge planning seven days per week
➢ Progress roll out of Out of Balance Methodology to support emergency capacity and demand planning utilising local site data.
➢ Progress actions to support improvements in the delivery of scheduled care relating to: - Patient and GP Communication - Clinical Risk Management - Reduction of Elective Cancellations - Theatre Improvement Programme
➢ Progress the work streams associated with the Outpatients Programme Board: - Roll out of advice only - Implement Planned Return Waiting Lists - RefHelp updates - Implement outpatient accommodation matrix - Review of triage categories
➢ Transform use of outpatient capacity through: - Patient Initiated Follow Up - Patient Experience - Key Performance Indicator Dashboard
➢ Finalise the Lothian Hospitals Plan by June 2017
➢ Progress plans for the re-provision of the Princess Alexandra Eye Pavilion
➢ Work with regional partners in developing the case for Diagnostic Treatment Centres at St. John's Hospital and Edinburgh BioQuarter Campus

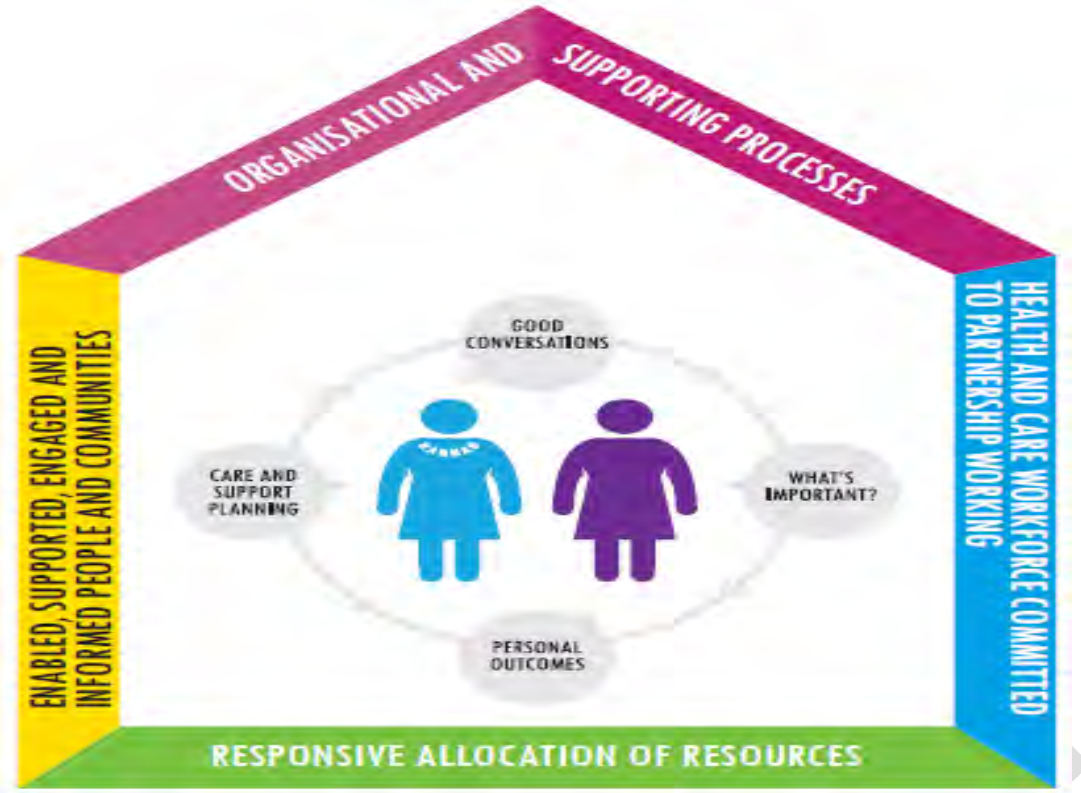
3.4 REALISTIC HEALTHCARE

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 undertaken 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 Performation 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.

Realistic Healthcare – Summary of Key Measures
➢ Continue to support implementation of the House of Care approach in collaboration with the Thistle Foundation and Lothian Health and Social Care Partnerships
➢ Deliver actions associated with nurturing realistic healthcare in NHS Lothian supported through clinical engagement, education and training.
➢ Embed NHS Lothian's Quality Management System to delivery best patient experience, outcomes and sustainable cost through: - Increase capacity in our Quality Academy Programme - Develop a quality improvement coaching framework - Build capacity to manage continuous quality improvement - Building a supportive organisational culture to support continuous quality improvement - Supporting innovation to drive quality improvements in Lothian - Measuring change across the whole system

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 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.

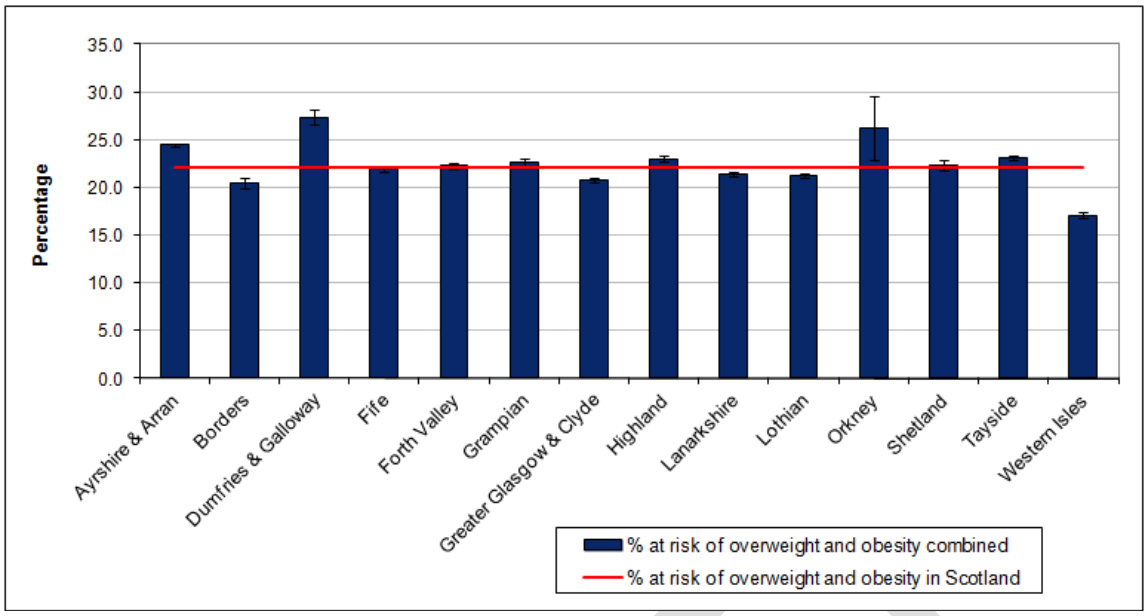
Working with local neighbourhood partnerships across the city we will facilitate ABI training and further develop our ABI toolkit for local authority staff. We will ensure that staff working in specialist projects which have been established to address the needs of people from disadvantaged communities, 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)



BMI Distribution in Primary 1 School Children by NHS Board – Clinical Categories

	School Year									
	06/07	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**
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

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. NHS Lothian's Child Healthy Weight Service continues to support children and young people affected by overweight and obesity. 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 if 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 Dieticians.

The weight management tiered model of care is shown below, with specific reference to Diabetes Prevention for adults.

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.

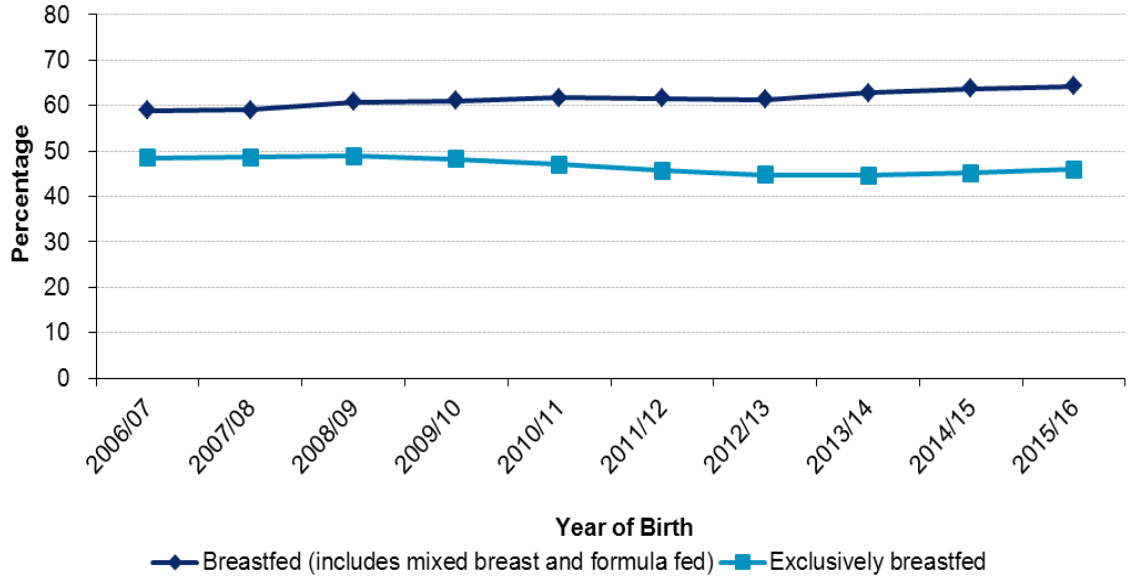
With this in place to ensure our core staff have the skills to universally support breastfeeding and relationship building, this year we are reviewing our wider support services with a view to developing a tiered service, providing the appropriate care at the appropriate time. We have already developed 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.

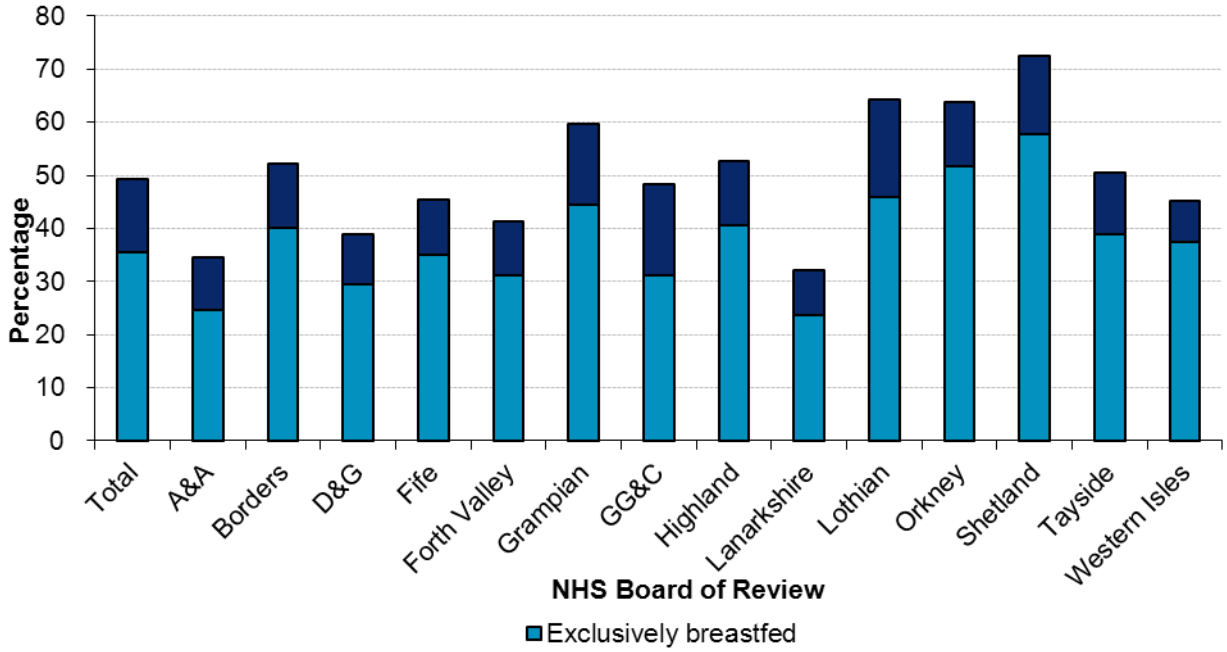
Breast Feeding Rates

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

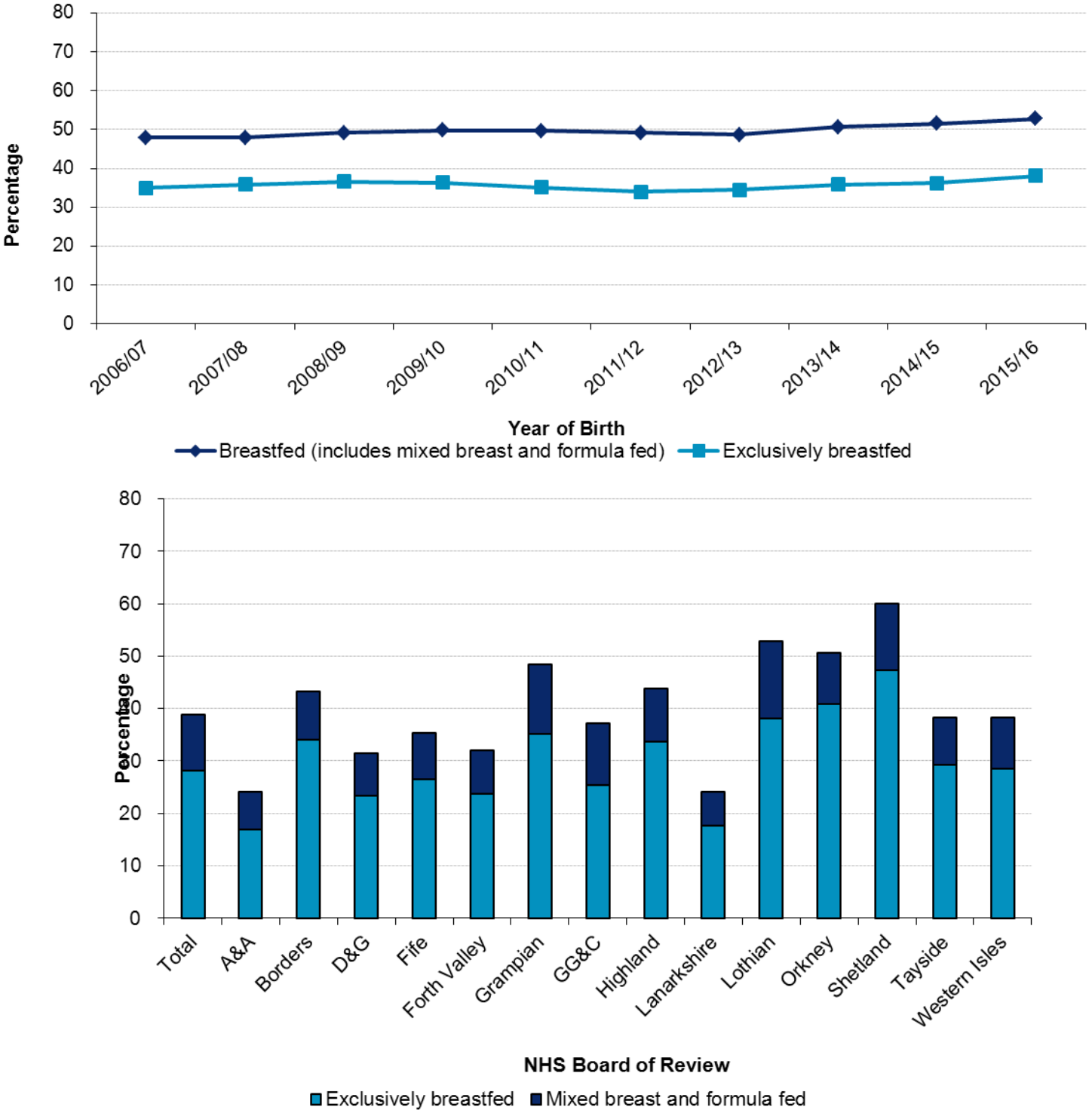


Overall, at first visit; 45.9% (35.5% Scotland) of Lothian women in 2015-16 were exclusively breast feeding; with 64.3% (49.3% Scotland) mixed feeding. Therefore, Lothian has the second highest exclusively breast fed rate in Scotland (and the highest mainland area) for 2015-16 data:



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 NHSL 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.

Public Health Improvement – Summary of Key Measures
➢ Progress actions to associated with the National Tobacco Strategy relating to Smokefree Lothian, health inequalities, prevention, protection and cessation.
➢ Work with the Lothian Drug and Alcohol Partnerships to review and agree a spending plan to reduce harm associated with drug and alcohol consumption.
➢ Continue to support delivery of Alcohol Brief Interventions (ABI) in the three priority settings (Primary Care, Antenatal and A&E) and sustain ABI training in the wider community.
➢ Utilising weight management tiered models of care continue to support reduction of obesity within both children and adults and focus on type 2 diabetes prevention in adults
➢ Support delivery of maternal and infant nutrition framework through accreditation within health visiting and family nurse teams, reaccreditation of Simpsons Maternity Unit and continue to roll out the Lothian breastfeeding assessment tool to continue to support breast feeding in Lothian.
➢ Work with community midwives and pharmacies to prepare for the roll out of universal vitamins to all pregnant women
➢ Support delivery of Scottish Government Strategy Let's Make Scotland Active through collaboration with local authority partners to promote physical activity and embed the national physical activity pathway in all appropriate clinical settings
➢ Continue to drive forward the Health Promoting Health Service agenda through emphasis on: - staff health and wellbeing - re-design of Healthy Working Lives - health promoting environment where health choices are the norm

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. ACOORD 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.

Research and Development – Summary of Key Measures
➢ The Academic and Clinical Central Office for Research and Development will: - ensure investment is used effectively to promote and deliver high quality research outputs - support research active clinicians through NHS Research Scotland fellowship scheme - support and champion the Development of Nursing, Midwifery and Allied Health Professional careers through close working with local Higher Education Institutes - continue to promote and provide resource to partner with Scottish patients and the public - invest time and effort to ensure strategic areas of local and national importance are advanced - develop a strategy to grow the commercial activity undertaken in NHS Lothian - co-ordinate and facilitate connection between clinicians with challenges and engineers, physical scientists, computer scientists and other areas of science to develop and provide solutions to NHS challenges
➢ Establish a new 5 year Nursing, Midwifery and Allied Health Professional (NMAHP) research strategy 2017-2022
➢ Develop a business case for a programme of NMAHP-led multidisciplinary research focusing on NHS Lothian priority areas (integration of health and social care, dementia, health inequalities, service redesign)
➢ Commission collaborative research studies at postgraduate degree level with our Higher Education Institute partners
➢ Work with Research and Development Director and University of Edinburgh Head of Medical School to optimise learning from the Edinburgh Clinical Academic Training module to further develop NMAHP clinical academic career pathways
➢ Work with regional NHS Boards to establish NHS Lothian as a national test area for NMAHP research career models
➢ Vigorously pursue the establishment of joint NMAHP clinical-academic posts at a senior level with Higher Education Institute partners
➢ Encourage suitable qualified NMAHPs to apply for a NRS Career Research Fellowship

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.

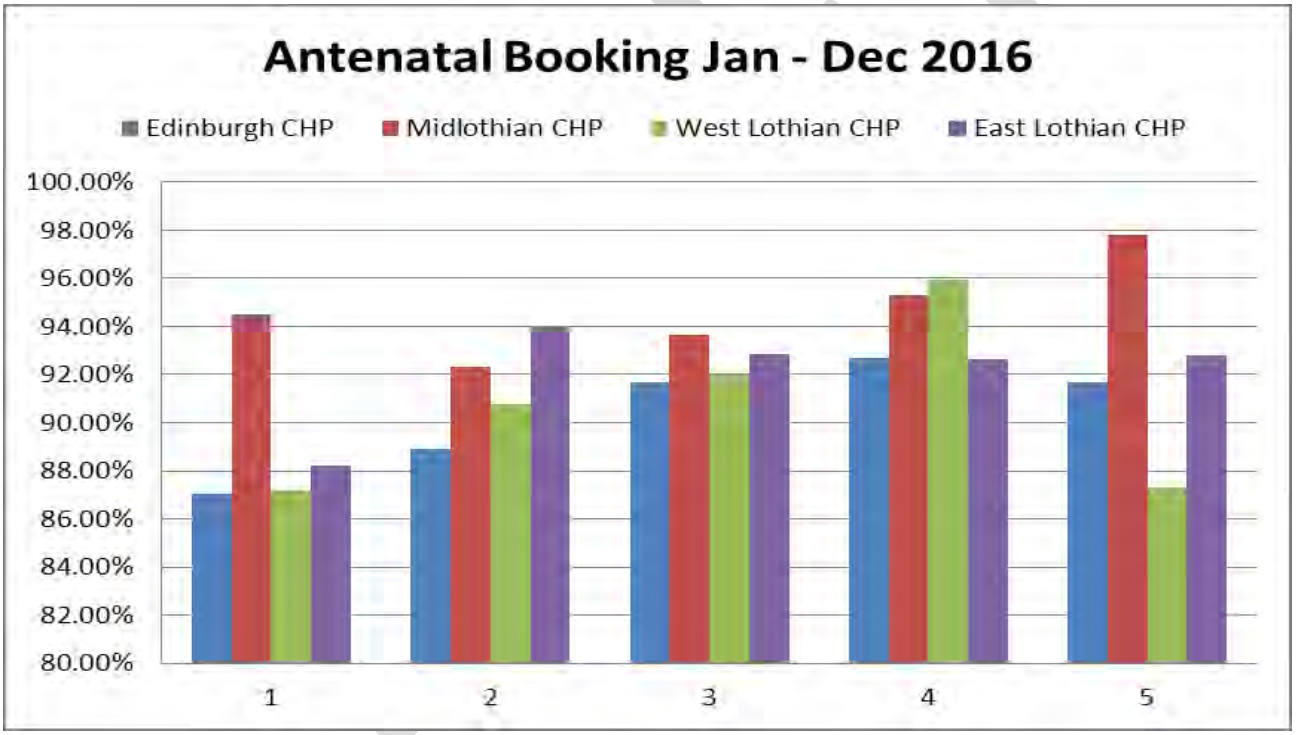
Progress following work streams;

- 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

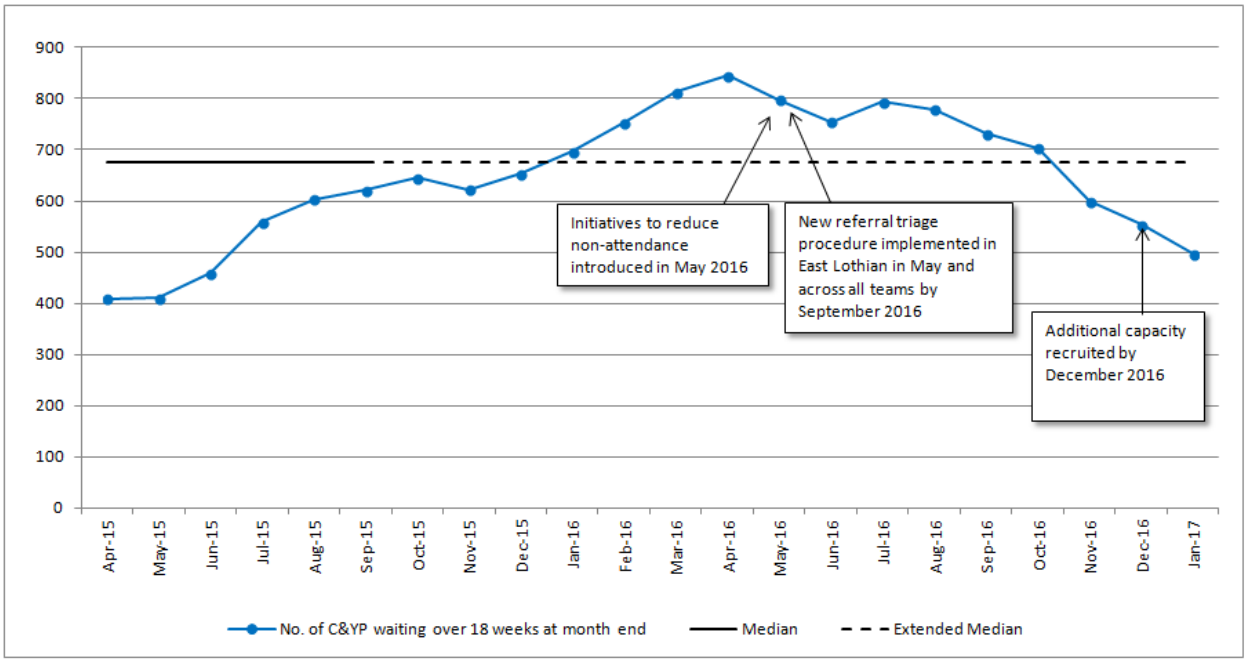
In January 2017 the performance showed a 42.4% against a target of 90% of patients meeting the target.

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.

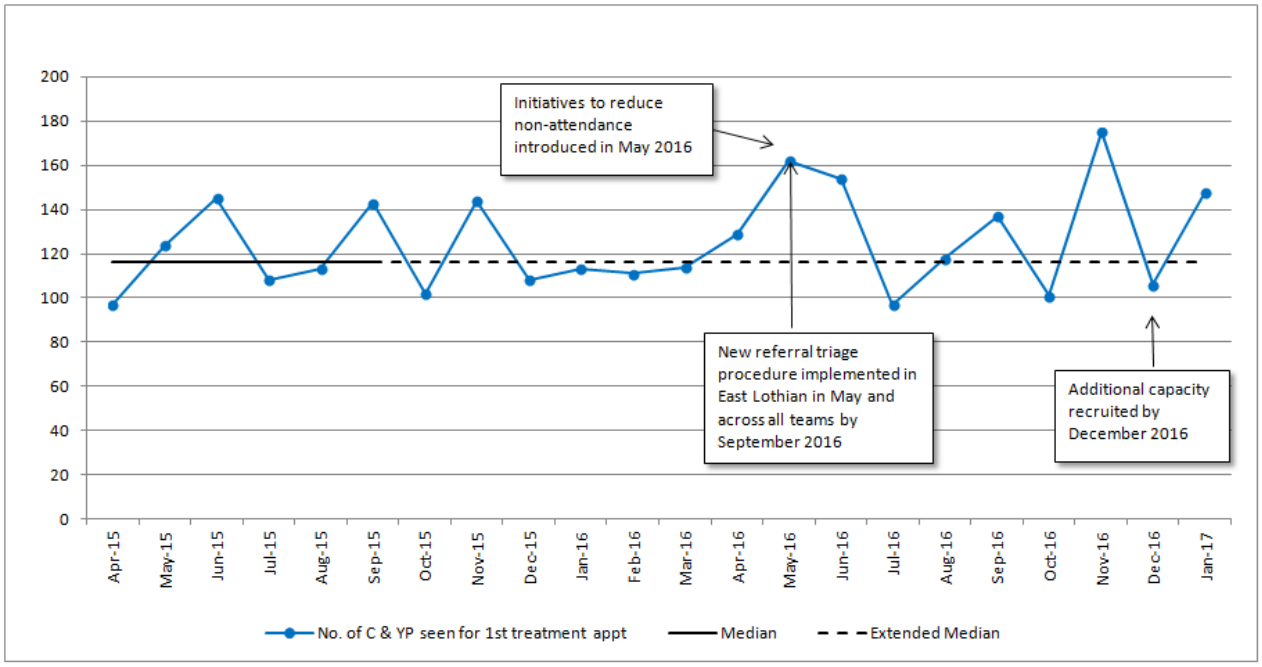
The CAMHS Recovery Plan was developed and implemented from September 2018. It covers the period of one academic year only and has 3 main strands designed to increase the number of patients treated and reduce long waits.

- Change in Link Worker Capacity Building Time
- Reduction in CHOICE assessment clinics
- Recruitment of additional staff

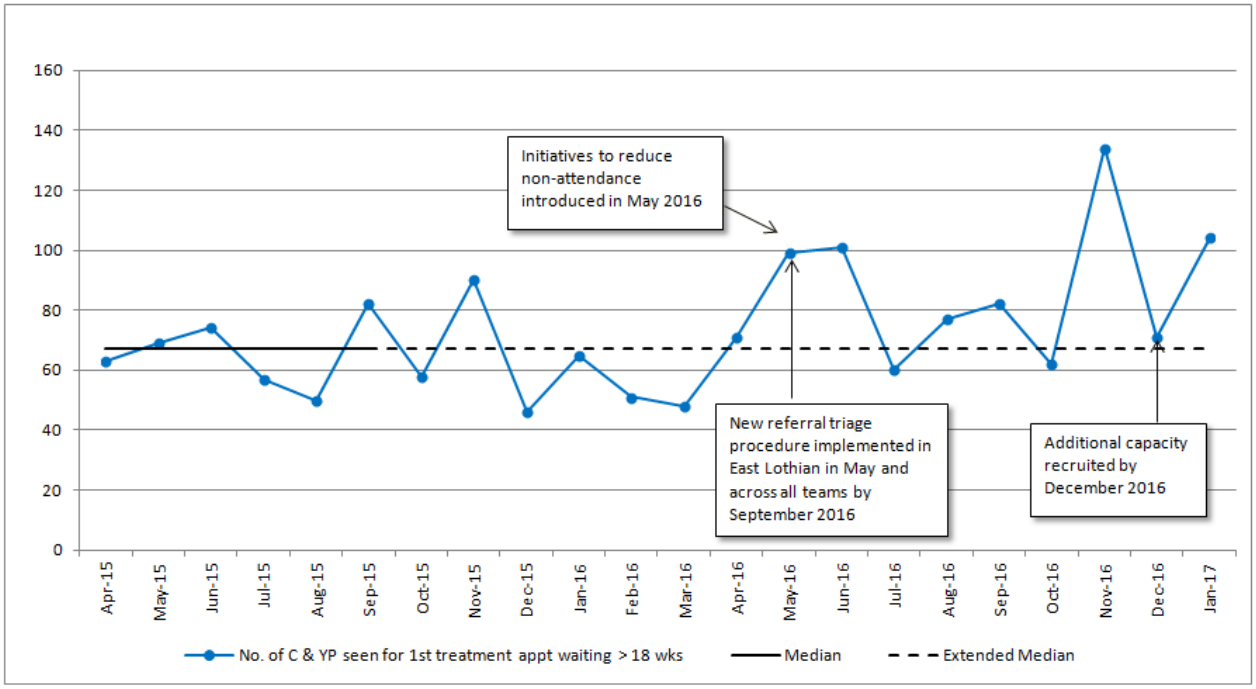
All Generic Teams - Number of children and young people waiting over 18 weeks



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.

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.

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 during 2017/18 and this will then influence our local policy.

In February 2017 4.78% 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 are being 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, these will continue.
- An Absence Dashboard available to all managers has been set up to facilitate effective performance monitoring at a local level.
- 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 have now been addressed.
- 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. A draft will be available by June 2017.

The sickness absence assurance levels were also discussed and reviewed at the Staff Governance Committee in March 2017. The committee took moderate assurance based on the information available that systems and processes are in place to help support the management of staff absence to achieve the 4% rate.

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.

Local Delivery Plan Standards – Summary of Key Measure
➢ LDP standards will be maintained and delivered within available resources and in line with peer performance
➢ NHS Lothian Board will review and discuss delivery of LDP standard performance on a regular basis

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 iinvolving 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
There is a risk of harm to patients through routine and essential clinical interventions	• 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.
There is a potential risk to patients through poor knowledge of staff regarding best practice relating to prevention and control of infection	• 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.
Poor compliance with standard and transmission based precautions can increase the risk of acquisition and transmission of infection.	• 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
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.	• 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 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. *C. difficile* 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
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	• 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	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 ***Responsible Person(s):* Head of Service Infection Prevention and Control, Tableaux Leads**	June 2017
2	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. ***Responsible Person(s): Lead IPCN, Clinical Scientist, Lead ICD and clinical representative***	Sept 2017
3	Raise awareness of national HIS/SAPG guidance regarding best practice regarding clinical management of SAB. ***Responsible Person(s): Local IPCN teams, Clinical Scientist, medical infection specialists***	March 2018
4	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. ***Responsible Person(s):* Head of Education and Employment / Patient Safety Programme Manager / Associate Medical Directors / Associate Nurse Directors / Senior Charge Nurse / Consultants**	Dec 2017
5	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):* Head of Services, HAI Executive Lead , IJB programme Leads**	March 2018
6	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. ***Responsible Person(s):* Associate Nurse Directors / Senior Charge Nurse. Infection Doctors, Senior Charge Nurses**	Nov 2017
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**	March 2018

	Manager / Senior Charge Nurses	
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	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). 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.	Sept. 2017

	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. 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. Site and ward level reports to be developed and shared with local practitioners and directly and on the AMT Intranet page. 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 Review of surgical prophylaxis policies ***Responsible Person(s):*** **Clinical Teams / Antimicrobial Management Team / Associate Medical Directors**	
4	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**	December 2017
5	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**	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	October 2017

	Responsible Person(s): **IPCT Clinical Scientist / Head of Infection Prevention and Control Services**.	
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

Patient Experience and Safety – Summary of Key Measures
➢ Continue to present patient experience results to the Healthcare Governance Committee and NHS Lothian Board including: - patient opinion - new complaints handling procedure - involving people meaningfully in service design and improvement
➢ The patient safety programme will work in collaboration with the Lothian Health and Social Care partnerships to focus on the priorities aligned to the Scottish Patient Safety Programme Core Themes: - improvement in falls - programme of safety walk rounds in primary and secondary care - improvement management of deteriorating patients in acute and mental health wards - improve medicine reconciliation at front door acute hospitals - improvement prevention and management of pressure ulcers - contribute to the reduction of SABs through reliable PVC/CVC insertion and maintenance
➢ Continue to manage and improve healthcare associated infections through risk management actions and improvement plans

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 and 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 16/17 Outturn £000's	Revised Total Growth £000's	Estimated Efficiencies £000's	Net Growth £000's	Net Growth %
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
Previoulsy 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
NRAC 17/18	19.0		**19.0**	the 16/17 Financial Plan Allocations
Reserves	8.3		**8.3**	recurringly
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 £000's	Medium Risk £000's	Low Risk £000's	Grand Total £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.

2017-18 Financial Plan – Summary of Key Measures
➢ Establishment of a local Sustainability and Value Programme Board to oversee delivery of identified improvement opportunities to minimise waste, reduce variation and drive efficiences in relation to; - the national effective prescribing workstream; - Programmes established following an NHS Lothian data diagnostic; - Pan Lothian Efficiency programmes; - Evaluation of resource improvement opportunities from projects being taken forward through the Quality Improvement Programme
➢ Investment of £2m in the development of a quality approach through GP Clusters to support the reduction in waste and unwarranted variation in GP Prescribing with the specific aim of significantly reducing forecast expenditure in 2017-18.
➢ Through an Acute Prescribing Forum work with clinical teams and pharmacists to identify opportunities to deliver a reduction in Acute Prescribing costs.

2017-18 Financial Plan – Summary of Key Measures
➢ On-going review of business unit recovery plans to manage expenditure pressures and high risk financial pressures, and delivery of local efficiency savings.
➢ Work with colleagues across the NHS in Scotland to identify any further non-recurring options to support the 2017-18 Financial Plan.
➢ Development of a longer term financial strategy.

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

Everyone Matters Implementation Plan – 2017/18

Actions for 2017/18	
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).	• 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.
Take action to promote the health, wellbeing and resilience of the workforce, to ensure that all staff are able to play an active role throughout their careers and are aware of the support available to them. (Sustainable)	• 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. • 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.

Build confidence and competence among staff in using technology to make decisions and deliver care by encouraging active participation in learning. (Capable)	• eHealth continue to offer a range of course to support staff in the use of clinical and non-clinical systems. Specifically within our Diagnostic Services we will: • 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
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)	• 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.

Working with partners, develop workforce planning capacity and capability in the integrated setting. (Workforce to Deliver Integrated Services)	• 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. • 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 Playing to your strengths 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
Implement the new development programme for board-level leadership and talent management. (Effective Leadership and Management)	• 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
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.

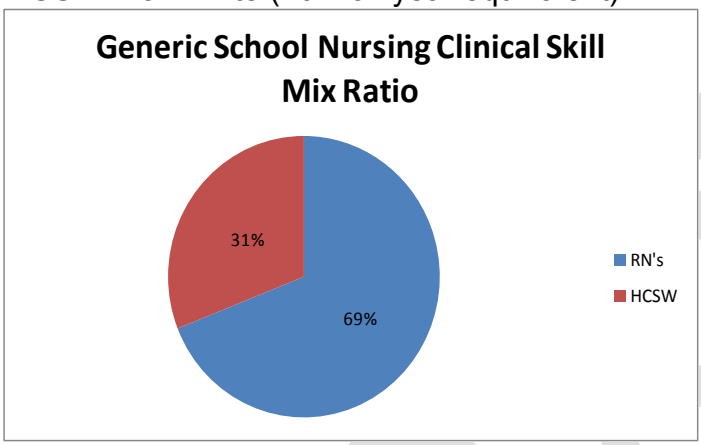
	Band 7	Band 6 (TT)	Band 6 (AY)	Band 5 (TT)	Band 5 (AY)	Band 3 (TT)	Band 3 (AY)
Edinburgh.	1(1)	0	3.62	7.53	8.04	13.54	0.53
West Lothian	0	3.81 (2)	0	0.66	1.73	0	0
East & Mid Lothian	0	0	2 (1)	11.44	0	3.37	0.8

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	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total	% over50
School Nursing Service B3		1	1	1	5	6	2	2	18	55.56
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.

Workforce Planning – Summary of Key Measures
➢ Deliver actions associated with NHS Lothian Everyone Matters Implementation Plan 2017-18 relating to: - healthy organisational culture - sustainable workforce - capable workforce - delivery of integrated services - effective leadership and management
➢ Edinburgh and Midlothian Health and Social Care Parnterships will develop workforce plans during 2017-18
➢ Delivery of children and young people workforce planning priority areas: - medical cover in paediatrics - implementation of school nursing pathway in Lothian

Appendix 1 2017/18 Summary Financial Plan

	NHS Lothian Total		
	Feb Board £000's	April Board £000's	Movement £000's
FULL YEAR RECURRING BUDGET	**1,536,033**	**1,536,033**	**1,536,033**
BASELINE PRESSURES 17/18	**(29,383)**	**(30,888)**	**(1,505)**
UPLIFTS & CONTRACTUAL OBLIGATIONS	(24,877)	(22,896)	1,981
GROWTH AND OTHER COMMITMENTS	(23,714)	(21,669)	2,045
POLICY DECISIONS	(16,391)	(3,770)	12,621
STRATEGIC INVESTMENTS	(3,050)	(1,744)	1,306
ESSENTIAL SERVICE DEVELOPMENTS	(3,038)	(4,459)	(1,421)
PROJECTED EXP, UPLIFTS & COMMITMENTS	**(71,070)**	**(54,538)**	**16,532**
TOTAL PROJECTED 17/18 COSTS	**(100,453)**	**(85,426)**	**15,027**
RECURRING RESOURCES	10,400	10,400	0
17/18 COSTS NET OF RECURRING RESOURCES	**(90,053)**	**(75,026)**	**15,027**
PERCENTAGE OF RECURRING BUDGET	**(5.9%)**	**(4.9%)**	**1.0%**
NON RECURRING FLEXIBILITY	14,000	14,000	0
ADDITIONAL FLEXIBILITY	0	3,110	3,110
ADDITIONAL FLEXIBILITY & RESERVES	0	10,000	10,000
GAP BEFORE RECOVERY PLAN	**(76,053)**	**(47,916)**	**28,137**
PERCENTAGE OF RECURRING BUDGET	**(5.0%)**	**(3.1%)**	**1.8%**
FINANCIAL RECOVERY PLANS IDENTIFIED	24,525	25,540	1,015
FINANCIAL PLAN GAP AFTER RECOVERIES	**(51,528)**	**(22,376)**	**29,152**
PERCENTAGE OF RECURRING BUDGET	**(3.4%)**	**(1.5%)**	**1.9%**

Appendix 2 2017/18 Financial Plan by Business Unit

	NHS Lothian Total	UHSS Total	Reas	East Lothian Partnership	Edinburgh Partnership	Midlothian Partnership	West Lothian Hsc Partnership	Facilities & Consort	Corporate Departs Total	Strategic Total	Inc + Assoc Hlthcare Purchases	Research & Teaching	Reserves
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
FULL YEAR RECURRING BUDGET	**1,536,033**	**633,678**	**62,326**	**79,209**	**268,732**	**55,371**	**121,477**	**151,712**	**79,517**	**23,284**	**12,995**	**0**	**47,734**
BASELINE PRESSURES 17/18	(30,888)	(16,198)	(880)	(1,346)	(2,142)	(938)	(2,845)	(836)	(1,713)	2,537	(6,148)	(534)	155
PROJECTED EXP, UPLIFTS & COMMITMENTS	(54,538)	(23,375)	(1,139)	(2,075)	(7,153)	(1,690)	(4,336)	(6,415)	(2,438)	(1,655)	(260)	(783)	(3,219)
TOTAL PROJECTED 17/18 COSTS	**(85,426)**	**(39,573)**	**(2,019)**	**(3,421)**	**(9,295)**	**(2,628)**	**(7,181)**	**(7,251)**	**(4,151)**	**882**	**(6,408)**	**(1,317)**	**(3,064)**
RECURRING RESOURCES	10,400	5,895	784	402	807	176	570	1,052	845	0	0	0	(132)
17/18 COSTS NET OF RECURRING RESOURCES	**(75,026)**	**(33,678)**	**(1,236)**	**(3,019)**	**(8,487)**	**(2,452)**	**(6,611)**	**(6,199)**	**(3,306)**	**882**	**(6,408)**	**(1,317)**	**(3,196)**
PERCENTAGE OF RECURRING BUDGET	**(4.9%)**	**(5.3%)**	**(2.0%)**	**(3.8%)**	**(3.2%)**	**(4.4%)**	**(5.4%)**	**(4.1%)**	**(4.2%)**	**3.8%**	**(49.3%)**		
NON RECURRING FLEXIBILITY	14,000	7,969	0	1,458	505	989	2,527	0	0	0	0	0	552
ADDITIONAL FLEXIBILITY	3,110	0	0	422	1,594	363	731	0	0	0	0	0	0
ADDITIONAL RESERVES	10,000	0	0	0	0	0	0	0	0	0	0	0	10,000
GAP BEFORE RECOVERY PLAN	**(47,916)**	**(25,708)**	**(1,236)**	**(1,139)**	**(6,388)**	**(1,100)**	**(3,354)**	**(6,199)**	**(3,306)**	**882**	**(6,408)**	**(1,317)**	**7,356**
PERCENTAGE OF RECURRING BUDGET	**(3.1%)**	**(4.1%)**	**(2.0%)**	**(1.4%)**	**(2.4%)**	**(2.0%)**	**(2.8%)**	**(4.1%)**	**(4.2%)**	**3.8%**	**(49.3%)**		
FINANCIAL RECOVERY PLANS IDENTIFIED	25,540	8,663	130	1,140	3,105	1,100	2,621	7,235	1,546	0	0	0	0
FINANCIAL PLAN GAP AFTER RECOVERIES	**(22,376)**	**(17,045)**	**(1,106)**	**1**	**(3,283)**	**(0)**	**(733)**	**1,036**	**(1,760)**	**882**	**(6,408)**	**(1,317)**	**7,356**
PERCENTAGE OF RECURRING BUDGET	**(1.5%)**	**(2.7%)**	**(1.8%)**	**0.0%**	**(1.2%)**	**(0.0%)**	**(0.6%)**	**0.7%**	**(2.2%)**	**3.8%**	**(49.3%)**		**0**

Appendix 3 2017/18 Financial Recovery Plan Detail

Financial Recovery Plan Summary		East Lothian Partnership £000's	Edinburgh Partnership £000's	Facilities & Consort £000's	Midlothian Partnership £000's	West Lothian Hsc Partnership £000's	Corporate Services £000's	University Hosp Support Serv £000's	Reas £000's	FRP Total £000's
Clinical Productivity	Demand Management							1,328		**1,328**
	Diagnostic Review							114		**114**
	Income Generation						15			**15**
	Other Local Schemes							158	90	**248**
	Service Redesign									
	Theatre Efficiency									
Clinical Productivity Total							**15**	**1,600**	**90**	**1,705**
Drugs & Prescribing	Drug Tariff/Pricing	711	2,805		642	1,342	428	1,487		**7,415**
	Homecare Contracts						46	133		**179**
	Other Local Schemes					148		110		**258**
Drugs & Prescribing Total		**711**	**2,805**		**642**	**1,490**	**474**	**1,729**		**7,851**
Estates & Facilities	Income Generation			5,510						**5,510**
	Other Local Schemes			1,391						**1,391**
	Service Redesign			333						**333**
Estates & Facilities Total				**7,235**						**7,235**
Procurement	Local Contracts					145		390		**535**
	National Contracts							277		**277**
	Other Local Schemes					30			40	**70**
	Service Redesign	185								**185**
	Standardise/Rationalise							70		**70**
Procurement Total		**185**				**175**		**737**	**40**	**1,137**
Support Services	Avoid Investment					64		615		**679**
	Income Generation					11	160			**171**
	Other Local Schemes					694	468			**1,162**
	Paperlite					1				**1**
	Service Redesign						171	76		**247**
	Transport & Travel					2				**2**
	Vacancy Management						259			**259**
Support Services Total						**772**	**1,057**	**691**		**2,520**
Workforce	Avoid Investment							100		**100**
	Income Generation							30		**30**
	Other Local Schemes				219					**219**
	Reduce Agency/Bank		300					1,725		**2,025**
	Reduce Medical Locums							226		**226**
	Reduce Overtime							198		**198**
	Reduce Sickness Absence					50		419		**469**
	Service Redesign	244			159			470		**873**
	Skill Mix Redesign				80	134		739		**953**
Workforce Total		**244**	**300**		**458**	**184**		**3,906**		**5,092**
FRP Total		**1,140**	**3,105**	**7,235**	**1,100**	**2,621**	**1,546**	**8,663**	**130**	**25,540**

Appendix 4 – 2017/18 Financial Plan Summary by Integrated Joint Boards

	East Lothian IJB	Edinburgh IJB	Mid Lothian IJB	West Lothian IJB	Acute Non Delegated	CHP Non Delegated	Corporate Non Delegated	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
FULL YEAR RECURRING BUDGET	**90,518**	**404,734**	**81,036**	**145,325**	**476,575**	**38,743**	**299,102**	**1,536,033**
BASELINE PRESSURES	(1,340)	(4,933)	(1,523)	(3,260)	(16,158)	(1,525)	(2,149)	**(30,888)**
PROJECTED EXP, UPLIFTS & COMMITMENTS	(2,518)	(10,649)	(2,363)	(5,116)	(18,608)	(693)	(14,591)	**(54,538)**
PROJECTED 17/18 COSTS	**(3,858)**	**(15,582)**	**(3,886)**	**(8,376)**	**(34,766)**	**(2,218)**	**(16,740)**	**(85,426)**
RECURRING RESOURCES	548	2,181	439	746	4,298	436	1,752	**10,400**
NON RECURRING FLEXIBILITY	1,574	1,058	1,086	2,728	7,001	0	552	**14,000**
ADDITIONAL FLEXIBILITY	422	1,593	363	731	0	0	0	**3,110**
ADDITIONAL RESERVES	0	0	0	0	0	0	10,000	**10,000**
ADDITIONAL RESOURCES	**2,545**	**4,832**	**1,888**	**4,205**	**11,299**	**436**	**12,304**	**37,510**
GAP BEFORE RECOVERY PLANS	**(1,313)**	**(10,750)**	**(1,998)**	**(4,171)**	**(23,467)**	**(1,782)**	**(4,436)**	**(47,916)**
PERCENTAGE OF RECURRING BUDGET	**(1.5%)**	**(2.7%)**	**(2.5%)**	**(2.9%)**	**(4.9%)**	**(4.6%)**	**(1.5%)**	**(3.1%)**
FINANCIAL RECOVERY PLANS	1,192	5,029	1,446	2,696	6,329	67	8,781	25,540
FINANCIAL PLAN GAP	**(121)**	**(5,721)**	**(552)**	**(1,475)**	**(17,138)**	**(1,715)**	**4,345**	**(22,376)**
PERCENTAGE OF RECURRING BUDGET	**(0.1%)**	**(1.4%)**	**(0.7%)**	**(1.0%)**	**(3.6%)**	**(4.4%)**	**1.5%**	**(1.5%)**

Appendix 5 2017/18 Financial Plan Risk Register

Key Assumptions / Risks	Risk rating	Impact
Recovery Actions	High	Delivery of planned recovery actions to the value required to cover the known pressures and developments within the individual Business Units.
New GP Contract	Medium	No additional costs of the new GP contract ie immunisation has been included in the financial plan
Waiting Times	High	There requires to be continued management of the financial exposure on elective capacity pressures. The risk is that Current investment plans to deliver capacity will not deliver the required volume and meet the DFP Strategy.
Delayed Discharge	High	Need to manage the volume of delayed discharges and the cost of new initiatives that will be required to deliver the required reductions.
Prescribing	Medium	A sustained level of ongoing growth and price increases have been included in the financial plan, however there is the potential for increases to be greater than projected.
Pharmaceutical Price Regulation Scheme (PPRS)	High	The Pharmaceutical Price Regulation Scheme has provided a source of funding in previous year to offset the cost of approved IPTRs and New Medicines. There is a risk that this source of funding will not be available at the level assumed in the plan.
Changes to pay T&Cs and backdated pay claims	Low	Any changes to pay, terms and conditions, have not been included in the Financial Plan. NHSL no longer has a provision for backdated pay claims, therefore any further claims will be an unplanned in year cost.
SGHD Allocations	High	Availability of SGHD funding for previously separately funded programmes and initiatives.
Capital Programme	High	NHSiL has an ambitious capital programme which requires significant resources in addition to those available to deliver. The revenue consequences of the programme are a significant pressure to the organisation.
Winter Costs	High	The risk remains whether sufficient additional resources are available to meet the pressures from anticipated winter demand
Integration	High	The plan has assumed that the additional resource passed to the IJBs from the Social Care Fund will create additional capacity and reduce the total level of Delayed Discharges in the Health System
Acute Prescribing	Medium	There is a risk that the level of growth exceeds the estaimte contained in the Financial Plan
Outcomes Framework	Medium	The Financial Plan assumes that plans are in place to reduce expenditure in line with reductions in ADP and Bundles Funding, however this has proved difficult in 2016/17

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NHS Lothian

John Connaghan
NHS Scotland Chief Operating Officer
Directorate for Health Performance
and Delivery
Scottish Government

Date 11 April 2017
Your Ref
Our Ref TPD/ac

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Dear John

NHS LOTHIAN 2017-18 DRAFT LOCAL DELIVERY PLAN (LDP)

Please find enclosed NHS Lothian's draft LDP 2017-18 which was discussed at the Lothian NHS Board meeting on 5 April 2017.

Our plan outlines our actions and measures to support healthy life expectancy, national Health and Social Care Delivery Plan, LDP standards, work associated with improving patient experience and safety, 2017-18 financial plan and risks and actions associated with workforce plans and organisational culture.

NHS Lothian's key challenges for 2017-18 outlined in the plan relate to delivery of the LDP standards and integration performance measures due to the impact of demographic growth in Lothian and caring for an increasing elderly population. This is reflected in the financial plan which has a remaining gap of £22.4m after distribution of all residual reserves. Work to close this gap is described in the financial plan including NHS Lothian's plan to deliver efficiency opportunities arising from the Sustainability and Value Work Programme, a resource evaluation of projects being taken through NHS Lothian's Quality Improvement Programme, in addition to other options to identify further non-recurring sources of funds.

NHS Lothian is working in collaboration with regional NHS Boards to begin developing a Regional Health and Social Care Delivery Plan which will be submitted in September 2017.

I look forward to receiving your feedback on our draft LDP in due course.

Yours sincerely

TIM DAVISON
Chief Executive

NHS LOTHIAN

Board Meeting
21st June 2017

2.3

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 15 measures considered across the Board, including those relating to the Hospital Scorecard, are currently met with 20 not met. It is not yet possible to assess performance on dementia post-diagnostic support; and

2.1.2 that Board Committees are continuing with the enhanced programme of assurance agreed, with a provisional timetable for remaining measures outlined in this paper To date, 15 measures have been considered with significant, moderate and limited assurance reached on 2, 7 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	*Hospital Length of Stay (2)* Hospital Readmission Rate (4)		*Staff Sickness Absence*
Equitable		*Early Access to Antenatal Care* Smoking Cessation	
Person-Centred		*Complaints (2)* Detecting Cancer Early *Dementia Post Diagnostic Support* Patient Experience	
Safe	*Cardiac Arrest Incidence* Hospital Standardised Mortality Ratio	*Falls with Harm* Healthcare Acquired Infection (2)	
Timely	*4 hr Unscheduled Care Wait* Cancer Waits (2) *Diagnostic Waits* Inpatient and Daycase Waits *IVF Waits* Outpatient Waits *Referral to Treatment Wait* Stroke Bundle Compliance *Surveillance Endoscopies Overdue*	*Access to General Practice (2)* Alcohol Brief Interventions *CAMHS Waits* Drug & Alcohol Waiting Time *Psychological Therapy Waits*	

Table B – Adopted Assurance Gradings

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

4 Notable Updates

4.1 Any recent changes to the Q&PI process or new data issues across the measures reported are highlighted in this section.

Programme of Assurance

4.2 It will be recalled from previous reports that a timetable for the assurance process be developed in order that all areas within the framework were subject to committee scrutiny. A provisional timetable for those areas yet to be assessed has been developed with the assistance of officers who support the Acute Hospitals and Healthcare Governance committees.

4.3 It is stressed that the timetable developed is flexible. It is important that the committees are able to exercise autonomy in their governance role Committees are likely to take account of information available from elsewhere, for example risk registers. In other instances aspects of the Q&PI process are already standing items on the committee's agenda, as, for example, is the case for SABs which is considered by Healthcare Governance at every other meeting.

4.4 This provisional timetable is set out in Table C below. It should be noted that this includes items that are scheduled to return for further consideration but not repeat standing items beyond their next occurrence. As the Staff Governance Committee considers staff absence rate alone of the Q&PI measures and a subject of ongoing focus, this is not included.

Table C – Provisional Assurance Timetable for New Items

	Healthcare Governance	Acute Hospitals Committee
July	Complaints HAI Antenatal	31 Day and 62 Day Cancer
August		Cardiac Arrest
September	Dementia	
October		IVF
November	No new items proposed	
December		Hospital Scorecard (Readmissions, Length of Stay, HSMR)
TBC	48-Hour GP Access	

Refinement of the Assurance Process

4.5 The quality and performance process has evolved over the last 18 months since it was introduced in its current form. Feedback from those involved has been key to informing this development and recent conversations with board members has suggested that there is merit in seeking efficiencies in the process.

4.6 Accordingly the Chief Quality Officer has asked for options for the further improvements to be explored. It is intended that these will be put before the Board at its next meeting.

GP Access

4.7 Data assurance processes in Analytical Services identified that the invalid responses had been included when access to members of a GP team within 48 hours had been calculated for 2015/6. Once corrected, performance on access moved above the required level of 90% and is therefore now reported as "met".

4.8 Relevant tables have been updated to take account of this change.

Amalgamation of Proforma

4.9 One of the items highlighted in the engagement sessions held with those completing and considering the proforma was that as many topics were closely related that it would be helpful if the proforma for these associated standards were pulled together.

4.10 Accordingly 4 measures have now been combined into 2 proforma. *Diagnostics (<=6 wks) - Gastroenterology/ Urology Diagnostics* and *Planned Repeat Surveillance Endoscopy (past due date)* have been joined up, as have *Cancer (<=31-day) (% treated)* and the *62-day* equivalent.

Planned Repeat Surveillance Endoscopy

4.11 In addition to being combined for the first time, the composition of the surveillance numbers has also altered following a change in the national return. There is no longer an "other" classification and those who would have appeared in this line previously have been reallocated to one of other four categories. Historical figures have been adjusted to reflect this new format.

Measures Adopted for 2017/8

4.12 Earlier this year the Board agreed roll over measures used for 2016/7, for which the precedent had been set nationally in the Local Delivery Plan process, pending the output from National Review into Targets and Indicators for Health and Social Care, chaired by Sir Harry Burns. As members will be aware, the Review is expected to preliminarily report imminently.

Drug and Alcohol Waiting Times

4.13 It has been requested that more timely data is sourced on Drug and Alcohol Performance. This is currently being investigated with colleagues within the Alcohol and Drug Partnerships and it is anticipated will be implemented shortly.

5 Recent Performance

5.1 Against the measures considered, most recent information demonstrates that NHS Lothian met 15 of the 36 measures considered, whilst 20 were not met. As detailed

above, it is not possible to make an assessment on Dementia Post-Diagnostic Support.

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 D below sets out the assessments by board committee. To date, 15 have been considered with significant, moderate and limited assurance being reached on 2, 7 and 6 instances respectively. On no occasion was 'no assurance' concluded;

Table D – Assessed Levels of Assurance

			Assurance Level				
			Not yet assessed	**None**	**Limited**	**Moderate**	**Significant**
Board	Met	14	-	-	-	-	-
	Not Met	21	-	-	-	-	-
Acute Hospitals Committee	Met	10	8	0	0	2	0
	Not Met	8	5	0	3	0	0
Healthcare Governance Committee	Met	5	4	0	0	0	1
	Not Met	11	3	0	3	4	1
Staff Governance Committee	Met	0	-	-	-	-	-
	Not Met	1	-	-	-	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)	1.76 (median)	Apr 17 (Mthly)	TG
Falls With Harm (per 1,000 occupied bed days)		Quality	Healthcare Governance (HGC)	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Not Applicable	Not Applicable	0.31 per 1,000 occupied bed days (median)	0.18 (median)	Apr 17 (Mthly)	TG
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)		LDP	HGC	Significant	Mar 17	Met		Better	Dec 16 (Quarterly)	0.32 (max) (<=262)	0.25 (rate) 17 (incidences)	Apr 17 (Mthly)	TG
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)		LDP	HGC	Moderate	Mar 17	Not Met	No Change	Better	Dec 16 (Quarterly)	0.24 (max) (<=184)	0.36 (rate) 23 (incidences)	Apr 17 (Mthly)	TG
Hospital Standardised Mortality Ratios (HSMR) (within limits)		Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	1 All sites within HS Limits	NHS L 0.87 / RIE 0.83 / SJH 0.91 / WGH 0.74	Dec 16 (Qtrly)	TG
48 Hour GP Access – access to healthcare prof	Timely	LDP	HGC	TBC	TBC	Met		Worse	2015/16	90% (min)	91.5%	2015/16	DS
48 Hour GP Access – GP appt		LDP	HGC	TBC	TBC	Not Met		Worse	2015/16	90% (min)	74.8%	2015/16	DS
Four hour Unscheduled Care (% <=4 hrs)		LDP	AHC	Moderate	Feb 17	Met		Better	Mar 17 (Monthly)	95.0% stretch to 98.0%	95.2%	Apr 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 (per Quarter)	22,291	Mar 17 (Qtrly)	AMcM
CAMHs[10] (<=18 wks)		LDP	HGC	Limited	Mar 17	Not Met	Improving	Worse	Dec 16 (Quarterly)	90.0% (min)	57.0%	Apr 17 (Mthly)	AMcM
Cancer (<=31-day) (% treated)		LDP	AHC	To be reviewed	To be reviewed	Not Met	Improving	Worse	Dec 16 (Quarterly)	95.0% (min)	94.3%	Apr 17 (Mthly)	JC
Cancer (<=62-day) (% treated)		LDP	AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Dec 16 (Quarterly)	95.0% (min)	84.7%	Apr 17 (Mthly)	JC
Diagnostics (<=6 wks) - Gastroenterology/ Urology Diagnostics			AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Mar 17 (At month end)	0 (max)	2,561	Apr 17 (Mthly)	JC
Diagnostics (<=6 wks) - Radiology			AHC										
Diagnostics (<=6 wks) – Vascular Labs			AHC										
Drug & Alcohol Waiting Times (% <=3 wks)		LDP	HGC	Limited	Mar 17	Not Met	Deteriorating	Worse	Dec 16 (Quarterly)	90.0% (min)	83.8%	Dec 16 (Qtrly)	AMcM
IPDC Treatment Time Guarantee (<=12 wks)		LDP	AHC	Limited	Feb 17	Not Met	Improving	Worse	Mar 17 (Quarterly)	0 (max)	83.8% 1,500	Apr 17 (Mthly)	JC
IVF (% <=12 months)		LDP	AHC	TBC	TBC	Met		Equal	Mar 17 (Quarterly)	90.0% (min)	94.1%	Apr 17 (Mthly)	JC
Outpatients (<=12 weeks)		LDP	AHC	Limited	Feb 17	Not Met	Improving	Worse	Mar 17 (at month end)	95.0% (min)	70.7% 17,311	Apr 17 (Mthly)	JC
Psychological Therapies (% <=18 wks)		LDP	HGC	Moderate	Nov 16	Not Met	Deteriorating	Worse	Dec 16 (Quarterly)	90.0% (min)	60.0%	Apr 17 (Mthly)	JF
Referral to Treatment (% <=18 wks)		LDP	AHC	Limited	Feb 17	Not Met	Deteriorating	Worse	Mar 17 (Monthly)	90.0% (min)	78.8%	Apr 17 (Mthly)	JC
Stroke Bundle (% receiving)		Quality	AHC	Moderate	Nov 16	Met	Improving	Not Applicable	Not Applicable	75.0% (min)	79.1%	Mar 17 (Mthly)	JC
Planned Repeat Surveillance Endoscopy (past due date)			AHC	To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0 (max)	4,357	Apr 17 (Mthly)	JC
Delayed Discharges (>3 days) – East Lothian IJB	Effective		HGC	To be reviewed	To be reviewed	Not Met	Improving	Worse	Mar 17 (Monthly)	0 (max)	204	Apr 17 (Mthly)	DS
Delayed Discharges (>3 days) – Edinburgh IJB			HGC										RMG
Delayed Discharges (>3 days) – Midlothian IJB			HGC										EM
Delayed Discharges (>3 days) – West Lothian IJB			HGC										JF
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days	Efficient	Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	All NHS L Sites (RIE; SJH & WGH), Within Hospital Scorecard Limits	NHS L 31.54 / RIE 32.30 / SJH 44.16 / WGH 29.75	Jul - Sep 16 (Qtrly)	TG
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met					52.88 / 60.45 / 60.94 / 53.64		TG
Hospital Scorecard – Standardised Medical Readmission rate within 7 days		Quality	AHC	TBC	TBC	Met					55.92 / 52.51 / 63.49 / 62.04		TG
Hospital Scorecard – Standardised Medical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met					119.93 / 128.76 / 134.75 / 117.46		TG
Hospital Scorecard – Average Surgical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met					0.95 / 0.91 / 0.89 / 1.07		TG
Hospital Scorecard – Average Medical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met					1.18 / 0.91 / 1.33 / 1.36		TG
Staff Sickness Absence Levels (<=4%)		LDP	Staff Governance	Moderate	Mar 17	Not Met	Improving	Better	2015/16	4.0% (max)	5.10%	Mar 17 (Mthly)	JB
Early Access to Antenatal Care (% <=12 wks)	Equitable	LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Better	2015/16	80.0% min for each SIMD[12] quintile	88.8%	Mar 17 (Mthly)	AMcM
Smoking Cessation (quits)		LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Not Met	Deteriorating	Better	2015/16	404 (min for this quarter)	203	Dec 16 (Qtrly)	AKM
Complaints - 3-Day (%<=3-day)	Person-Centred	Quality	HGC	Moderate	Nov 16	Not Met	Improving	Worse	2015/16	100.0% (min)	90.0%	Mar 17 (Mthly)	AMcM
Complaints - 20-Day (% <=20-day)		Quality	HGC	Moderate	Nov 16	Not Met	Deteriorating	Worse	2015/16	80.0% (min)	68.0%	Mar 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 Years)	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: 25.5% / Part 2: 64.3%	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	Improving	Not Applicable	Not Applicable	9 (out of 10)	8.80	Mar 17 (Mthly)	AMcM

Notes:-

1. Much of this reporting uses management information and is therefore subject to change;
2. 6 Domains of Healthcare Quality http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html
3. This describes the standard type – 'LDP' target/standards are Local Delivery Plan (previously HEAT), target/standards; Quality standards were originally reported under a separate Quality Paper.
4. Performance Against Target/Standard – describes where Latest Performance meets or does not meet Target.
5. Trend - describes Improvement, No Change or Deterioration for Latest Performance, where Performance Against Target/Standard is 'Not Met', against an average of the last two relevant reported data points. HAI measures use HIS run chart assessment to ascertain trend. (Black cells indicate that a Standard is 'Met' so a Trend is not available').
6. Published NHS Lothian vs. Scotland – describes most recent published Lothian position against the most recent (directly comparable) published Scotland position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest Performance.
7. Date of Published NHS Lothian vs. Scotland – describes most recent published Lothian position against the most recent (directly comparable) published Scotland position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest Performance.
8. 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.
9. Proforma Narrative Updated since Last Report – Trajectories and/or Action Plans and/or Comments updated since last report.
10. 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
11. SIMD - Scottish Index of Multiple Deprivation, http://www.gov.scot/Topics/Statistics/SIMD
12. 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 **June 2017** meetings

Target/Standard:

- 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)	**1.76 per 1,000 (median)**	Apr 17	2222 Database	Yes	Yes	DF

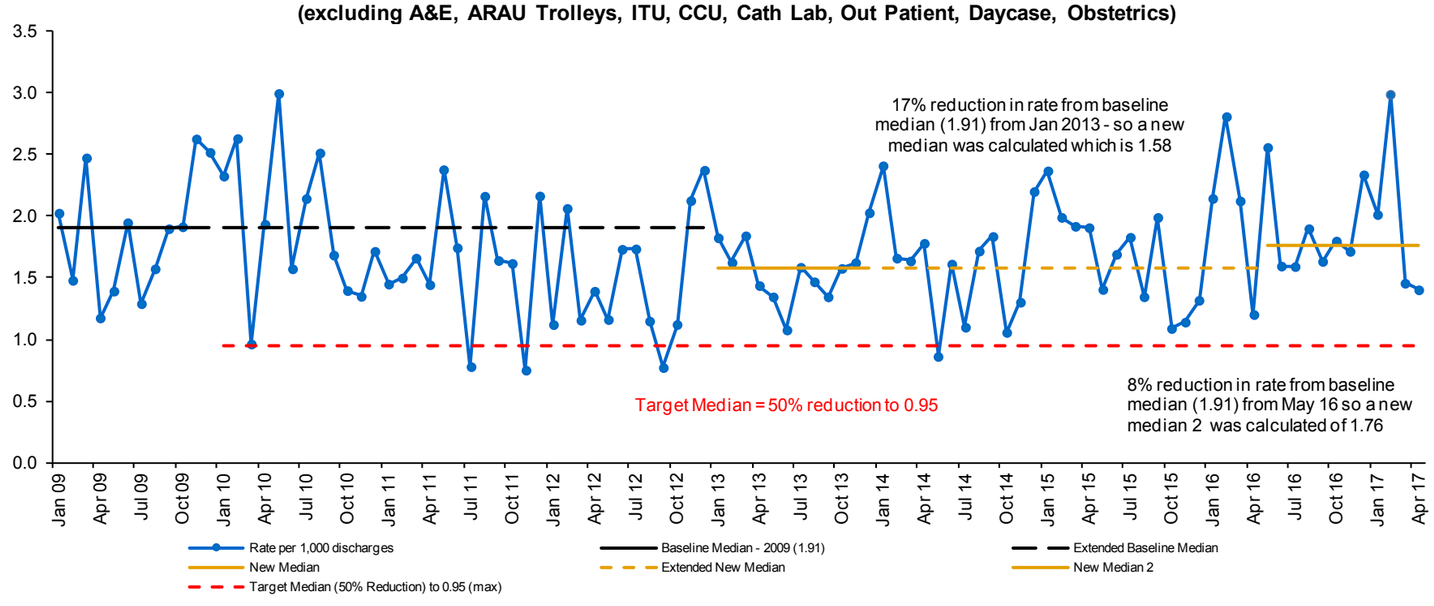
Summary for Committee to note or agree

NHS Lothian has achieved an 8% reduction and the median is 1.76 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 – against Standard

Figure 1: NHS Lothian Cardiac Arrest Rate per 1,000 Discharges – Lower Median is Better

(excluding A&E, ARAU Trolleys, ITU, CCU, Cath Lab, Out Patient, Daycase, Obstetrics)

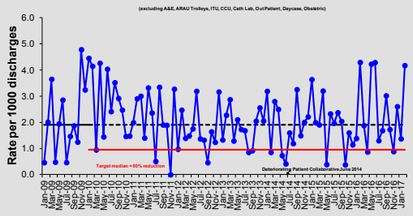
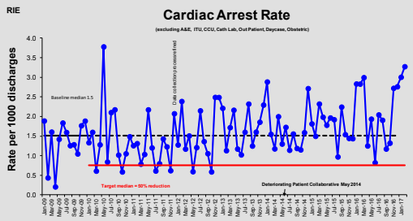
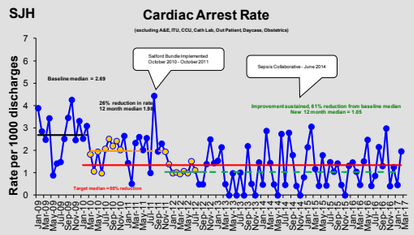


Timescale for Improvement

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. • 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	• 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.
As agreed at HCG we are undertaking a review of both Cardiac Arrests and Peri Arrests to inform an improvement plan to be submitted to the July HCG. The focus of the review is on cardiac and peri arrests at RIE and WGH which have seen a sustained increase compared with SJH who have continued to experience a sustained improvement (see charts below).	July 2017	• To obtain a full understanding of the contributory factors leading to the increase in cardiac and peri arrests led by service teams supported by QIST. This learning will inform a plan to be presented to HCG in July 2017. • To learn from good practice across NHS Scotland to inform the improvement plan using the Patient Safety Programme managers network.	Review taking place April/May 2017 to inform improvement pan to enhance the management of the deteriorating patient in acute hospitals in NHS Lothian.	• Service teams identified with clinical lead. Notes being sourced and review to take place **May** • Triangulation of data qualitative and quantitative in **June**, led by Medical Director and Chief Quality Officer • Interviews with staff taking place and questions have been tested **and being entered onto database.** • Review of unplanned admissions to Critical Care has taken place and data being analysed Interviews conducted with Forth Valley and Grampian. Visit planned to NHS Fife, **16th**

WGH  RIE  SJH  The review includes:- • RIE and WGH MDT reviews of cardiac and peri arrests as identified by the Cardiac Arrest Database to inform the plan. The tools to be used have been thoroughly tested to ensure they capture key themes and learning • We are seeking to understand current ward-based systems and reliability of care - ward-based interviews and care reviews are being undertaken by QIST in order to build a picture of patient care. The review will include goals of care, reliable conversations; and communication across the team and with patients and families; ward teamwork, structures rounds, escalation, reliability of time taken to review at escalation and senior medic involvement. • Reviewing Unplanned Admissions to Critical Care • We are actively seeking to learn from other health boards who have made sustained improvements. These areas include: Forth Valley, Highland, Grampian, Dumfries & Galloway and Fife.				**May.**

Comments

Reasons for Current Performance

All three sites are approximately the same rate and do not give cause for concern. **The HIS 50% reduction from our current baseline by December 2017 was ambitious**. 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 across **NHS Lothian**. 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 **opportunities to reduce** the overall rate, based on the findings of the review. The review of cardiac arrests will include cardiac arrests over the last year including the period when the numbers started to increase (see above).

Healthcare Acquired Infection – *Staphylococcus aureus* Bacteraemia (SAB)

Healthcare Quality Domain: Safe

For reporting at **June 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:-

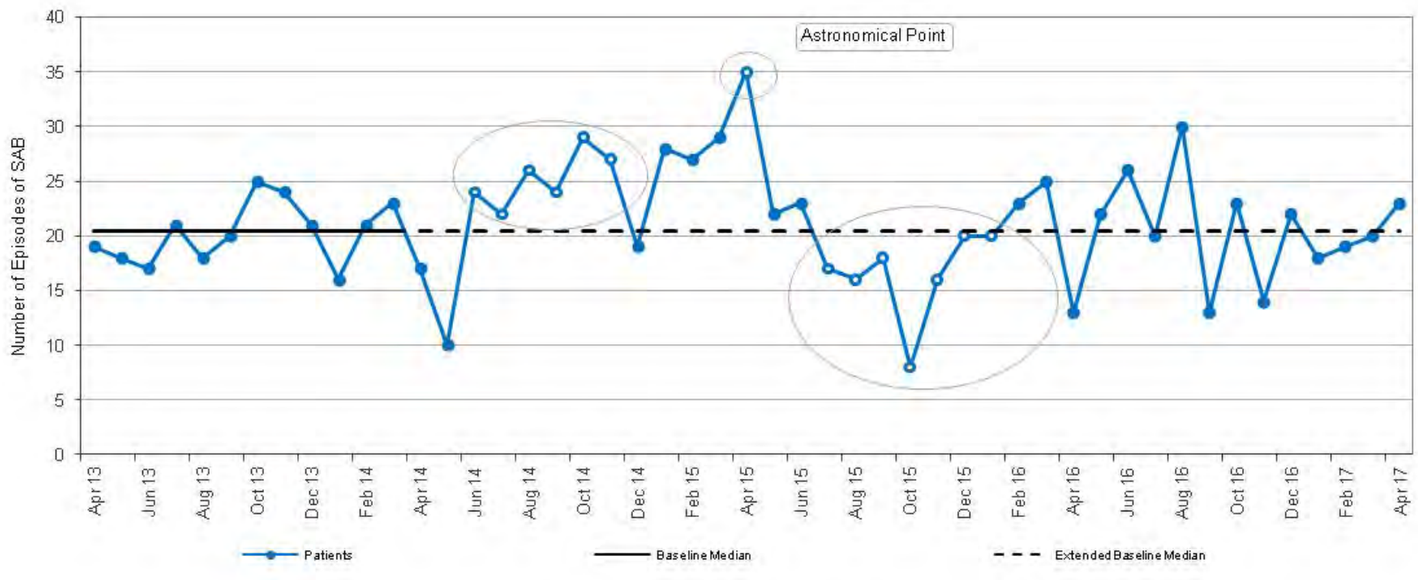
Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Moderate	Mar 17	Not Met	No Change	Better	Oct – Dec 16	0.24 (max) (<184)	0.36 (23)	Apr 17	Infection Prevention and Control Team	Yes	Yes	TG

Summary for Committee to note or agree

- **NHS Lothian has not sufficiently lowered its incidence of *Staphylococcus aureus* bacteraemia to deliver the 0.24 per 1000 bed days (<184 incidences) LDP target by 31st March 2017, with an end of year incidence of 0.30 (n=240).**
- **Health Protection Scotland published quarter 4 data (October – December 16), indicated NHS Lothian *S. aureus* bacteraemia incidence (predominantly due to MSSA bacteraemia), rate of 0.30 was less than the overall NHS Scotland *Staphylococcus aureus* Bacteraemia incidence (0.33).**
- **The Local Delivery Plan target from the Scottish Government has been reset for the reporting year 1st of April 17 – 31st March 2018 and remains unchanged as 0.24 per 1000 bed days (<184 incidences) .**

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
Infection Prevention and Control to improve quality of information reported to clinical and senior teams in relation to SAB through the development of Tableaux dashboards ***Responsible Person(s):*** **Head of Service Infection Prevention and Control, Tableaux Leads**	June 2017	There is an organisational shift to accessing key performance data within the dashboards. By using these as source of data sharing is it is anticipated that senior managers will have clearer oversight of local performance		
Utilisation of enhanced surveillance data to inform areas of higher risk ***Responsible Person(s): Chairs of local ICC, Geographical Lead IPCNs and Infection Doctors***	June 2017	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.		
Integrate SAB HAI related deaths into the Severe Adverse Events reporting structure ***Responsible Person(s):*** **Patient Safety Programme Manager / Senior Charge Nurses**	August 2017			
Collaborative work with clinical teams such as diabetic team which has been highlighted through enhance surveillance as a risk factor associated in patients presenting with SAB in NHS Lothian ***Responsible Person(s): Lead IPCN, Clinical Scientist, Lead ICD and clinical representative***	Sept 2017	Early identification can facilitate early treatment preventing deterioration and development of systemic infection		
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. ***Responsible Person(s):*** **Quality Improvement Teams / Clinical Teams / Microbiology**	Oct 2017	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.	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	Ongoing, needs to be rolled out to other sites (RIE, RHSC & SJH)
Improve compliance with National MRSA Screening Clinical Risk Assessment ensuring decolonisation/suppression therapy is implemented where clinically indicated. Staff undertaking screening should be encouraged to complete the NES screening and MRSA education packages ***Responsible Person(s):*** **Associate Nurse Directors / Senior Charge Nurse. Infection Doctors, Senior Charge Nurses**	Nov 2017	Key performance indicator is 90% current performance is in region 60-70%. Early identification of at risk facilitates screening and appropriate use of isolation facilities To improve staff knowledge and understanding. The course is available electronically via Learn Pro and is anticipated that the tutorial will take around 1-2 hours of online learning time.		
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	Dec. 2017	Evidence of education and improvement in the management of invasive lines.	Education is progressing. There is a focus on areas that have been identified within the enhanced SAB reviews as having device related SABs	

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. ***Responsible Person(s):*** **Head of Education and Employment / Patient Safety Programme Manager / Associate Medical Directors / Associate Nurse Directors. / Senior Charge Nurse / Consultants**			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. It is anticipated that once pilot work complete at WGH, this will be adopted across all sites as best practice.	
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			
Develop and establish a community and integrated joint board committee to manage and share information on matters related to HAI ***Responsible Person(s):*** **Head of Services, HAI Executive Lead , IJB programme Leads**	March 2018	The ICC provides a means of communications with IJBs to share information and to monitor progress on HAI agenda and standards		
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. ***Responsible Person(s):*** **Patient Safety Programme Manager/Clinical Nurse Managers/Senior Charge Nurses**	March 2018	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.	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. 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.	
SPSP to promote the use of Visual Phlebitis scoring as part of the patient safety bundle ***Responsible Person(s):*** **Patient Safety Programme Manager / Senior Charge Nurses**	March 2018	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. 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		

Comments

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.

48 Hour GP/HCP Access & Advance Booking

Healthcare Quality Domain: Timely

For reporting at **June 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	48 Hour HCP Access: Met	N/A	Worse	2015/16	90% (min)	**91.5%**	2015/16	Management Information	No	No	DS
TBC	TBC	Advance GP Appt: Not Met	N/A	Worse	2015/16	90% (min)	**74.8%**	2015/16	Management Information	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

48 Hour GP/ HCP Access	Mar 12	Mar 14	Mar 16
NHS Scotland	92.6%	92.4%	91.8%
NHS Lothian	91.8%	92.4%	91.5%

Advance Booking	Mar 12	Mar 14	Mar 16
NHS Scotland	79.6%	78.1%	76.4%
NHS Lothian	80.0%	76.7%	74.8%

Timescale for Improvement

A trajectory has not been agreed with SGHD.

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.

Child & Adolescent Mental Health Services (CAMHS)

Healthcare Quality Domain: Timely

For reporting at **June 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	Improving	Worse	Dec 16 (Qtrly)	90% (min)	**57.0%**	Apr 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, with 372 CYP waiting over 18 weeks compared to 825 at implementation of the recovery plan.

To date, all the Generic Teams are delivering as per the original Projection with the exception of the North Generic Team. This is due to delay to recruitment meaning new starts were not in place until end December/beginning of January compared to September 2016 as per Plan.

There remain some waits over 52 weeks, although the number is reducing. From March, these have been scrutinised on a monthly basis to ensure that longest waits are being prioritised for treatment and any wrong coding corrected.

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 453 longest waits have been treated/removed - a 55% reduction.

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

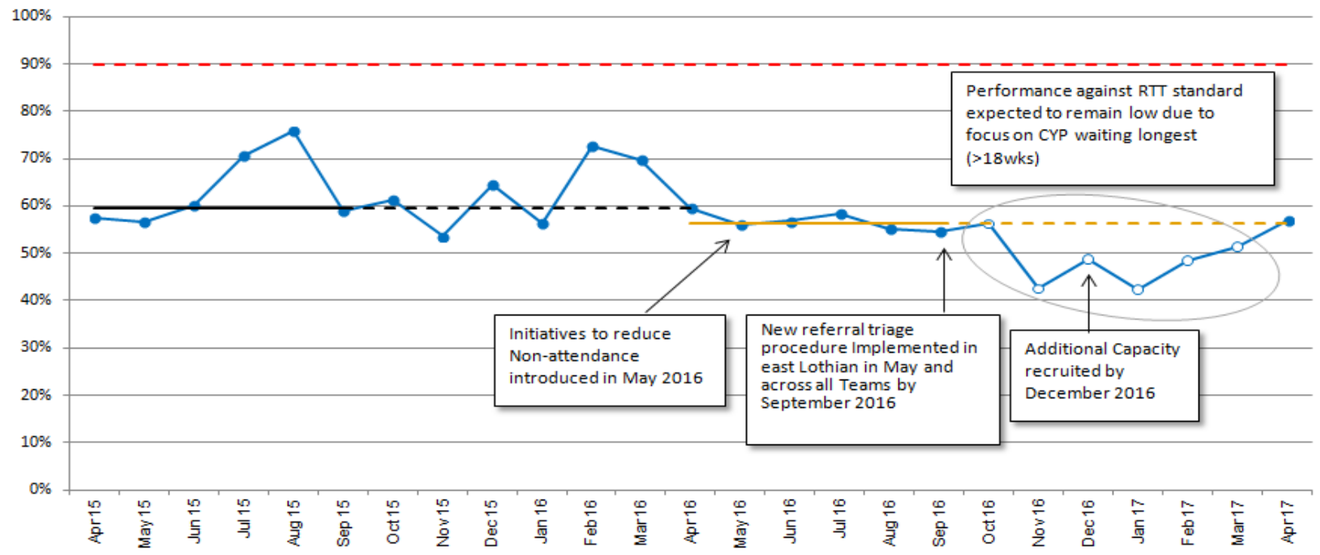


Figure 2: All Teams - Number of children and young people waiting over 18 weeks – Lower Count is Better

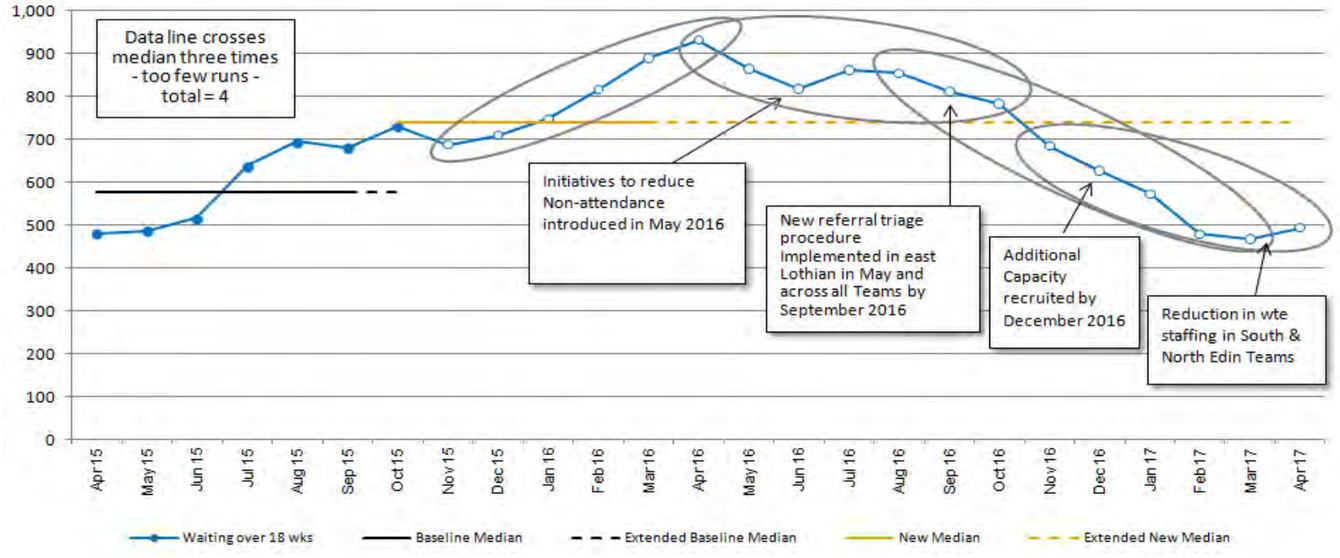


Figure 3: Generic Teams - Number of children and young people seen for 1st treatment – Higher Count is Better

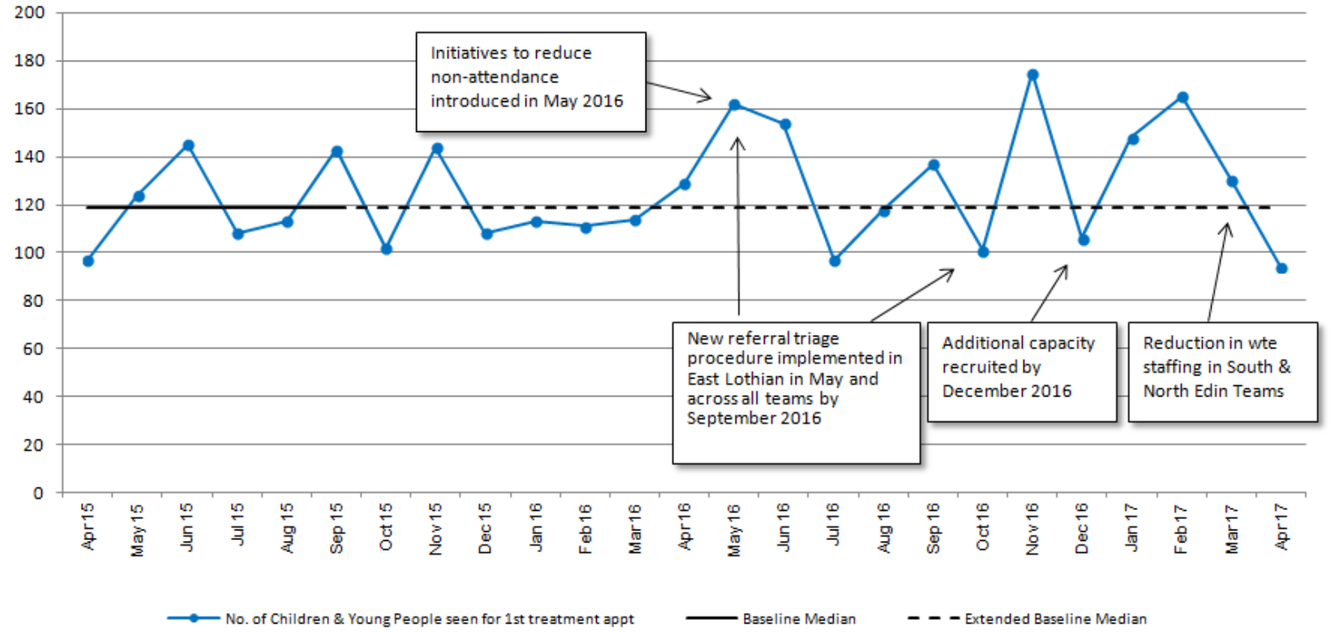


Figure 4: Generic Teams - Number of children and young people seen for 1st treatment waiting over 18 weeks when seen – Lower Count is Better

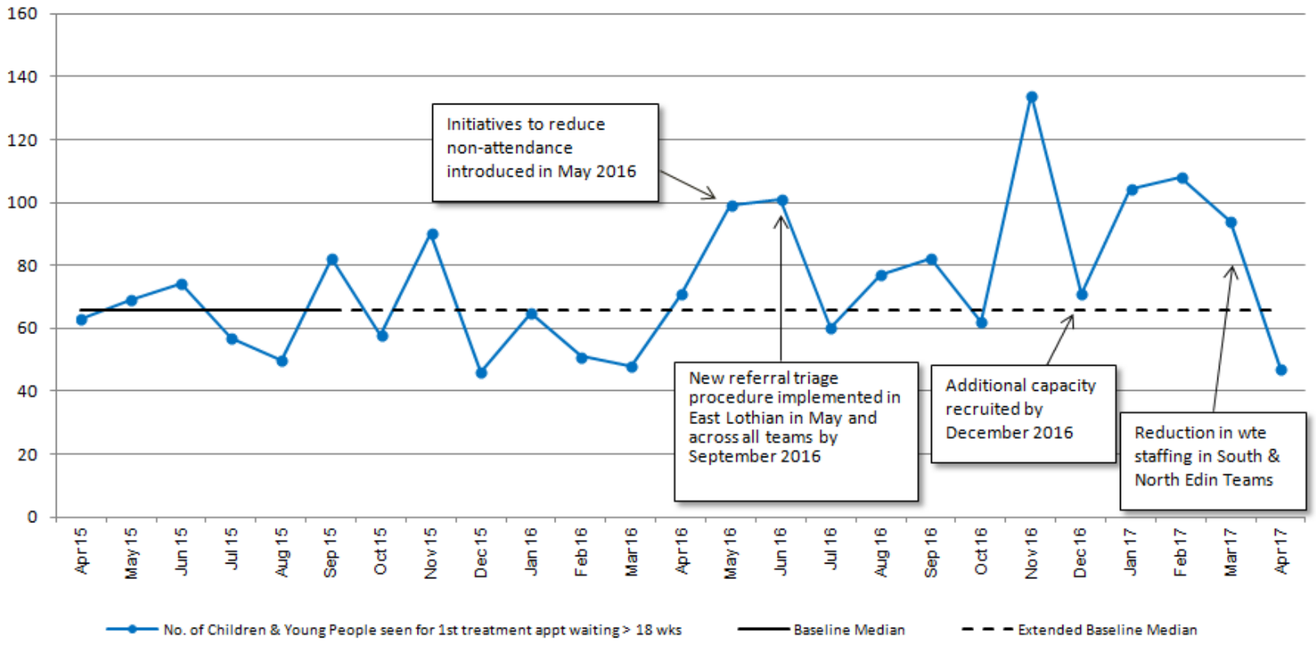


Figure 5: Generic Teams - Number of children and young people waiting over 18 weeks – Lower Count is Better

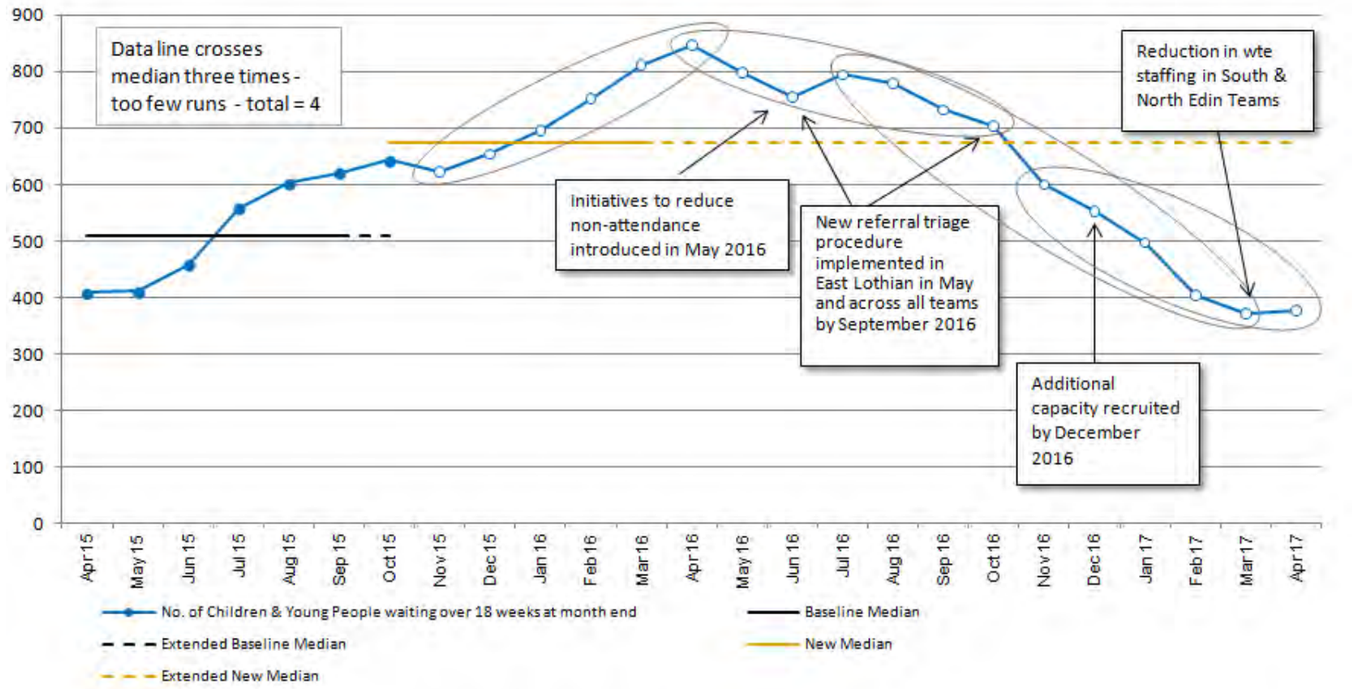


Figure 6: Generic Teams - Referrals by month

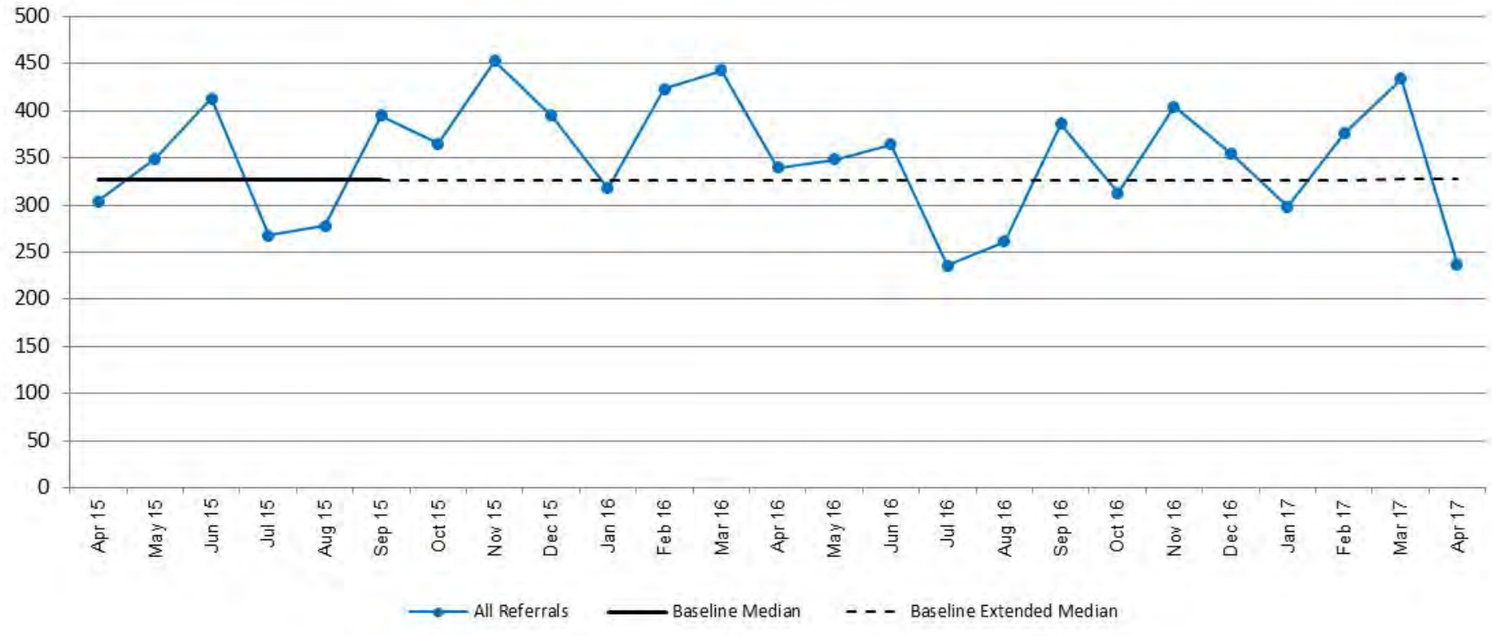


Figure 7: Generic Teams - Accepted referrals rate by month

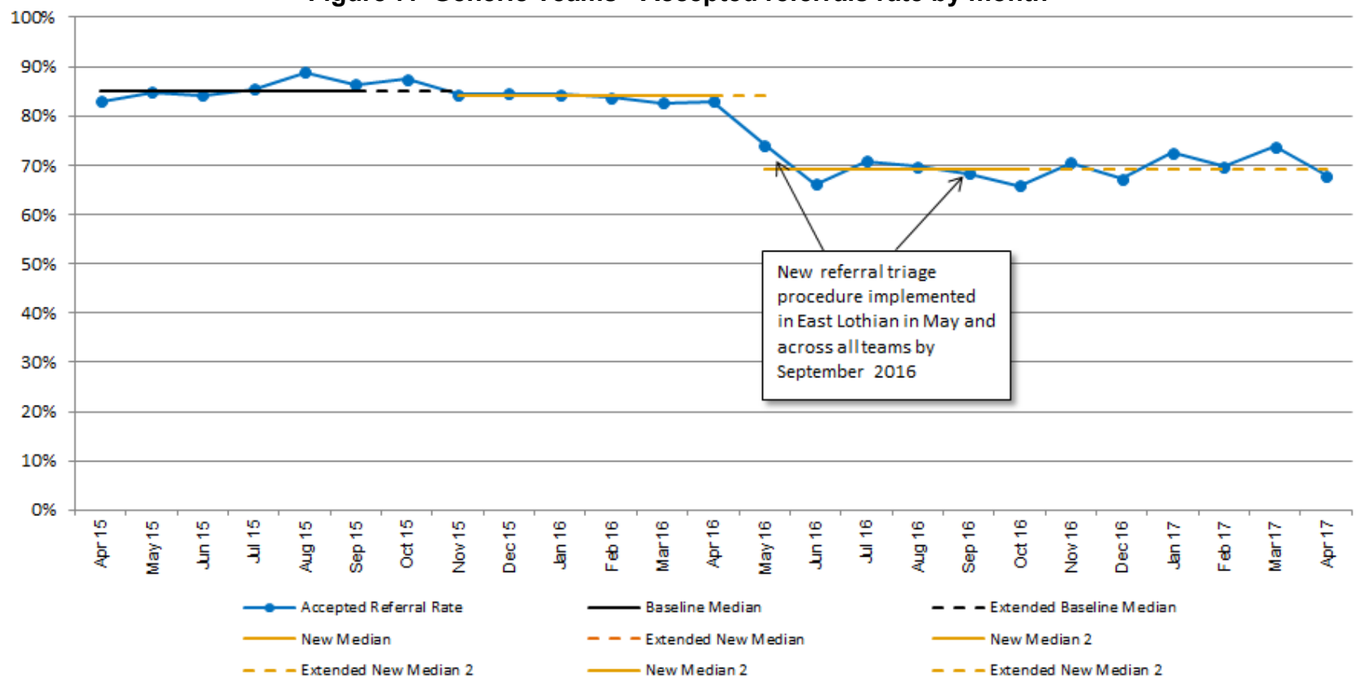
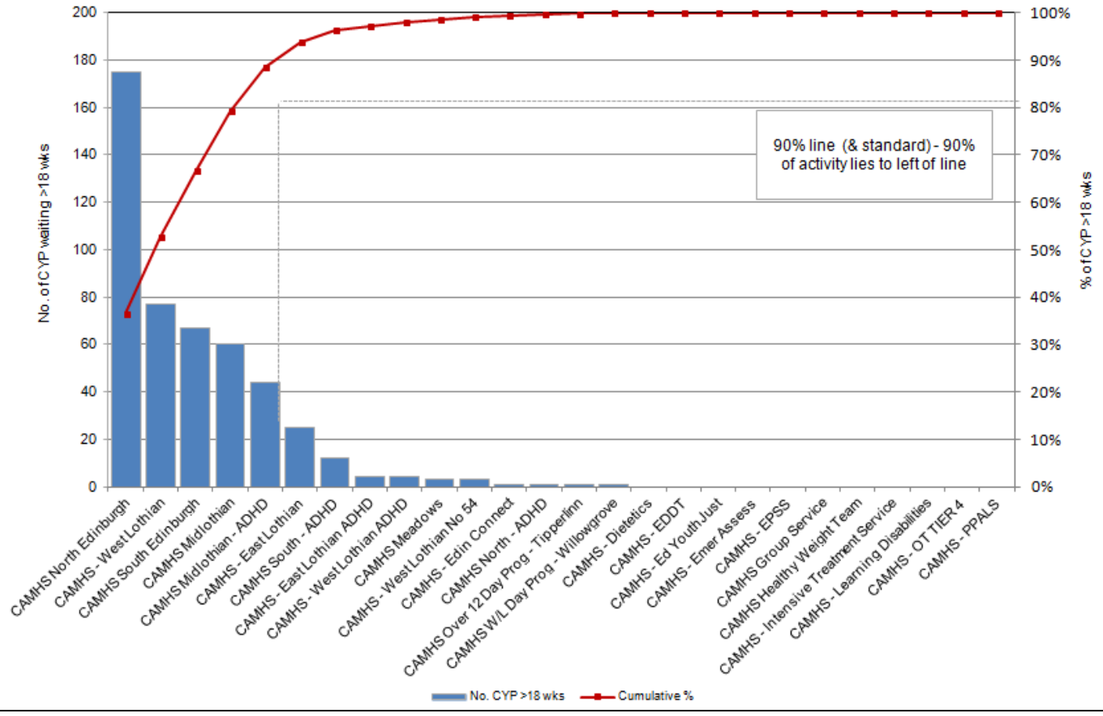


Figure 8: Pareto – children & young people waiting >18 weeks per team – as at end of Feb 2017 - Lower Count is Better



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. The North team is behind trajectory due to vacancies and recruitment being later than anticipated.

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 – initial launch with the South team in March 2017.	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 September 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
Further productivity gains identified and being explored with a view to supporting recurrent achievement of the 18 weeks target following removal of the “backlog”.	End September 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. Work is ongoing to model the position going forward when the recovery plan ceases at end of September 2017.

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.

Significant progress has been made to reduce the numbers of CYP waiting over 18 weeks.

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 & 62 day

Healthcare Quality Domain: Timely

For reporting at **June 2017** meetings

Target/Standard:

1. 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.

2. 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
1. 31 Day: To be reviewed	To be reviewed	Not Met	Improving	Worse	Oct – Dec 16	95% (min)	**94.3%**	Apr 17	Management Information	Yes	Yes	JC
2. 62 Day: To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Oct - Dec 16	95% (min)	**84.7%**	Apr 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

31 Day

- Note 31 day target was met for March.

62 Day

- Overall performance in February at 92.8% for 62 day pathway.
- The number of eligible patients who met the 62 pathway was 149 out of a total number of 160.
- 7 tumour groups achieved the 95% target with 5 of those achieving 100%.
- Capacity pressures in Colorectal and Urology pathways and performance pressures associated with the 31 day portion of the pathway have contributed to continuing difficulties with the target. Underlying capacity pressures remain in these services.
- Additional scrutiny started in February in Colorectal and Urology have delivered impact in March as predicted but with focus on ensuring improvement is sustained.

Recent Performance – Percentages achieved towards standard

Table 1: 31-Day Performance – Higher % is Better

Cancer Type	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
All Cancer types	93.6%	93.5%	96.2%	95.8%	91.8%	91.3%	91.3%	90.9%	95.1%	88.4%	90.6%	96.3%	94.3%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	0.0%	n/a	0.0%	100.0%	n/a	50.0%	0.0%
Colorectal (screened excluded)	89.3%	100.0%	100.0%	100.0%	89.5%	90.3%	88.0%	88.9%	96.3%	100.0%	88.5%	97.7%	95.8%
Colorectal (screened only)	100.0%	80.0%	100.0%	100.0%	66.7%	100.0%	80.0%	72.7%	85.7%	60.0%	100.0%	100.0%	75.0%
Head & Neck	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	85.7%	100.0%	95.2%	100.0%
Lung	100.0%	98.1%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	100.0%	100.0%	98.4%
Lymphoma	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	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%
Multiple Myeloma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100.0%	n/a
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
Ovarian	66.7%	87.5%	83.3%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	60.0%	100.0%	50.0%	71.4%
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
Upper Gastro-Intestinal (GI)	100.0%	100.0%	100.0%	100.0%	96.2%	86.7%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%
Urological	68.8%	67.4%	82.2%	73.0%	62.5%	59.5%	69.6%	55.0%	73.8%	56.0%	57.9%	85.7%	82.7%

Table 2: 62-Day Performance – Higher % is Better

Cancer Type	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
All Cancer types	89.0%	91.4%	97.7%	91.5%	86.5%	83.7%	78.7%	82.5%	82.5%	81.3%	88.7%	93.8%	84.7%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	95.8%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	97.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	n/a	100.0%	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	100.0%	100.0%	n/a
Cervical (screened only)	100.0%	100.0%	n/a	n/a	0.0%	n/a	0.0%	n/a	0.0%	0.0%	n/a	0.0%	100.0%
Colorectal (screened excluded)	77.8%	80.0%	100.0%	60.0%	53.3%	77.3%	69.2%	68.8%	62.5%	78.6%	77.8%	95.7%	76.9%
Colorectal (screened only)	40.0%	60.0%	75.0%	80.0%	50.0%	66.7%	80.0%	63.6%	85.7%	50.0%	100.0%	75.0%	37.5%
Head & Neck	80.0%	75.0%	50.0%	75.0%	66.7%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%
Lung	100.0%	95.5%	100.0%	100.0%	94.7%	94.7%	72.7%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%
Lymphoma	n/a	80.0%	100.0%	80.0%	83.3%	66.7%	71.4%	50.0%	80.0%	42.9%	75.0%	100.0%	100.0%
Melanoma	83.3%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Multiple Myeloma	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
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
Ovarian	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	33.3%	100.0%	0.0%	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
Upper Gastro-Intestinal (GI)	85.7%	100.0%	100.0%	100.0%	90.0%	87.5%	50.0%	75.0%	50.0%	83.3%	83.3%	100.0%	87.5%
Urological	76.9%	76.9%	96.2%	78.3%	58.8%	53.8%	52.9%	40.7%	60.0%	54.2%	63.2%	83.8%	62.5%

Figure 1: 31-Day Performance – Higher % is Better

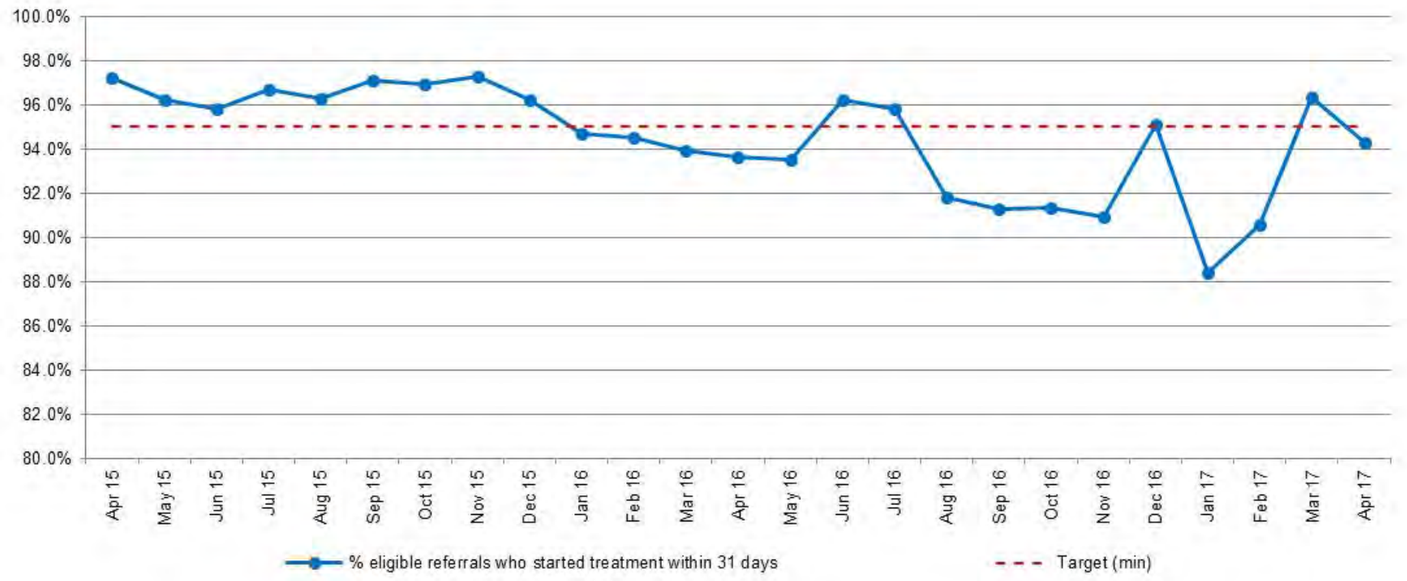


Figure 2: 62-Day Performance – Higher % is Better

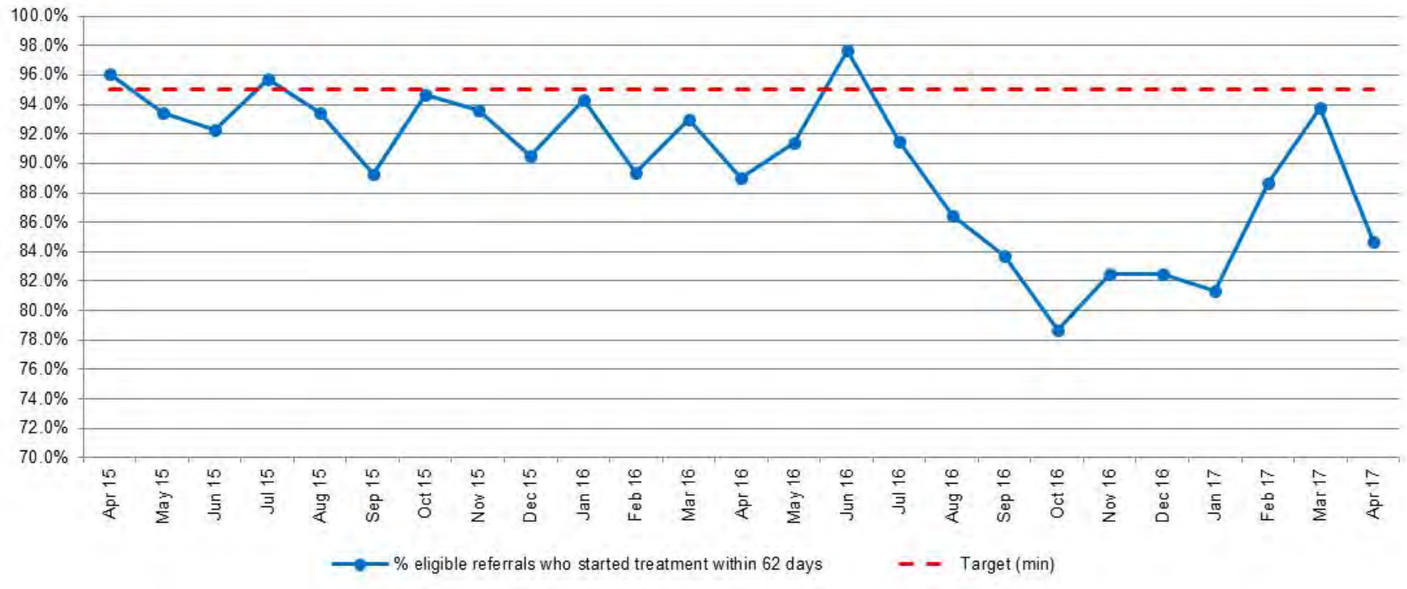


Figure 3: Number of Eligible Referrals Starting Treatment within and out-with 31 Day Standard - Apr 2015-Mar 2017 incl.

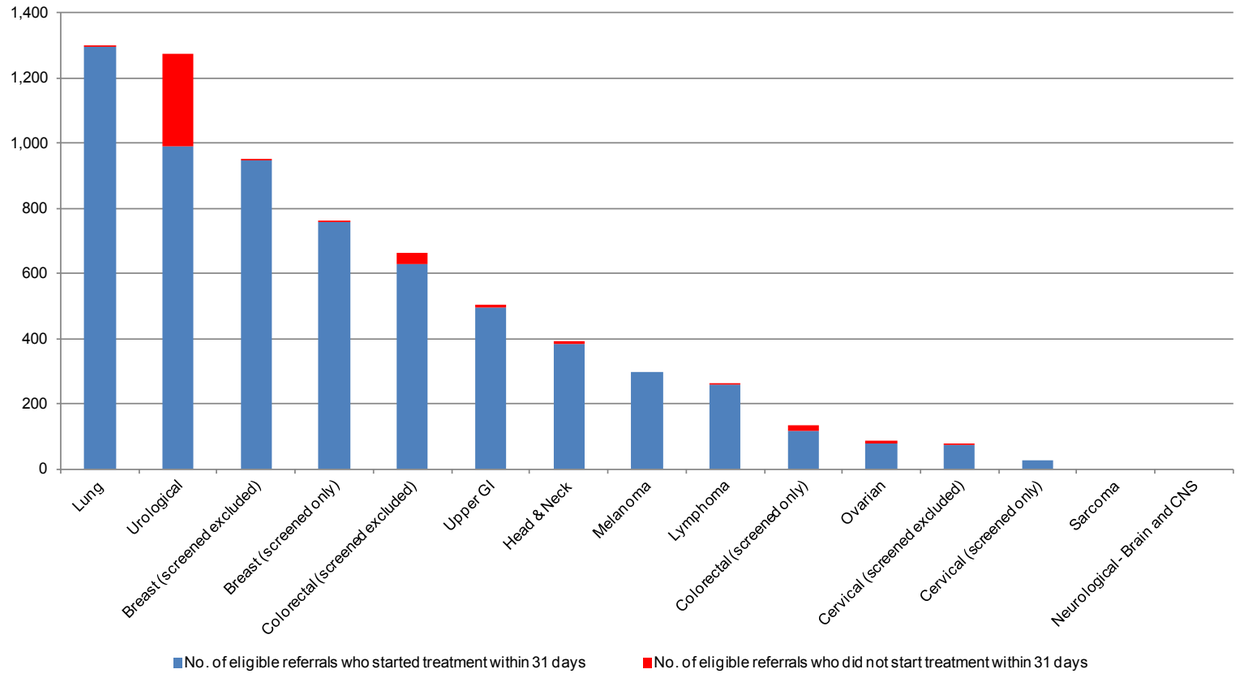
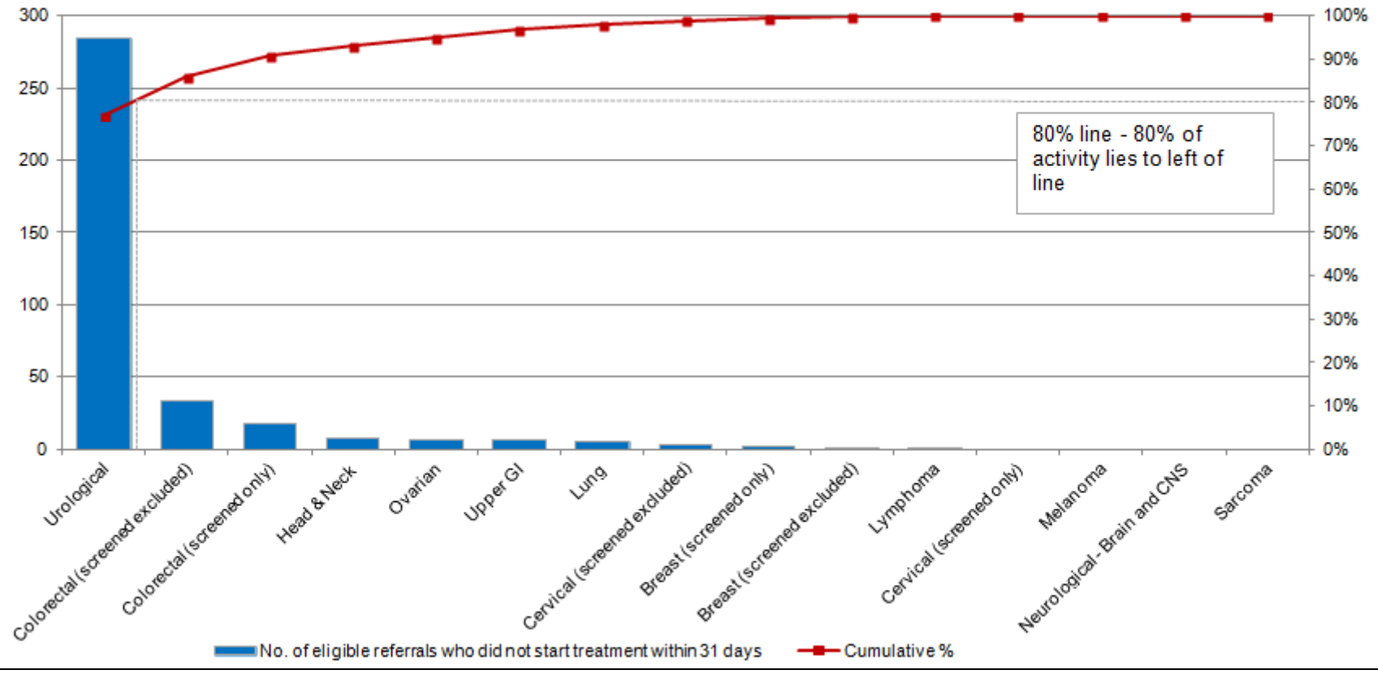


Figure 4: Did Not Start Treatment within 31 Days by Cancer Type – Apr 2015-Mar 2017 incl. - Pareto[1]



[1] Most patients who did **not** start treatment within 31 days between Apr 15 and Mar 17 incl. were urological patients but urological patients were also the second largest group to start treatment **within** 31 days (please see Fig. 3).

Figure 5: Number of Eligible Referrals Starting Treatment within and out-with 62 Day Standard - Apr 2015-Mar 2017 incl.

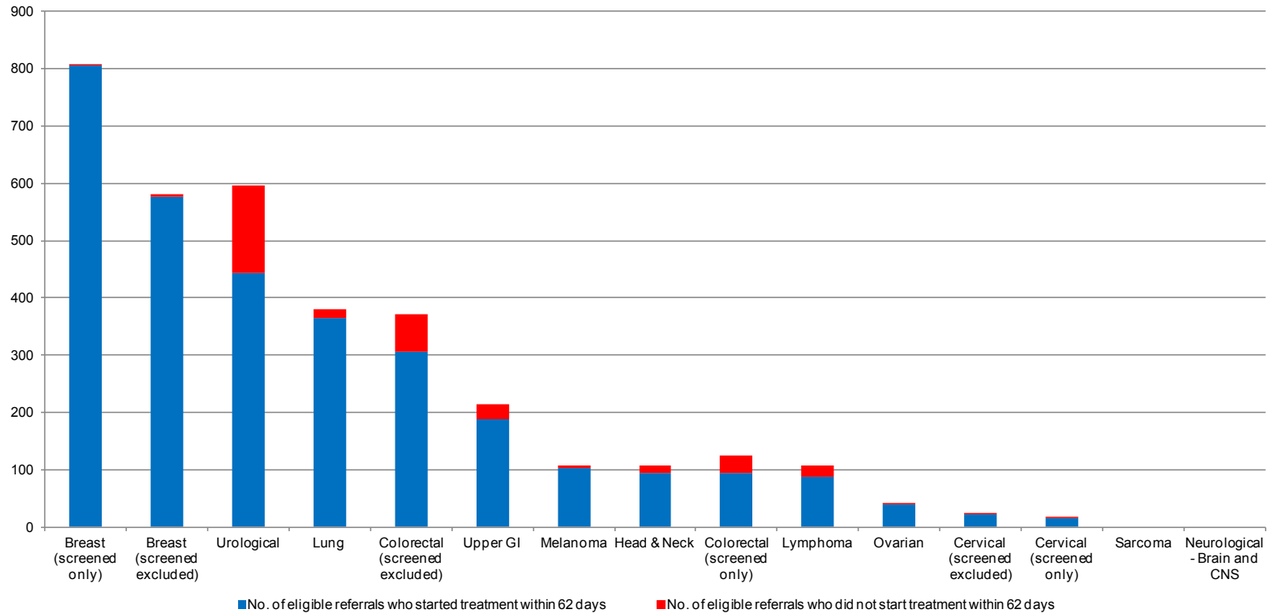
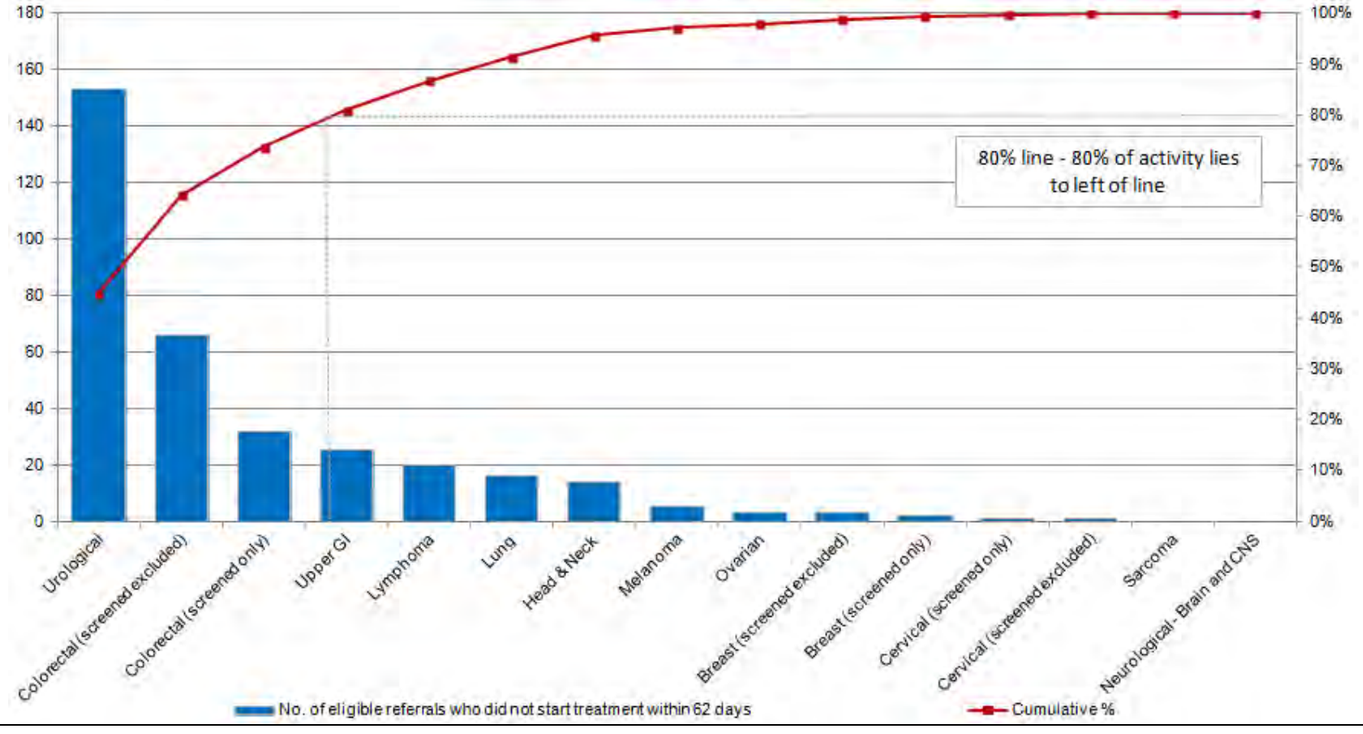


Figure 6: Did Not Start First Treatment within 62 Days by Cancer Type – Apr 2015-Mar 2017 incl. - Pareto[2]



[2] Most patients who did **not** start first treatment within 62 days between Apr 15 and Mar 17 incl. were urological patients but urological patients were also the third largest group to start first treatment **within** 62 days (please see Fig. 5).

Timescale for Improvement

1. 31 Day - A recovery trajectory has not been agreed with SGHD. Health Boards are expected to deliver the 31 day target.
2. 62 Day - 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
Commission a review of the current cancer tracker structure across all tumour groups to report recommendations to Acute SMT	September 2017	Provide a proposed structure which delivers greater resilience for cross-cover between specialties and assesses the level of resource required for cancer tracking to better reflect changes in workload and increases in the numbers of patients being tracked. Group to provide recommendations for improved framework for training.	Improvement in compliance	Partnership membership confirmed. Group to be established, Chaired by Site Director, WGH.
Development of actions to address identified capacity bottlenecks in urology (nephrectomy, prostatectomy and bracytherapy)	June 2017	Pathway analysis has revealed opportunities for focus in addition to underlying capacity pressure associated with consultant urologist gaps. Service working to identify solutions with theatre service to facilitate agreed capacity.	Improved compliance and access for patients	On going
Development of agreed letter to GPs 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 – to be tested in May in 2 specialties.	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.**
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	This action has now been embedded as an on-going practice and will continue as part of an improved tracking process within these specialties. **COMPLETE: ACTION NOW CLOSED.**

Comments – for 31 & 62 Day
Reasons for Current Performance Note 31 day target is “met” for March. Continuing capacity pressures within Urology remain the most significant contributing factor to the performance decline in terms of volume with 6 patients out of 35 not achieving the standard in March. Delays for prostatectomy and nephrectomy surgery due to underlying capacity gaps due to 3 consultant vacancies represent an ongoing issue. 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. The colorectal service also have 2 consultant gaps at present. **Mitigating Actions** There is an ongoing additional scrutiny of cancer reporting process by Colorectal/Urology Service Manager to ensure early escalation of delays and appropriate action for urology, colorectal and GI patients. The improvement in performance in February and March is linked to this additional focus. Additional performance reporting information has been put in place to support clinical services who are responsible for their performance against the standard more effectively monitor their progress. These reports are being evaluated for their impact and effectiveness and will be adapted following feedback. 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 took place in April/May with the WGH site Director and individual tumour sites to identify pathway issues associated with the current performance. A Cancer Tracker training and development session is being scheduled for the 31st May as part of provision of support for cancer trackers. Actions to recruit urology and colorectal consultant vacancies continue with the relevant services.

Diagnostics – Gastroenterology/ Urology Diagnostics & Planned Repeat Surveillance Endoscopy

Healthcare Quality Domain: Timely

For reporting at **June 2017** meetings

Target/Standard:

A **six week maximum** waiting time for eight key diagnostic tests (four for Gastroenterology/ Urology Diagnostics, and four for Radiology/Imaging (one of which covers data for Vascular Labs - please see separate proformas for Radiology/Imaging and for Vascular Labs data)), from 31st March 2009.

Surveillance Endoscopy performance is also reported on this proforma – the target for which is "**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
Gastroenterology/Urology: To be reviewed	To be reviewed	Not Met	Deteriorating	Worse	Mar 17 (Mthly)	0 (max)	**2,561** 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.)	Apr 17	Management Information	Yes	Yes	JC
Surveillance: To be reviewed	To be reviewed	Not Met	Deteriorating	Not Applicable	Not Applicable	0 (max)	**4,357**[3]	Apr 17	Management Information	Yes	No	JC

Summary for Committee to note or agree

Gastroenterology/ Urology Diagnostics

- 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.

Planned Repeat Surveillance Endoscopy

- 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.

[3] Please note, from reporting for June 17 meetings inclusive onwards, the figures for Overdue Patients will be provided under a different format. Apr 17 will be the first set of new data to be presented in this format but historical data will also be provided from Apr 15 in the same format for consistency. Figures will no longer be reported within an 'Other' category.

Key Diagnostic Tests - Gastroenterology/ Urology Diagnostics

The four diagnostic tests in Gastroenterology/Urology Diagnostics are

1. Colonoscopy;
2. Upper Endoscopy;
3. Flexible Sigmoidoscopy (Lower Endoscopy - excluding Colonoscopy)
4. and Flexible Cystoscopy.

Recent Performance: Numbers against Standard/Target for Diagnostics - Gastroenterology/ Urology Diagnostics & Planned Repeat Surveillance Endoscopy

Table 1: Gastroenterology/ Urology Diagnostic Tests ONLY - Numbers over 6 Week Standard – Lower Count is Better

	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
Upper Endoscopy	552	567	620	730	710	792	922	873	786	807	758	668	774
Colonoscopy	448	507	568	682	716	742	767	780	746	728	660	669	762
Flexible Sigmoidoscopy (Lower Endoscopy)	209	198	192	244	347	391	395	375	308	345	299	311	372
Flexible Cystoscopy	43	73	56	99	55	95	186	247	326	442	429	495	570
Total Gastroenterology/ Urology Diagnostics Patients Over 6 Week Standard	1,252	1,345	1,436	1,755	1,828	2,020	2,270	2,275	2,166	2,322	2,146	2,143	2,478

Table 2: All 8 Diagnostic Tests - Numbers (Total) Over 6 Week Standard – Lower Count is Better

	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
Total Diagnostics Patients Over 6 Week Standard	**1,513**	**1,549**	**1,640**	**1,810**	**1,887**	**2,047**	**2,308**	**2,308**	**2,250**	**2,439**	**2,209**	**2,187**	**2,561**

Figure 1: All 8 Diagnostic Test Patients & Total Gastroenterology/ Urology Diagnostics Patients - Numbers over 6 Week Standard – Lower Count is Better

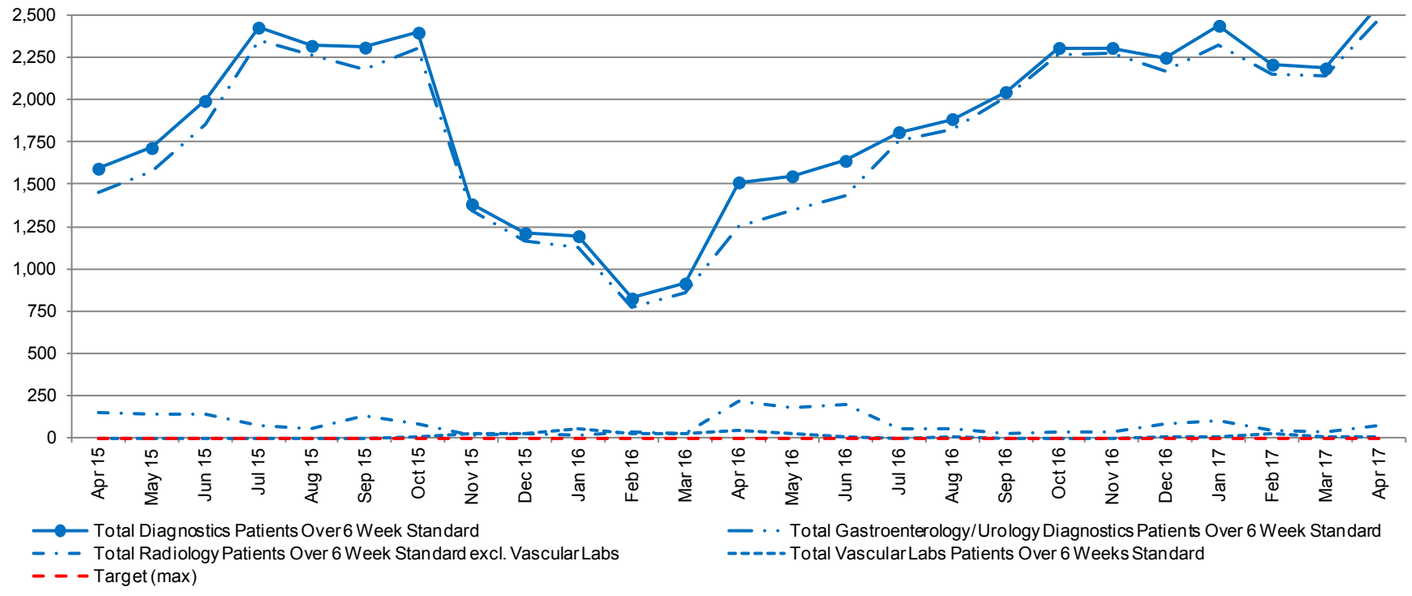


Figure 2: Total Gastroenterology/ Urology Diagnostics Patients - Numbers over 6 Week Standard – Lower Count is Better

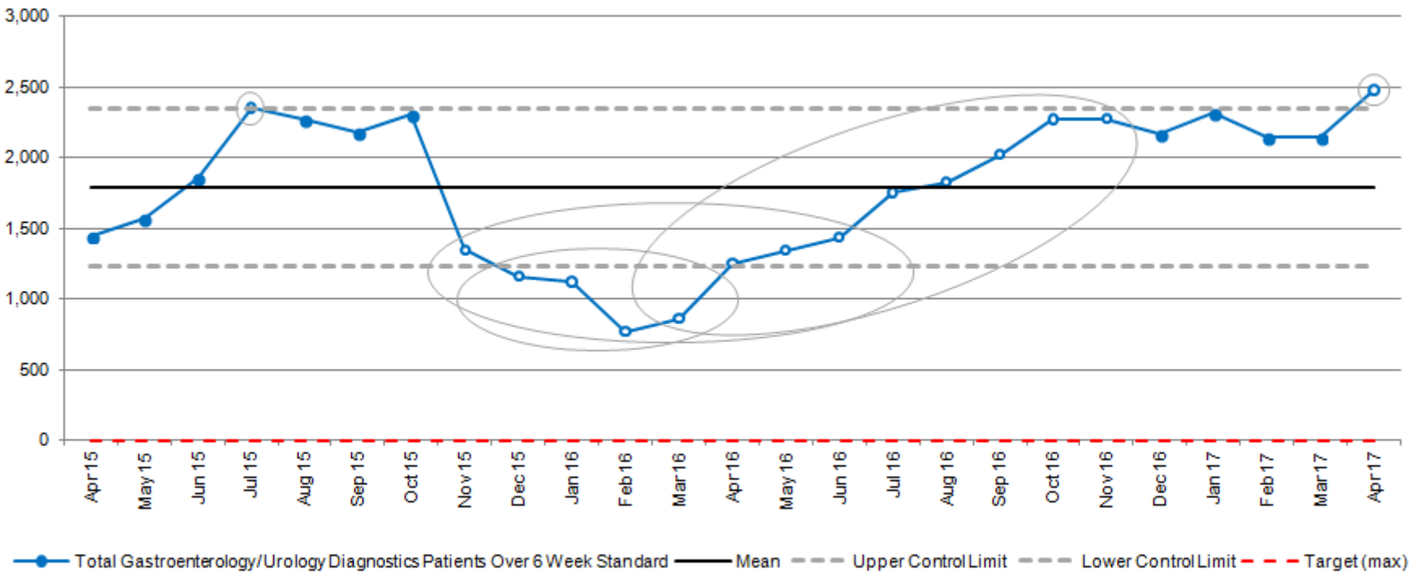


Figure 3: Upper Endoscopy Diagnostics Patients - Numbers over 6 Week Standard – Lower Count is Better

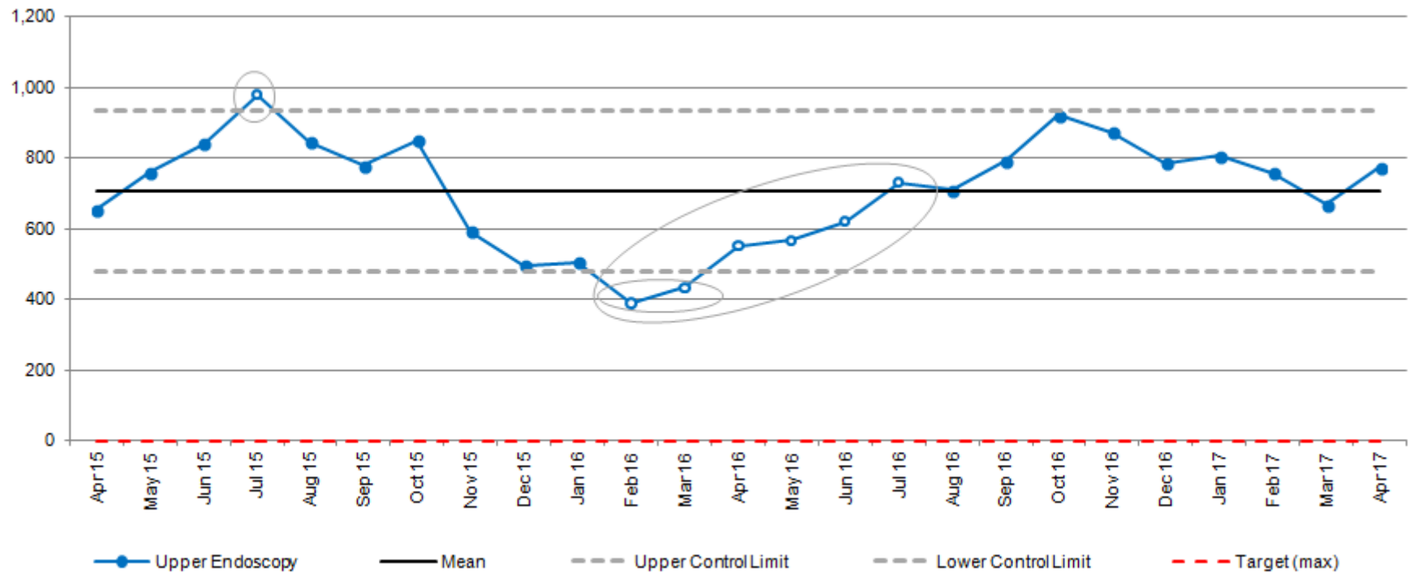


Figure 4: Colonoscopy Diagnostics Patients - Numbers over 6 Week Standard – Lower Count is Better

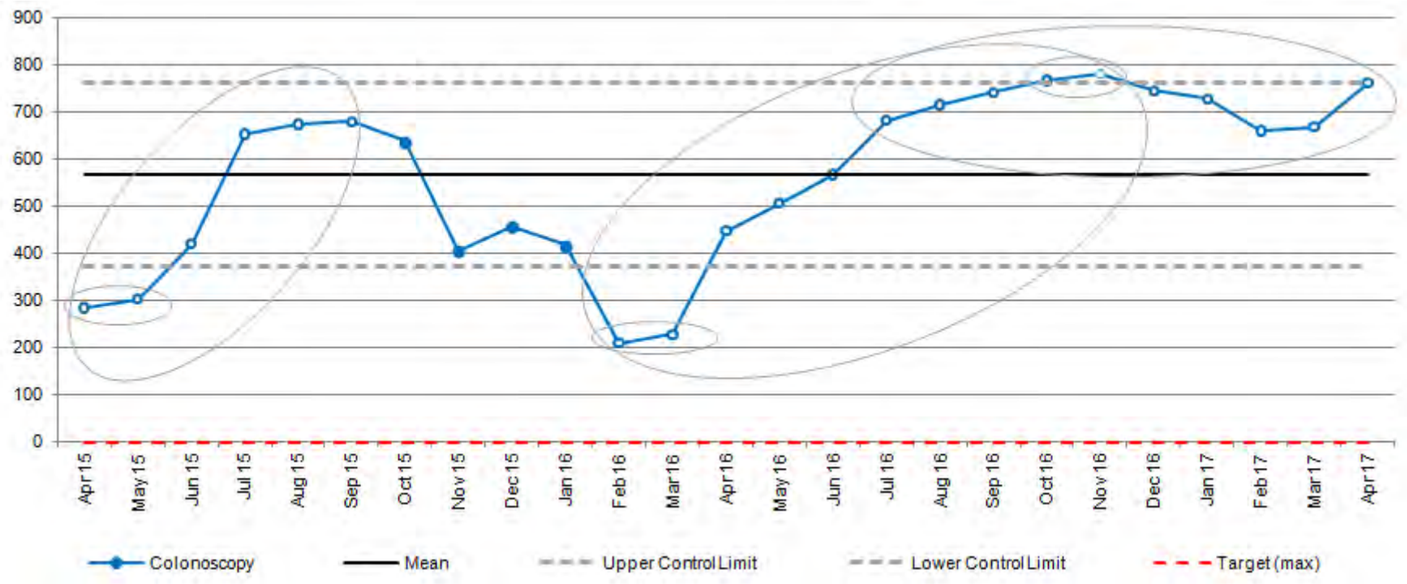


Figure 5: Flexible Sigmoidoscopy (Lower Endoscopy) Diagnostics Patients - Numbers over 6 Week Standard – Lower Count is Better

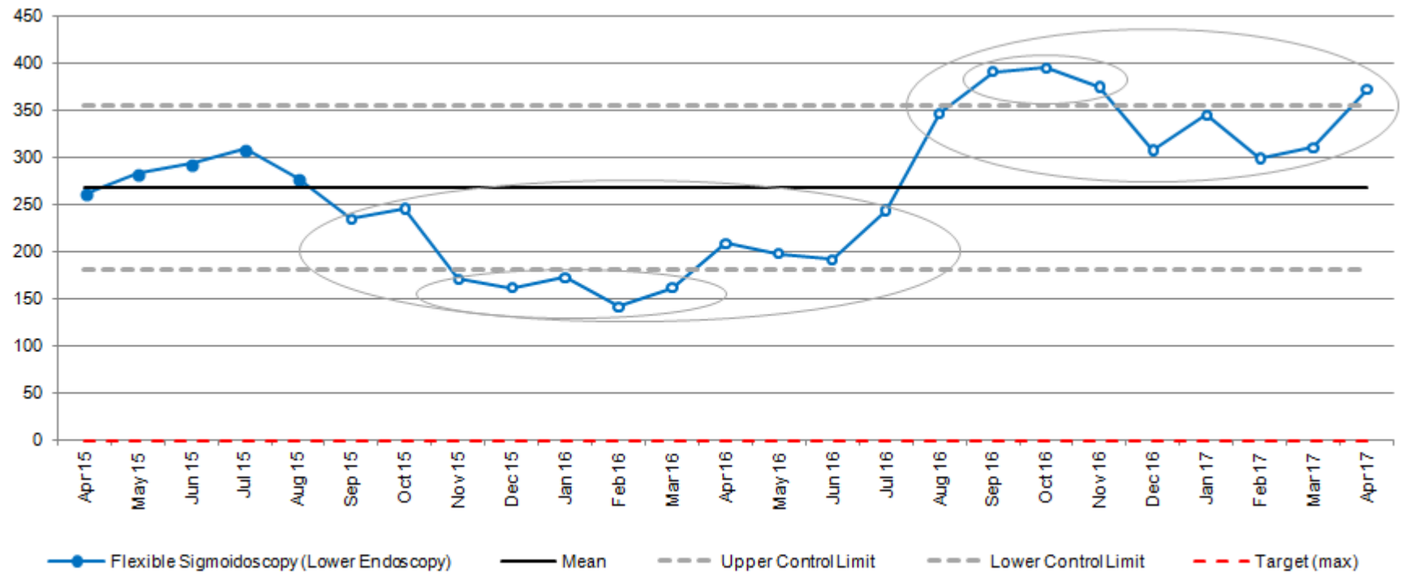


Figure 6: Flexible Cystoscopy Diagnostics Patients - Numbers over 6 Week Standard – Lower Count is Better

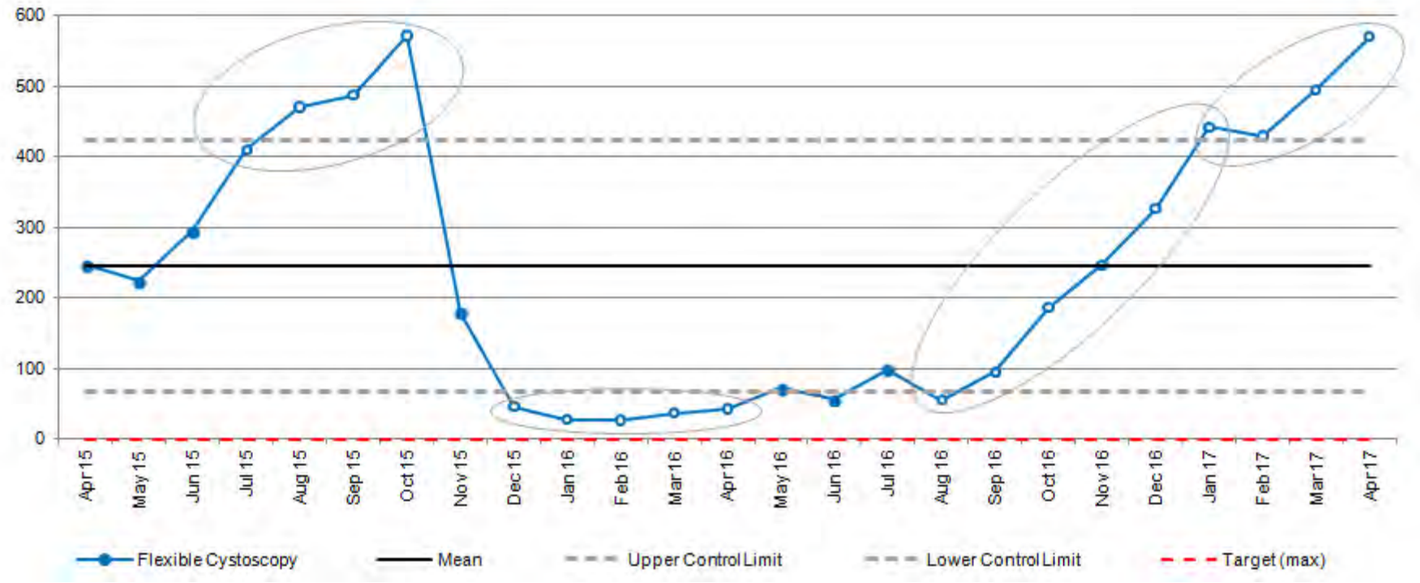


Figure 7: Planned Repeat Surveillance Endoscopy and Review Patients Overdue Appointment – Lower Count is Better[3]

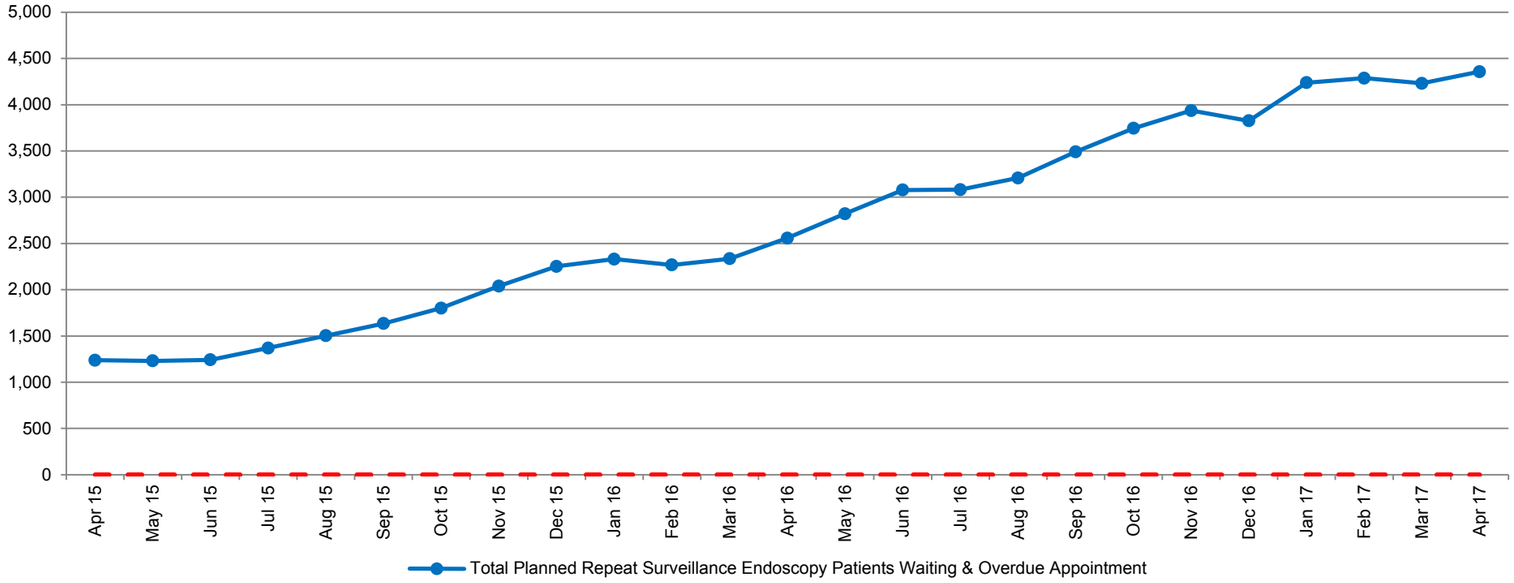


Table 3: Planned Repeat Surveillance Endoscopy Patients Overdue Appointment – Lower Count is Better[3]

	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
Colonoscopy	1,598	1,790	2,030	2,068	2,073	2,210	2,347	2,482	2,511	2,696	2,752	2,759	2,852
Flexible Cystoscopy	114	145	82	53	163	250	321	377	298	419	450	459	465
Flexible Sigmoidoscopy	206	220	236	227	222	240	249	252	237	265	251	238	237
Upper Endoscopy	640	666	730	734	749	791	827	825	779	857	833	775	803
Total	**2,558**	**2,821**	**3,078**	**3,082**	**3,207**	**3,491**	**3,744**	**3,936**	**3,825**	**4,237**	**4,286**	**4,231**	**4,357**

Timescale for Improvement

Gastroenterology/ Urology Diagnostics :- DCAQ work has been refreshed to support the development of a trajectory from April 2017 to end of March 2018.

Planned Repeat Surveillance Endoscopy:- Timelines for various actions outlined below.*

Actions Planned and Outcome - Gastroenterology/ Urology Diagnostics :-

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.

Introduce nurse validation and telephone screening model for repeat endoscopies.	1st June 2016 See status for updated outcome dates.	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 – Action to remain open until June 2017 to monitor impact and sustainability of early benefits.**
Faecal Calprotectin tests in Primary Care to reduce demand on the GI and Endoscopy service.	July 2016 See status for updated outcome dates.	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 commenced 27th February 2017. Impact to be measured by reduction in incoming referrals. First results to become available in June 2017**
Implement Nurse-Led Faecal Calprotectin clinics for backlog of Gastroenterology patients	January 2017 See status for updated outcomes.	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 22nd February 2017.Patients will be removed from waiting list where FCP result is negative-impact expected in April/May 2017.Initial results very encouraging.
Review of Nurse Endoscopist workloads and recruitment of further Nurse Endoscopist	Dec 2016 See status for updated outcome dates.	Work ongoing to maximise capacity of existing Nurse Endoscopists.	Aim to increase fixed lists for Nurse Endoscopists while retaining flexibility for backfill	Review now complete but 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.
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.- **Action now closed**
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. **– Action now closed**
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. **ACTION NOW CLOSED**
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. **ACTION NOW CLOSED**
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**

Actions Planned and Outcome - Planned Repeat Surveillance Endoscopy*:-

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	-	Quarterly reviews re-commenced in February 2017. Meeting arranged between DfP team and service management team for May 2017 to assess additional support needs to complete DfP Review actions.
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	1st June 2016 **Action to remain open until June 2017 to monitor impact and sustainability of early benefits.**	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.	System now in place with weekly monitoring ongoing.
Capacity ringfenced for Urgent Surveillance patients.	January – May 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 and May.
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 – **Action now completed**

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 resulted in a substantial reduction of patients waiting over 12 weeks .As this has now ceased this number is expected to increase again.
Increase in Flexi Cysto numbers due in part to Botox procedures being added to this demand, resulting in lists being adjusted to accommodate these more complex procedures.

Reasons for Current Performance - Gastroenterology/Urology Diagnostics

Demand continues to outstrip capacity. Sourcing both nursing and operators for Waiting list initiatives (evenings and weekends) continues to be a challenge.

Mitigating Actions - Gastroenterology/Urology Diagnostics

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.

Reasons for Current Performance - Planned Repeat Surveillance Endoscopy

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 though challenged by clinical criteria of patients who are able to attend and acceptance rates.

Mitigating actions - Planned Repeat Surveillance Endoscopy

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.

Diagnostics – Radiology/Imaging

Healthcare Quality Domain: Timely

For reporting at **June 2017** meetings

Target/Standard:
A **six week maximum** waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology/Imaging (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	Mar 17 (Mthly)	0 (max)	**2,561** 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.)	Apr 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 Standard[4] – Lower Count is Better

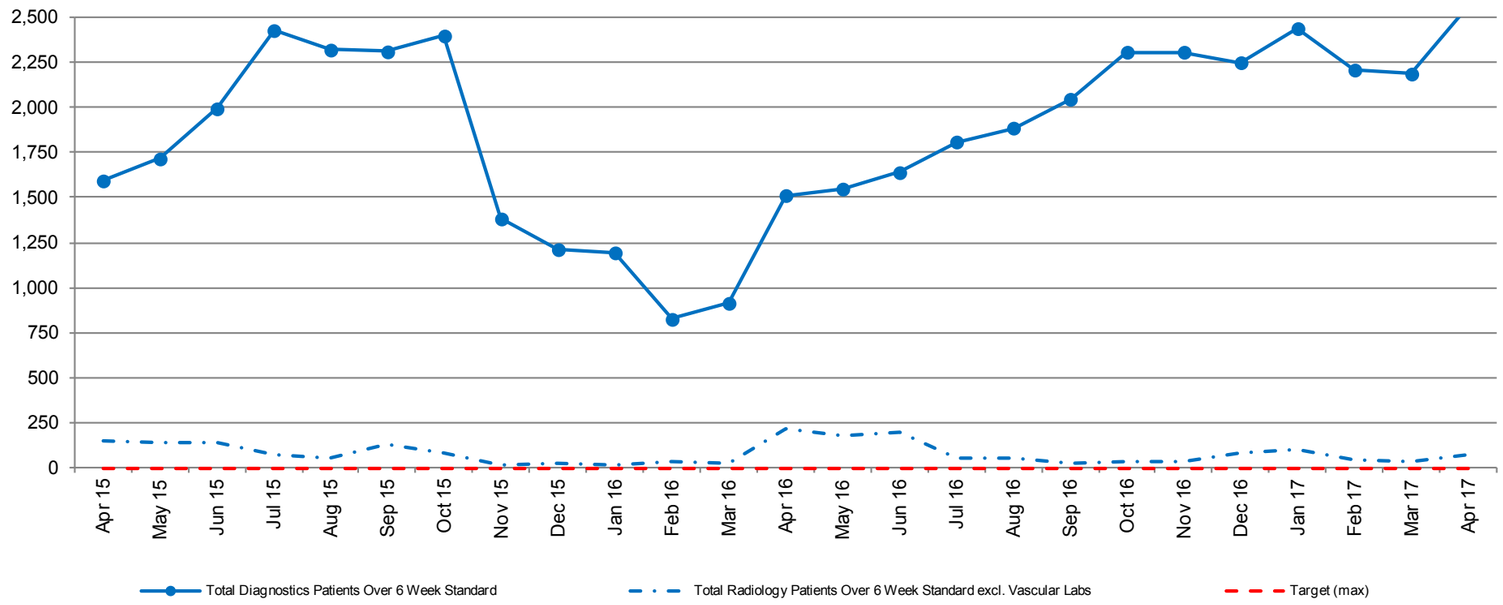
	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
MRI	204	172	176	45	43	22	28	20	68	90	26	29	68
CT	7	3	19	5	7	4	8	4	3	10	7	1	6
General Ultrasound excl. Vascular Labs	3	3	3	5	5	1	2	9	9	6	8	3	4
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Radiology Patients Over 6 Week Standard excl. Vascular Labs	214	178	198	55	55	27	38	33	80	106	41	33	78

[4] From Oct 15 inclusive onwards, Vascular Labs figures are not included in 'General Ultrasound' but are reported on the separate Vascular Labs proforma;

Table 2: All 8 Diagnostic Tests - Numbers (Total) Over 6 Week Standard – Lower Count is Better

	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
Total Diagnostics Patients Over 6 Week Standard	1,513	1,549	1,640	1,810	1,887	2,047	2,308	2,308	2,250	2,439	2,209	2187	2,561

Figure 1: All 8 Diagnostic Test Patients & Total Radiology Patients - Numbers over 6 Week Standard – Lower Count is Better



Timescale for Improvement against Target/Standard - Radiology

1st April to 30th June 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 June 2017	700 patient examinations per month	Sustain TTG	Implemented
Patients requiring MRI L. Spine invited to attend GJNH	End of June 2017	40-50 patient examinations per month	Sustain TTG	Implemented

Comments - Radiology

For Current Performance

75 patient Radiology examinations tripping the 6 weeks referral to unverified report at end **April 17**.

65 are MRI, mainly due to unplanned downtime and PH lost session. Extra internal MRI sessions arranged in May to reduce and timely reporting. 6 CT and 4 US.

Diagnostics – Vascular Laboratory

Healthcare Quality Domain: Timely

For reporting at **June 2017** meetings

Target/Standard:
A **six week maximum** waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology/Imaging (one of which covers data for the Vascular Laboratory. Please see separate proformas for Gastroenterology/Urology Diagnostics and for Radiology/Imaging 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	Mar 17 (Mthly)	0 (max)	**2,561** 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.)	Apr 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 has been 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 has been under review and the trainee has required additional support and training since Oct 2016, which has contributed 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. Two qualified and very experienced Band 7 staff have been appointed – 0.2WTE started on 6th March and 1.0 WTE started on 17th April 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

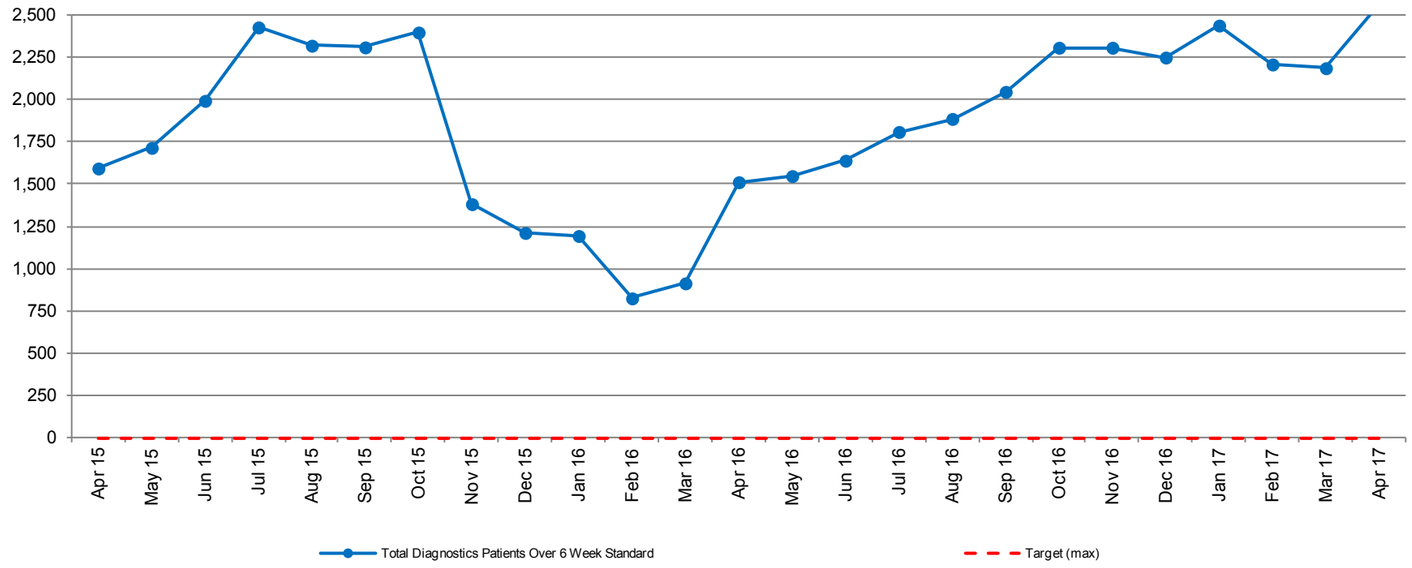
Table 1: Vascular Lab Test ONLY - Numbers over 6 Week Standard – Lower Count is Better

	Apr 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
Total Vascular Labs Patients Over 6 Weeks Standard	47	26	6	0	4	0	0	0	4	11	22	11	5

Table 2: All 8 Diagnostic Tests - Numbers (Total) Over 6 Week Standard – Lower Count is Better

	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
Total Diagnostics Patients Over 6 Week Standard	1,513	1,549	1,640	1,810	1,887	2,047	2,308	2,308	2,250	2,439	2,209	2,187	2,561

Figure 1: All 8 Diagnostic Test Patients & Total Vascular Patients - 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
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. Meeting has taken place. Additional clinics delivered to address staff sickness absence. **ACTION CLOSED.**
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 6th March. 1.0WTE post commenced 17th April. **ACTION CLOSED.**

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 of qualified staff in March 2017 and 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. 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 **June 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	Deteriorating	Worse	Oct - Dec 16	90% (min)	**83.8%**	Oct - Dec 16	ISD	Yes	Yes	AMcM

Summary for Committee to note or agree

This is based on ISD published figures hence 2016

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 and East 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

- NHSL SMS Services in East & Midlothian continue to meet / exceed the target;
- Performance in West Lothian has reduced
- 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.
- All areas have reduced against the target

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	Dec 16
NHS Lothian	**83.5%**	**82.9%**	**80.0%**	**84.1%**	**84.2%**	**85.4%**	**83.8%**
Edinburgh City Alcohol & Drug Partnership (ADP)	80.7%	81.1%	75.8%	77.7%	77.9%	81.9%	80.7%
Midlothian and East Lothian ADP (MELDAP)	91.9%	94.8%	94.0%	96.3%	97.2%	97.4%	96.3%
East Lothian	91.5%	95.0%	90.5%	97.2%	95.6%	96.9%	94.1%
Midlothian	92.4%	94.5%	98.0%	95.4%	98.5%	97.9%	97.8%
West Lothian ADP	85.8%	80.0%	82.4%	93.2%	91.2%	87.2%	86.2%

Table 2: % Seen within 3 Weeks – Prisons - Higher % is Better

	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16
NHS Lothian	**75.0%**	**82.1%**	**90.4%**	**79.0%**	**90.6%**	**93.6%**	**84.0%**
West Lothian ADP: HMP Addiewell	44.6%	48.7%	71.4%	68.9%	81.7%	89.1%	84.0%
Edinburgh City ADP: HMP Edinburgh	100.0%	98.1%	98.3%	87.9%	96.9%	97.0%	-

Timescale for Improvement

This will be decided with each H&SC partnership as all community services moved into localities on 1st April 2017 and will be operationally managed by them

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
IJBs/NHSL to agree funding plans for financial year 17/18	End May 2017	Clarify budget available to support front line and hosted services (Ritson/LEAP/Harm reduction) to clarify status for each service and protect frontline staff	To be confirmed	RED

Comments

Reasons for Current Performance

City of Edinburgh -SG colleagues are meeting with Edinburgh ADP leads to discuss future improvements
Midlothian continue to meet target
West Lothian starting to improve again as staffing stabilises
East Lothian has a particular nurse staffing issue currently which is having an impact. This is unlikely to be resolved quickly but the locality will work with SMS services to look at improvements that can be made in the interim. Clinical Director is retiring but returning to undertake sessions in East and Mid Lothian whilst they work through recruitment process to provide consistency. Previously retired bank staff being utilised where possible
Short term contracts continue to be an issue that can hopefully be resolved in each of the localities

Ritson will reduce beds, introduce a day programme and align it to additional community detox pathways. The potential impact and risk of this have still to be clearly articulated
LEAP will increase capacity and reduce Out of area placements

Inpatient & Day Case (IPDC) Treatment Time Guarantee (TTG)

Healthcare Quality Domain: Timely

For reporting at **June 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	Improving	Worse	Mar 17 (Qtrly)	0 (max) (100% min)	**1,500 (83.8%)**	Apr 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 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
Urology	122	136	182	221	296	386	398	458	490	509	557	600	574
Orthopaedic Surgery	73	52	32	47	77	105	119	226	326	392	368	271	344
General Surgery	51	71	59	67	45	117	155	128	134	132	149	124	151
Vascular Surgery	18	5	3	4	14	10	38	87	138	138	128	111	117
Gynaecology	37	37	18	13	17	28	43	40	57	53	53	45	46
Paediatric Surgery	45	53	54	46	42	43	35	36	29	42	46	34	42
Ear Nose and Throat	1	1	3	4	2	2	3	11	15	39	39	32	38
Others	57	61	48	61	90	100	119	128	129	129	157	145	188
Total	**404**	**416**	**399**	**463**	**583**	**791**	**910**	**1,114**	**1,318**	**1,434**	**1,497**	**1,362**	**1,500**

Figure 2: % Patients seen within 12 Week Treatment Time Guarantee – Higher % is Better

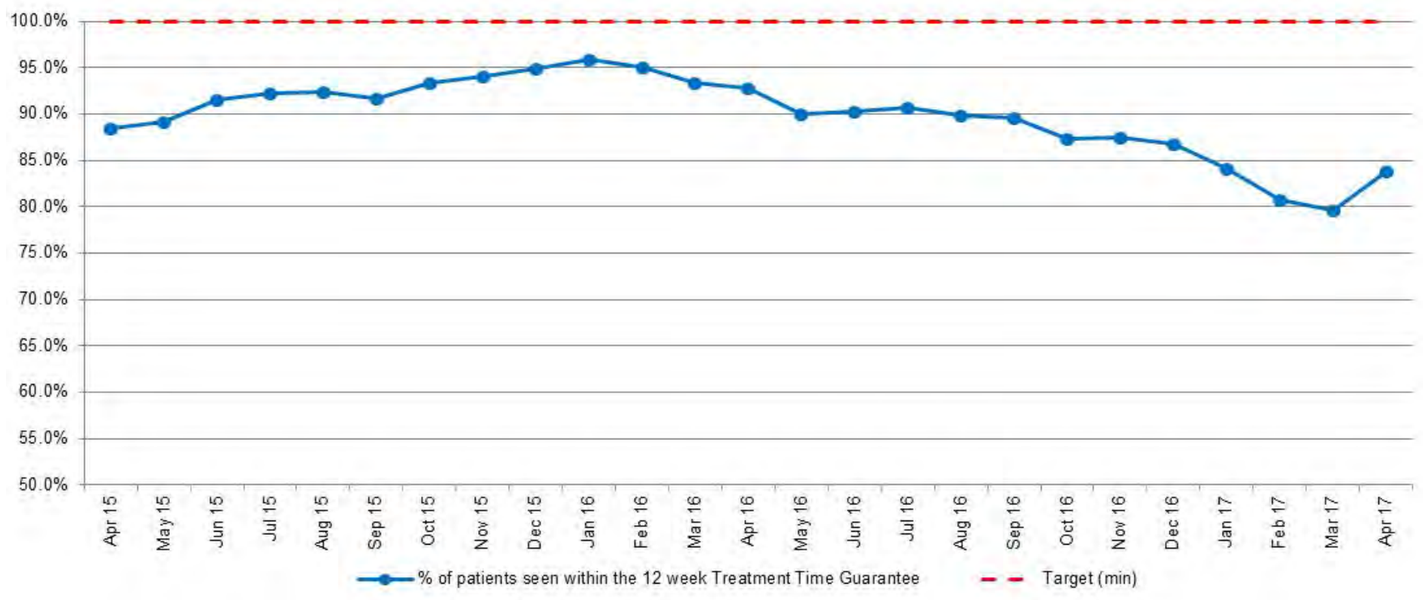


Table 2: % Patients seen within 12 Week Treatment Time Guarantee – Higher % is Better

	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
TTG Seen Within 12 Weeks	3,845	3,663	3,680	3,123	3,583	3,228	3,113	3,513	2,930	2,957	2,799	3,285	2,806
TTG Seen Over 12 Weeks	297	404	398	318	402	373	454	500	444	559	668	839	543
Total Number Seen	4,142	4,067	4,078	3,441	3,985	3,601	3,567	4,013	3,374	3,516	3,467	4,124	3,349
% of patients seen within the 12 week Treatment Time Guarantee	**92.8%**	**90.1%**	**90.2%**	**90.8%**	**89.9%**	**89.6%**	**87.3%**	**87.5%**	**86.8%**	**84.1%**	**80.7%**	**79.7%**	**83.8%**

Table 3: List Size and Unavailability

	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
Total List Size (TTG)	8,625	8,628	8,856	9,031	8,948	9,271	9,202	9,351	9,630	9,669	9,813	9,995	9,751
Available	7,727	7,623	7,668	7,902	7,954	8,374	8,441	8,442	8,589	8,957	9,053	9,159	8,948
Unavailable	898	1,005	1,188	1,129	994	897	761	909	1,041	712	760	836	803
Percentage Unavailable	10.4%	11.6%	13.4%	12.5%	11.1%	9.7%	8.3%	9.7%	10.8%	7.4%	7.7%	8.4%	8.2%
Non-TTG	976	1,073	1,091	1,064	1,096	1,147	1,167	1,220	1,174	1,261	1,234	1,200	1,159

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
Detailed review of Acute Services' available capacity and demand was 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.	Initial output which was completed at the end Jan 2016 has made way for Quarterly meetings established with each service. This will continue each quarter as a standard operating procedure for the future	Improved performance against agreed efficiency targets, example improved Day Case rate. Standardisation of clinicians theatre and clinic templates amongst peers to ensure maximum output. These quarterly meetings are held is to ensure that this remains a key area of focus for Service Management Teams and to provide advice, support and sharing of good practice	This enables teams to identify improvement opportunities where capacity can be maximised.	Quarterly meetings now established with services to monitor performance and are now considered standard operating procedure The Benchmarking group to complete a mapping exercise of tools currently in use and identify KPIs to focus on. A paper has been previously submitted which describes a new process for reallocating poorly utilised lists which can then be allocated to another service which requires it. Work is ongoing and the completion of a new theatre at St John's due to be operational at the beginning of July17 allows for greater scope
Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams to improve theatre efficiency.	Full implementation by December 2016 Programme duration – 3 years (December 2019) initially with potential to extend	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 was also 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 remains on reduction of cancellation rates within Orthopaedics as part of the HSDU work stream which commenced at RIE, Preoperative assessment at WGH and workforce work

				stream. Initial measurements demonstrate a reduction in cancellation rates from 9.71% t o 8.85% (just below national average of 8.9%)
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.	This was fully implemented by October 2016 and continues weekly since	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 was planned to be in place by end April 2017. It has not been possible to implement due to the high numbers of backlog patients not pre-assessed and the need to pre-assess newly listed patients within 4 weeks. Revised date 1st September 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 specialities is being established throughout 2017. Colorectal and Urology have been unable to start this process due to Winter pressures and resources available. It is also compounded by the high numbers of patients over 12 weeks.
Development of trajectories and detailed actions maximising internal capacity; New trajectories build up from, DCAQ work. Process endorsed by SG early May. Trajectories are now being developed as a standard operating procedure	These are reviewed amended and actioned at regular intervals throughout the year	Optimise internal capacity and maintain focus on delivery of TTG	These trajectories are the focus for th weekly TTG and OP monitoring meeting for Service Managers. This enables teams to identify improvement opportunities where capacity can be maximised.	Trajectories for 2017/8 have been submitted and discussions are taking place with SG to describe our methodology which has been seen as best practise. Trajectories will be refined throughout the year as they need remain relevant and linked to actual activity numbers.

Comments

Reasons for Current Performance

Demand for services is greater than core capacity
Agreement to use Independent Sector for the specialities under pressure and with the longest waiting time and to improve the position was agreed from up to end of March 2017 from November 2016. This is likely to continue in soem form with finance available from SGHD

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 **June 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	Mar 17 (at month end)	95% (min)	**17,311 (70.7%)**	Apr 17	Management Information	Yes	Yes	JC

Summary for Committee to note or agree

Details of DCAQ work including efficiency improvements that we are undertaking are described below. Use of independent Sector has now ceased. The Modern Outpatient: - A Collaborative Approach 2017 – 2020' has been launched by SG and its implementation is being progressed through the Outpatient Programme Board. NHS Lothian Medical Director leads this programme.

Recent Performance – Numbers beyond Standard

Figure 1: Patients waiting over 12 weeks for a new outpatient appointment – Lower Count is Better

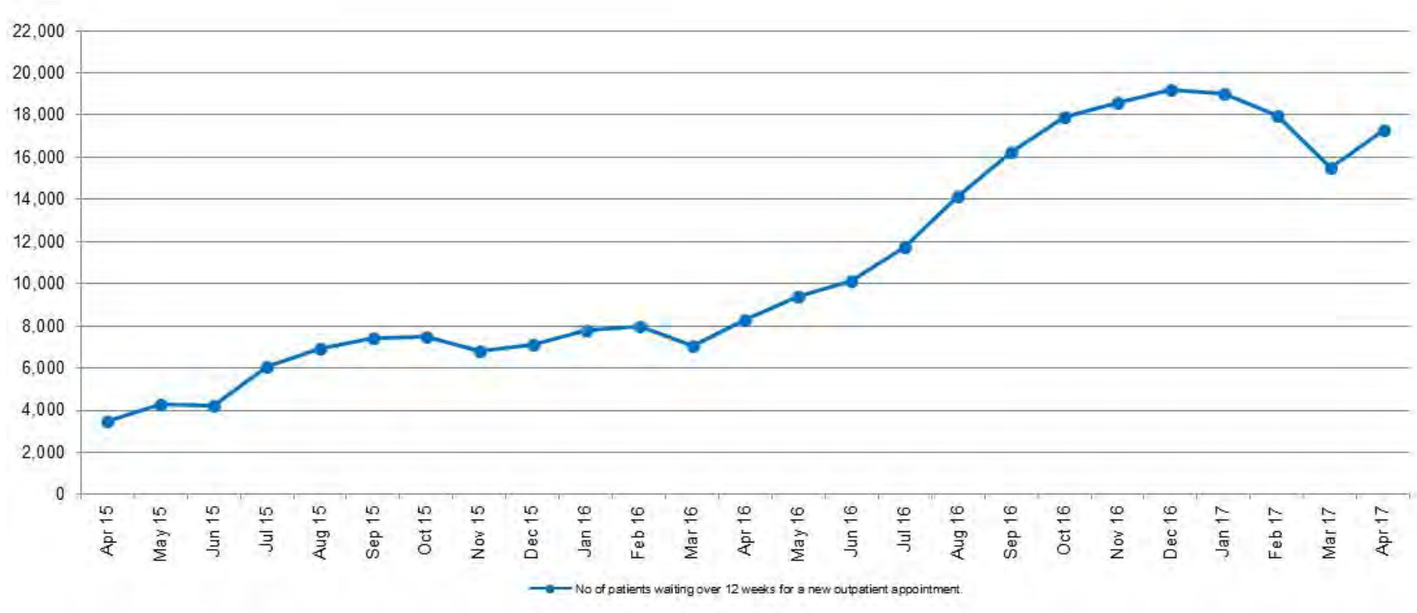


Table 1: Patients waiting over 12 weeks for a new outpatient appointment – Lower Count is Better

	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
GASTROENTEROLOGY	1,845	2,087	2,327	2,596	3,112	3,686	3,999	4,360	4,296	4,159	3,875	3,419	3,496
TRAUMA AND ORTHOPAEDIC SURGERY	2,201	2,255	2,321	2,660	2,927	2,977	3,078	3,176	3,213	3,172	3,071	2,566	2,796
GENERAL SURGERY (EXCL VASCULAR)	1,684	2,064	2,042	2,116	2,196	2,438	2,671	2,773	2,757	2,830	2,891	2,527	2,742
DERMATOLOGY	80	44	32	213	1,130	1,839	2,425	2,443	2,439	2,249	1,854	1,723	2,090
EAR, NOSE & THROAT (ENT)	492	596	827	921	1,072	1,155	1,239	1,490	1,869	2,113	1,831	1,413	1,572
VASCULAR SURGERY	333	339	362	447	578	667	795	964	1,103	1,194	1,254	980	990
OPHTHALMOLOGY	189	224	216	342	350	356	346	354	534	752	782	651	960
UROLOGY	386	391	351	326	471	669	744	551	462	604	657	608	790
NEUROSURGERY	180	254	193	200	350	512	565	461	559	398	262	215	266
NEUROLOGY	79	184	240	294	263	304	290	303	293	228	219	192	234
OTHERS	791	966	1,224	1,596	1,719	1,662	1,738	1,705	1,686	1,317	1,271	1,193	1,375
TOTAL	**8,260**	**9,404**	**10,135**	**11,711**	**14,168**	**16,265**	**17,890**	**18,580**	**19,211**	**19,016**	**17,967**	**15,487**	**17,311**

Figure 2: % of patients waiting 12 weeks or less for a new outpatient appointment – Higher % is Better

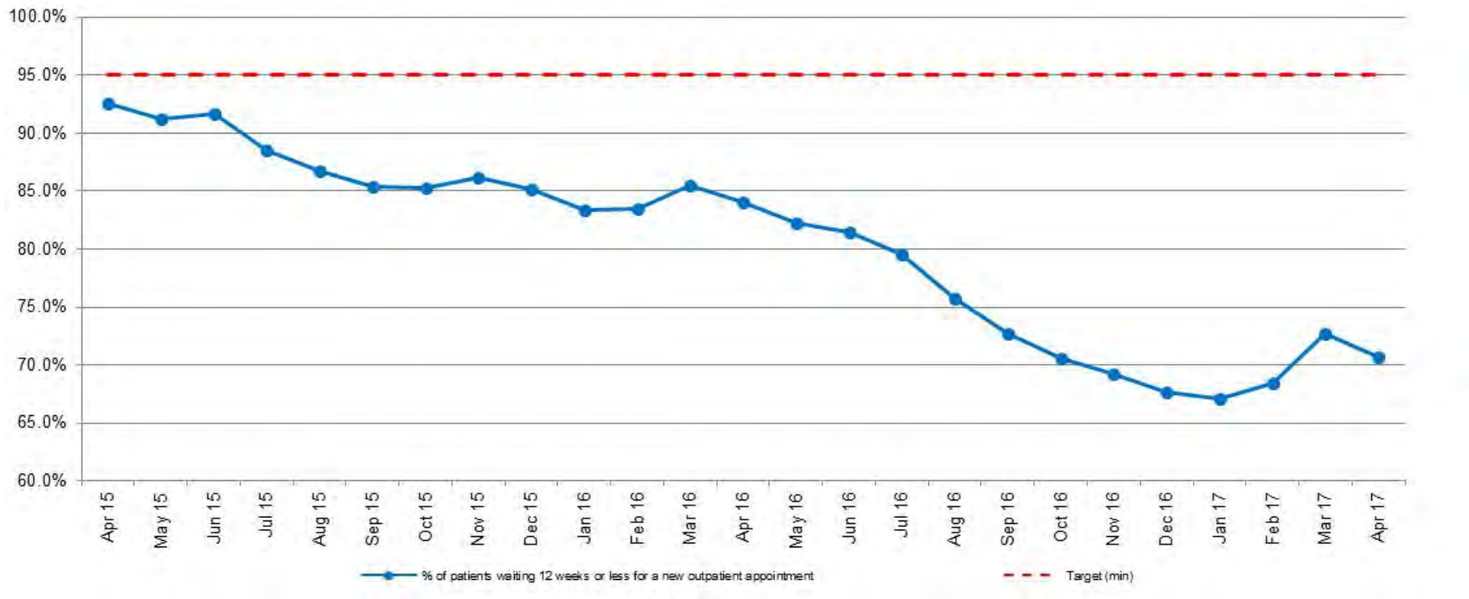


Table 2: % of patients waiting 12 weeks or less for a new outpatient appointment – Higher % is Better

	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
% of patients waiting 12 weeks or less for a new outpatient appointment	**84.0%**	**82.2%**	**81.5%**	**79.6%**	**75.8%**	**72.8%**	**70.6%**	**69.2%**	**67.6%**	**67.2%**	**68.4%**	**72.7%**	**70.7%**

Table 3: Outpatients List Size and Unavailability

	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
Total List Size	51,574	52,886	54,777	57,280	58,481	59,696	60,854	60,339	59,377	57,907	56,911	56,796	59,076
Available	50,912	51,652	53,490	56,083	57,414	58,721	59,783	59,268	58,154	56,692	55,608	55,634	58,384
Unavailable	662	1,234	1,287	1,197	1,067	975	1,071	1,071	1,223	1,215	1,303	1,162	692
Percentage Unavailable	1.3%	2.3%	2.3%	2.1%	1.8%	1.6%	1.8%	1.8%	2.1%	2.1%	2.3%	2.0%	1.2%

Timescale for Improvement

Following recent DCAQ work an out-patient trajectory has been developed until end March 2018.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
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	Programme of further work around performance monitoring –quarterly review process in place. Meetings being scheduled now for June 17.	Improved performance against agreed efficiency targets, example reduced DNA rate.	Once implemented fully this will enable teams to identify improvement opportunities where capacity can be maximised.	Further work on activity and capacity is being taken forward under the mantle of DfP (Delivering for Patients) with the next set of quarterly reviews being scheduled for June 17. Further meetings with individual service management teams are also in progress, to identify any additional support needs for the completion of DfP Review actions.
The Outpatient Modernisation programme aims to revise the model of service delivery to be more responsive, with less inappropriate visits to hospital, with patients signposted to the right clinician at the right time and in the right place to ensure that clinical time is spent wisely and effectively in both primary and secondary care. 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. • 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.	Specific work streams have various local target dates but overall programme delivering by 2020. • 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 is ongoing. • Template with key specialty waits to be made available to GPs by end of December 2016. See **Status** column for an update on this. • GP engagement sessions ongoing • Engagement sessions with Practice Manager groups ongoing	Decrease in number of new outpatient appointments (better demand management). Achieve upper quartile for the return: new ratio. Decrease DNAs. Improve patient and referrer awareness of waits Clear NHS Lothian strategy development for Outpatient services	Advice only clinics set up – able to triage letters and provide GP / patient with advice without attending the hospital. OP Matrix – identify clinic space & nursing during core times – reducing the need for WLI weekend / evening clinics Return waiting lists - able to manage return demand, – able to track patientt journey to ensure no patients are missed. Reported weekly at WT meetings. Harmonisation – better patient / Dr experience – patient triage outcomes are aligned to the correct appointment slot – reducing the need for further visits Ref Help – providing GP with essential advice before referring pt to hospital – reduce unnecessary referrals / ensuring referrals are suitable for acute site	Progressing each of these work streams through the outpatient operational group. Advice only in place in 17 specialties. Work ongoing to implement in other areas. 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. 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. PRL implementation group for Ophthalmology now progressing implementation of planned review waiting lists, initially with 5 sub specialty queues. New outpatient wait lengths are now available on Ref Help and will be refreshed on a monthly basis.

Independent sector capacity for see and treat patients switched on at Spire Healthcare and The Edinburgh Clinic. Re-engagement with Medinet for Adult and Paediatric ENT and Dermatology	31st March 2017	Reduction in length of new outpatient waits.		4094 referrals transferred to Spire and 200 referrals transferred to TEC. Dermatology clinics commenced on 7th January and ran until 26th March. Capacity available for 990 patients. Adult ENT clinics commenced from Roodlands on 11th February and ran until 15th March with capacity for 500 patients Paediatric ENT clinics ran on 22- 24 February and on 22 – 24 March with capacity for 150 patients. **ACTION CLOSED**

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.
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 **June 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)	**60.0%**	Apr 17	Management Information	Yes	No	JF

Summary for Committee to Note or Agree

Recent Performance – Percentages against Standard

Table 1: Patients Seen for 1st Treatment – Higher % is Better

	Patients seen for 1st treatment (adjusted)				
Service	**Number seen**	**Within 18 wks**	**Over 18 wks**	**% within 18 wks**	**% over 18 wks**
CAMHS	6	2	4	33.3%	66.7%
General Adult Services	205	67	138	32.7%	67.3%
Learning Disabilities	12	9	3	75.0%	25.0%
Older Adult Services	27	21	6	77.8%	22.2%
Psychotherapy	5	0	5	0.0%	100.0%
Specialist Service [Adult]	42	31	11	73.8%	26.2%
Clinical Health Psychology	110	88	22	80.0%	20.0%
Neuropsychology	55	49	6	89.1%	10.9%
GSH (3rd Sector)	25	25	0	100.0%	0.0%
Overall Performance	**487**	**292**	**195**	**60.0%**	**40.0%**

Figure 1: Psychological Therapies: % of Patients seen within 18 wks for 1st Treatment

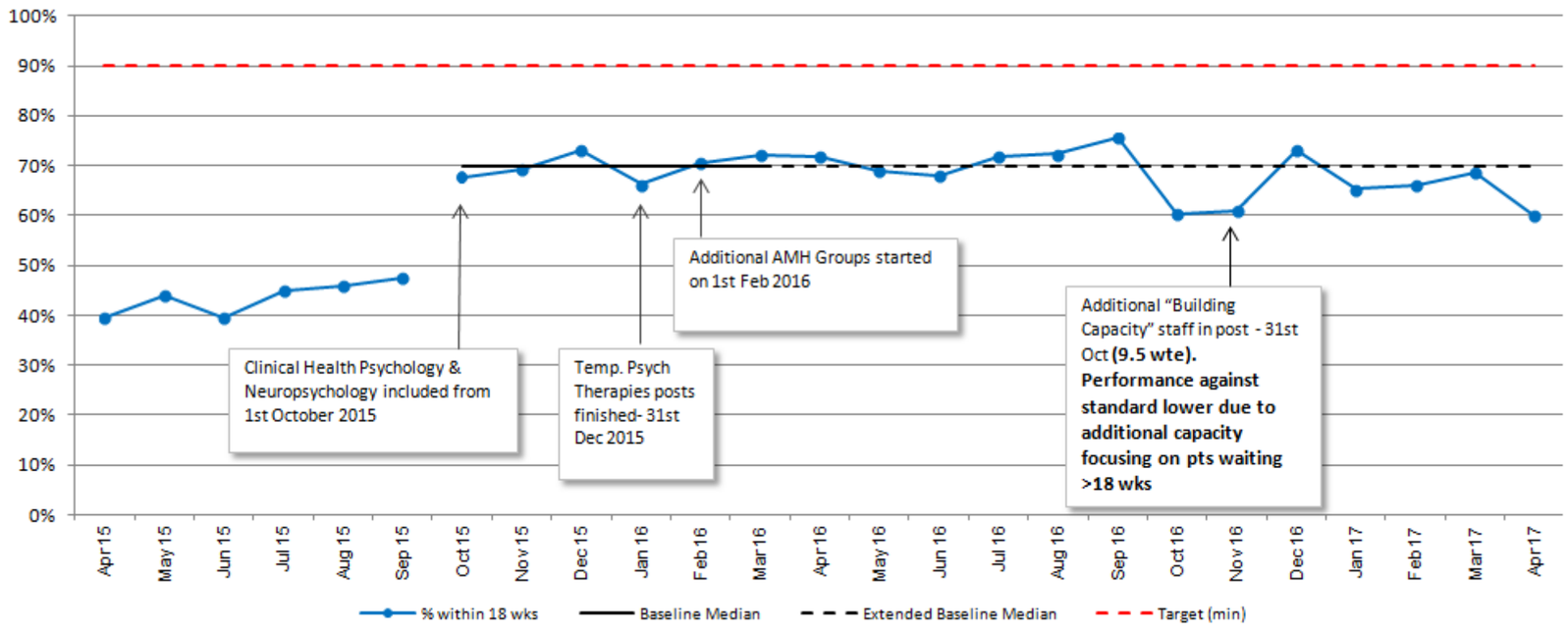


Table 2: Patients Waiting at Month End

	Patients waiting at month end adjusted				
Service	Number waiting	Within 18 wks	Over 18 wks	% within 18 wks	% over 18 wks
CAMHS	29	9	20	31.0%	69.0%
General Adult Services	2,696	1,711	985	63.5%	36.5%
Learning Disabilities	41	36	5	87.8%	12.2%
Older Adult Services	167	129	38	77.2%	22.8%
Psychotherapy	196	46	150	23.5%	76.5%
Specialist Services [Adult]	448	321	127	71.7%	28.3%
Clinical Health Psychology	585	513	72	87.7%	12.3%
Neuropsychology	118	103	15	87.3%	12.7%
GSH (3rd Sector)	136	132	4	97.1%	2.9%
Total waiting	**4,416**	**3,000**	**1,416**	**67.9%**	**32.1%**

Figure 2: Psychological Therapies: Number of Patients waiting >18 wks at Month End by Month – Lower Count is Better

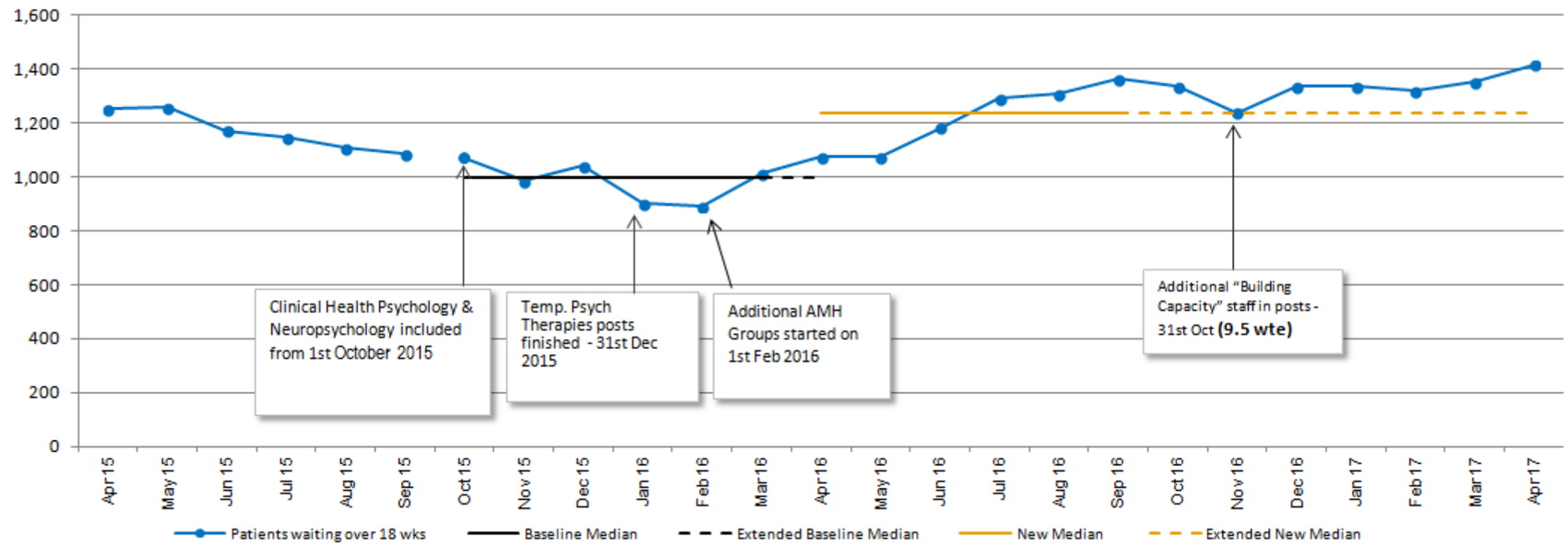


Figure 3: Referrals for Psychological Therapy (All Teams)

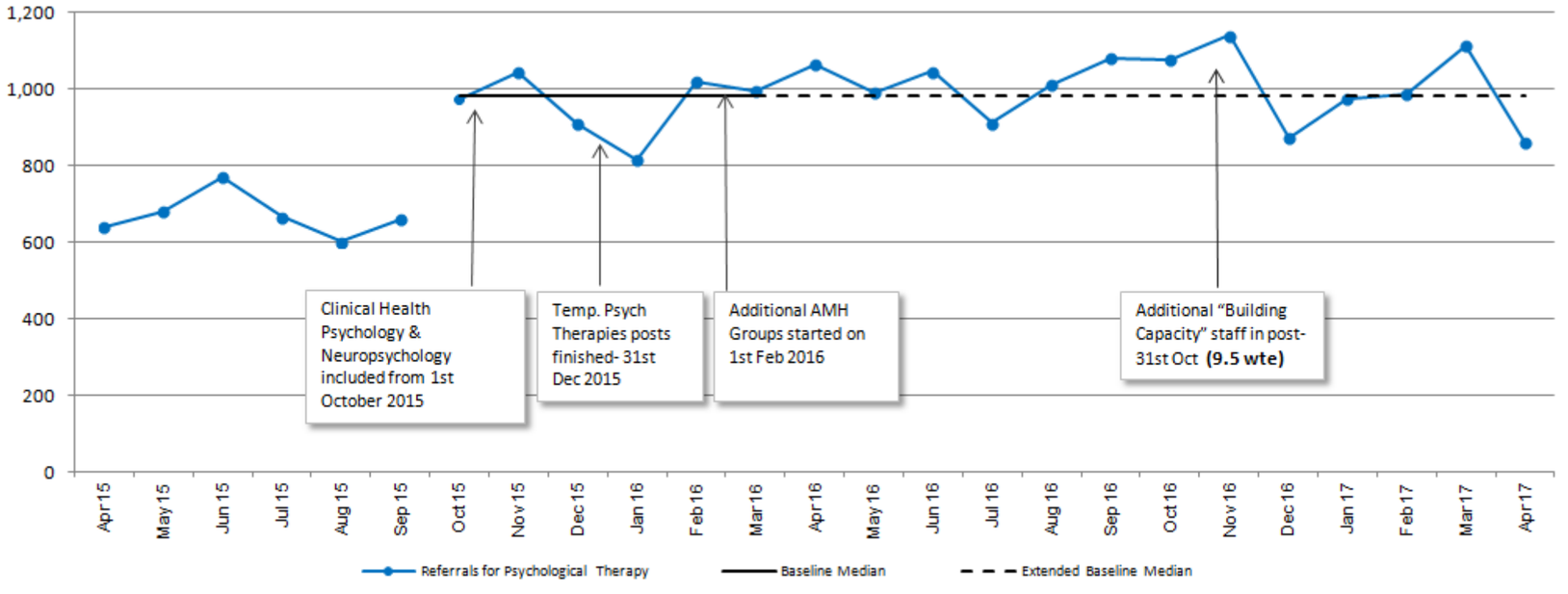


Figure 4: General Adult Services: Number of patients seen for 1st Treatment – Higher Count is Better

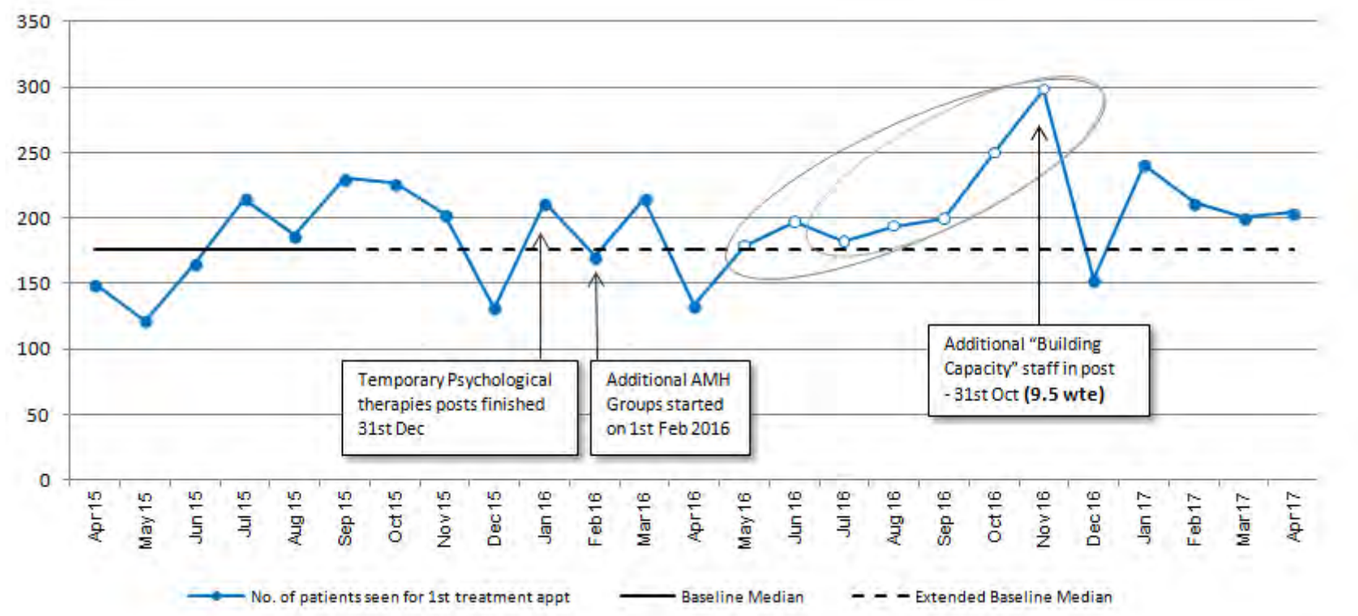


Figure 5: General Adult Services: Number of patients seen for 1st Treatment waiting >18 wks – Lower Count is Better

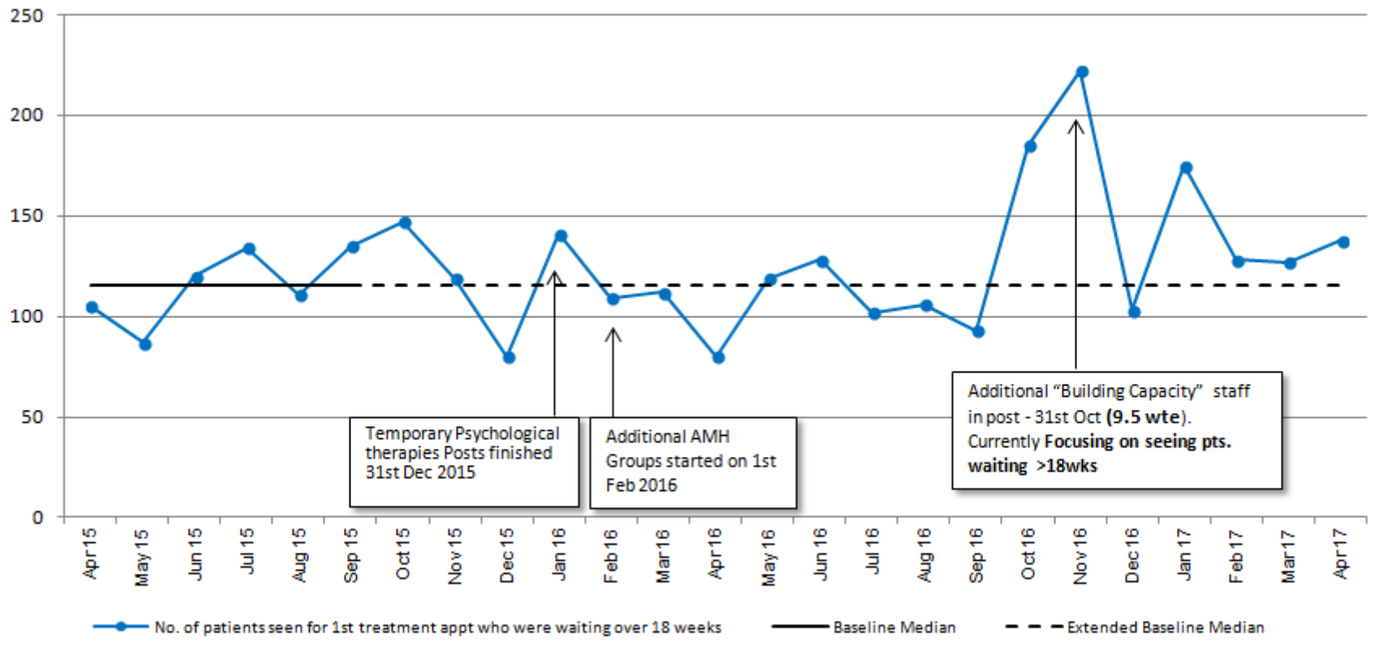


Figure 6: General Adult Services: Number of patients waiting >18 wks at Month End – Lower Count is Better

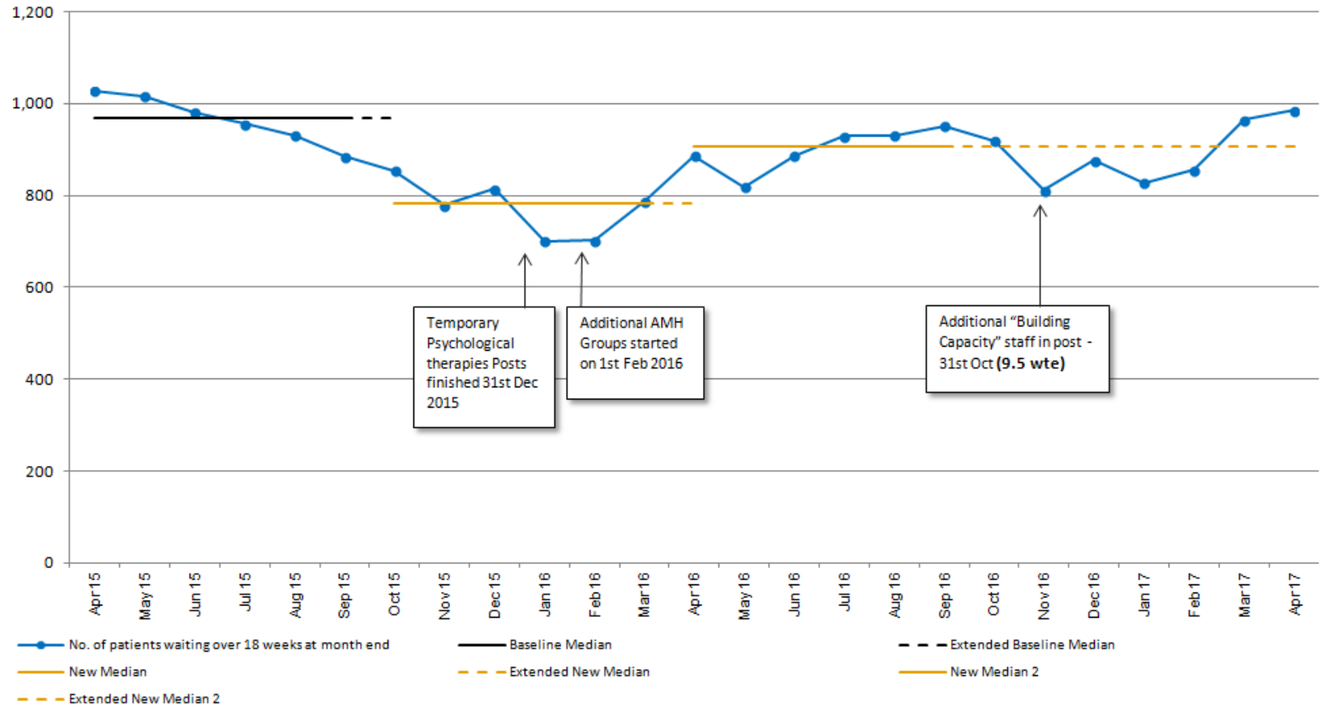


Figure 7: General Adult Services: Referrals for Psychological Therapies

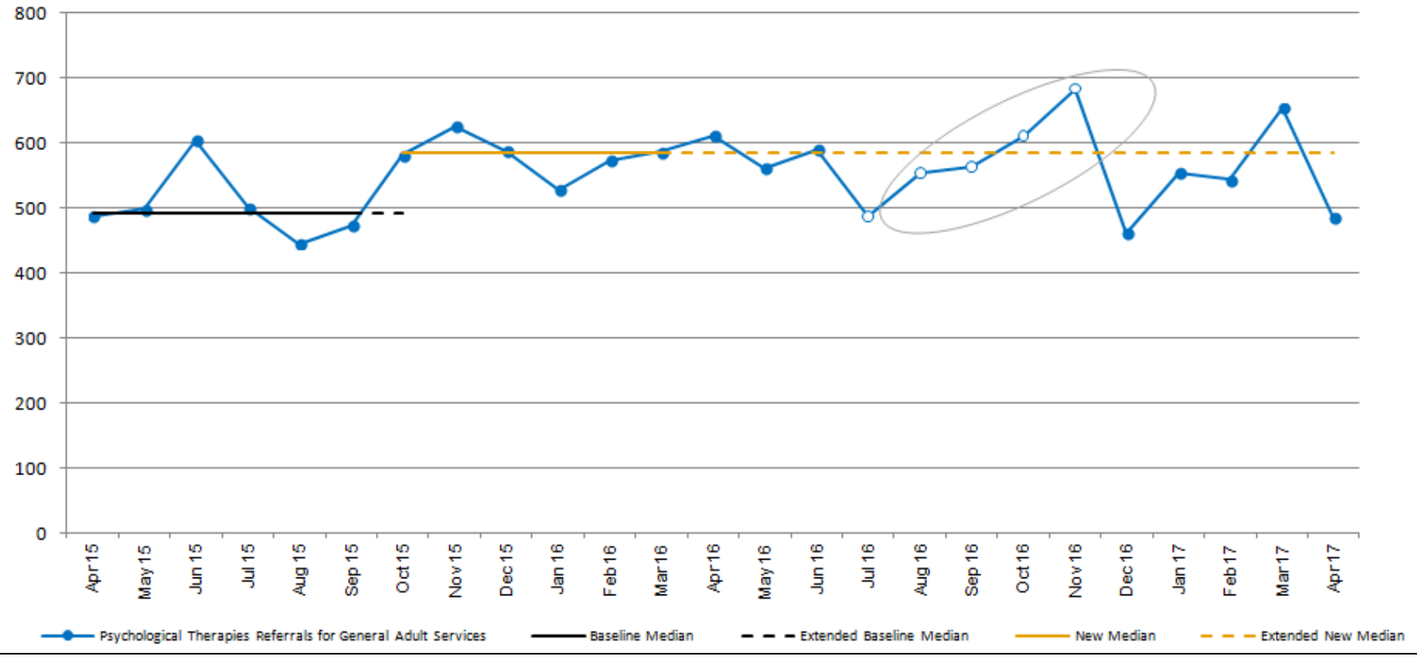
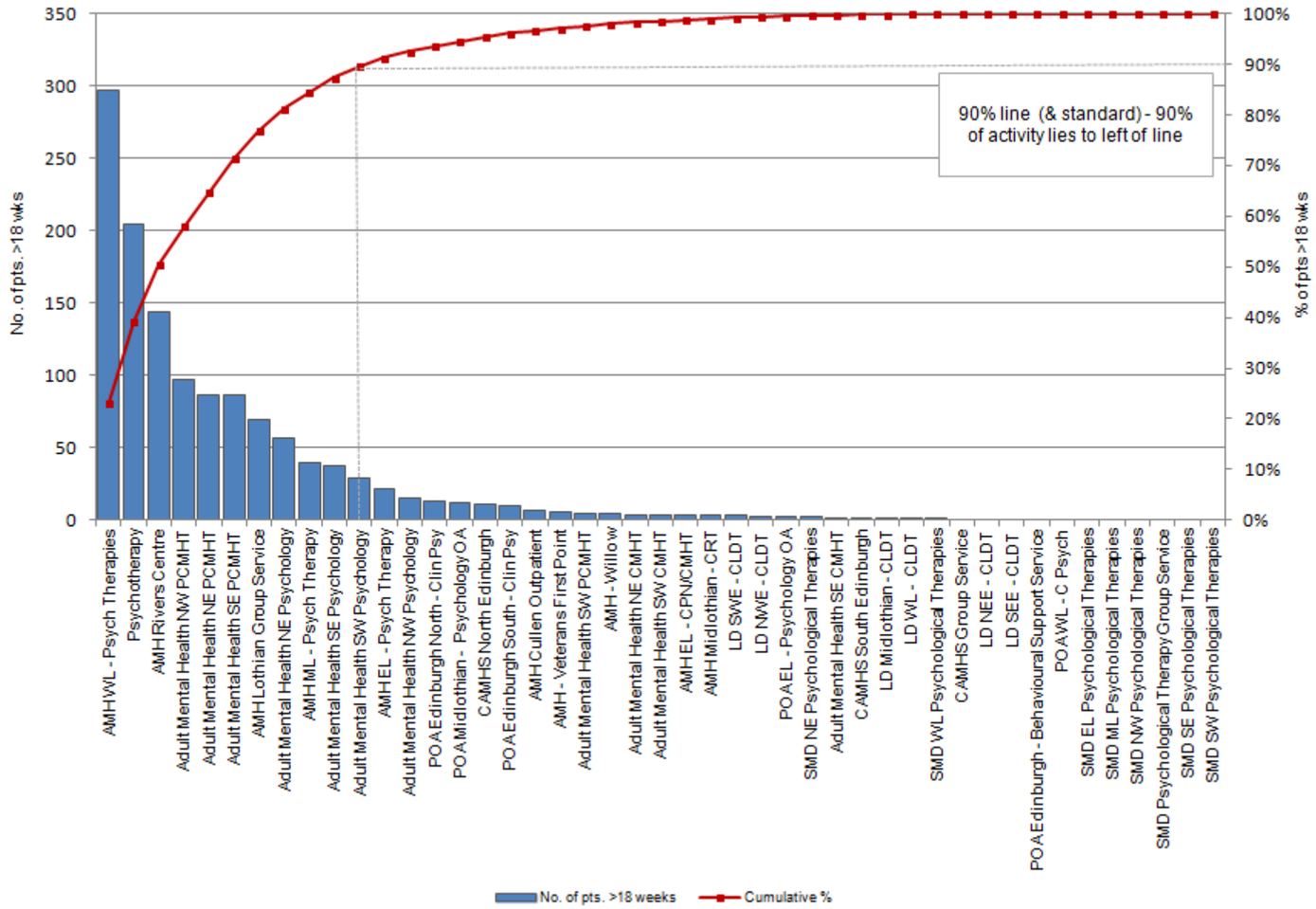


Figure 8: Pareto – Patients Waiting >18 Weeks For Treatment Per Team – as at end Feb 17 - Lower Count is Better



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	Original date was May 2016. Due to configuration issues	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non	Centralised service implemented at REH and booking for SW OPD. Agreed process for utilizing TRAK PFB with Edinburgh PCMH &	Amber

across all service delivering psychological therapies.	now anticipated July 2016. Pilot started.	attended appointments. Improved compliance with waiting times rules related to reasonable offer, unavailability and clock resets.	Edinburgh Psychology Services Clinic Templates submitted to eHealth for PCMHTs & Psychology Staff training booked for end Nov/ Beginning Dec 2016.	
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 1st 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.	1st 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 is currently being recruited to for Psychodynamic Psychotherapy services to be fixed term for 18 months to address those who have waited the longest.

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. Review of the patients who are being offered treatment through employment of QI methodology in Adult Mental Health Psychology services. QI lead has been identified and working closely with MHAIST team.

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 **June 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	Mar 17	90% (min)	**78.8%**	Apr 17	Management Information	Yes	Yes	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

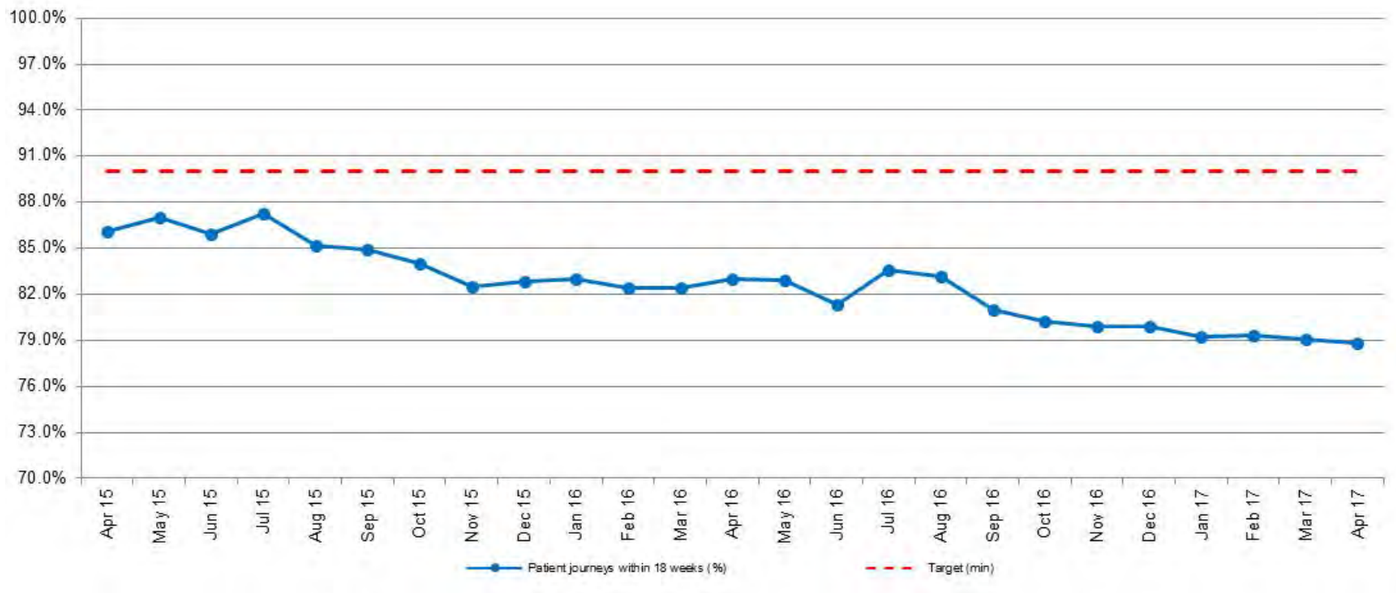


Table 1: Trend in 18 Week Performance and Measurement – Higher % is Better

	Apr 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
Patient journeys within 18 weeks (%)	83.0%	82.9%	81.3%	83.6%	83.2%	81.0%	80.2%	79.9%	79.9%	79.2%	79.3%	79.1%	78.8%
Number of patient journeys within 18 weeks	13,157	13,067	13,303	11,213	13,080	11,498	11,307	12,485	10,409	11,030	10,578	12,279	9,935
Number of patient journeys over 18 weeks	2,688	2,703	3,061	2,197	2,632	2,691	2,785	3,146	2,614	2,888	2,763	3,252	2,674
Patient journeys that could be fully measured (%)	87.0%	87.0%	89.3%	87.3%	87.6%	87.0%	87.3%	87.2%	87.1%	87.0%	86.8%	86.5%	87.2%

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 was completed at the end of January 2016. Phase to monitoring of performance against key indicators commenced April 2016. We have now moved to regular performance meetings on an ongoing basis every quarter. This involves scrutiny of progress with the Clinical Service Managers against performance indicators, and monitoring of actual activity against baseline capacity 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 was available in December 2016 and is now available on a monthly basis	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.

Delayed Discharges – East Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

For reporting at **June 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	Mar 17	0 (max)	**204** (>3 days, excl. Code 9s[5] & 100s[6])	Apr 17	Trak	Yes	Yes	DS
		East Lothian IJB Performance					17 (8.3% of NHS Lothian Performance)					

Summary for Committee to note or agree

- East Lothian's performance had been steadily improving from a peak of 43 delayed discharges 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. Since August 2016 the hospital delayed discharge numbers have steadily reduced, even allowing for an expected seasonal surge in December 2016 and January 2017.
- 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.
- Whilst continued support by EL H&SCP of the Living Wage – contributes to having a stabilising effect on the workforce within home care sector providers, this remains a relatively unattractive career prospect.
- 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.
- East Lothian continues to have no 'complex' 9 code delayed discharge clients (April 2017).
- The ELH&SCP step down capacity continues to run at 27 beds – temporarily provided at Liberton Hospital – whilst East Lothian Community Hospital is under construction.
- East Lothian validated number for standard delayed discharges at April 2017 census was 29 against a trajectory target of 15 (10 of the 29 were over two weeks). This was the first month in six that East Lothian had been above its trajectory. Across the Monday/Tuesday of the census week 19 patients were declared as a delayed discharge – when we would have expected 8-9 patients and the Partnership struggled to find discharge solutions in the two days before census. East Lothian met the census target two days after the census date.
- 12 of our 29 delayed discharges in April were less than 3 days.

[5] 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.

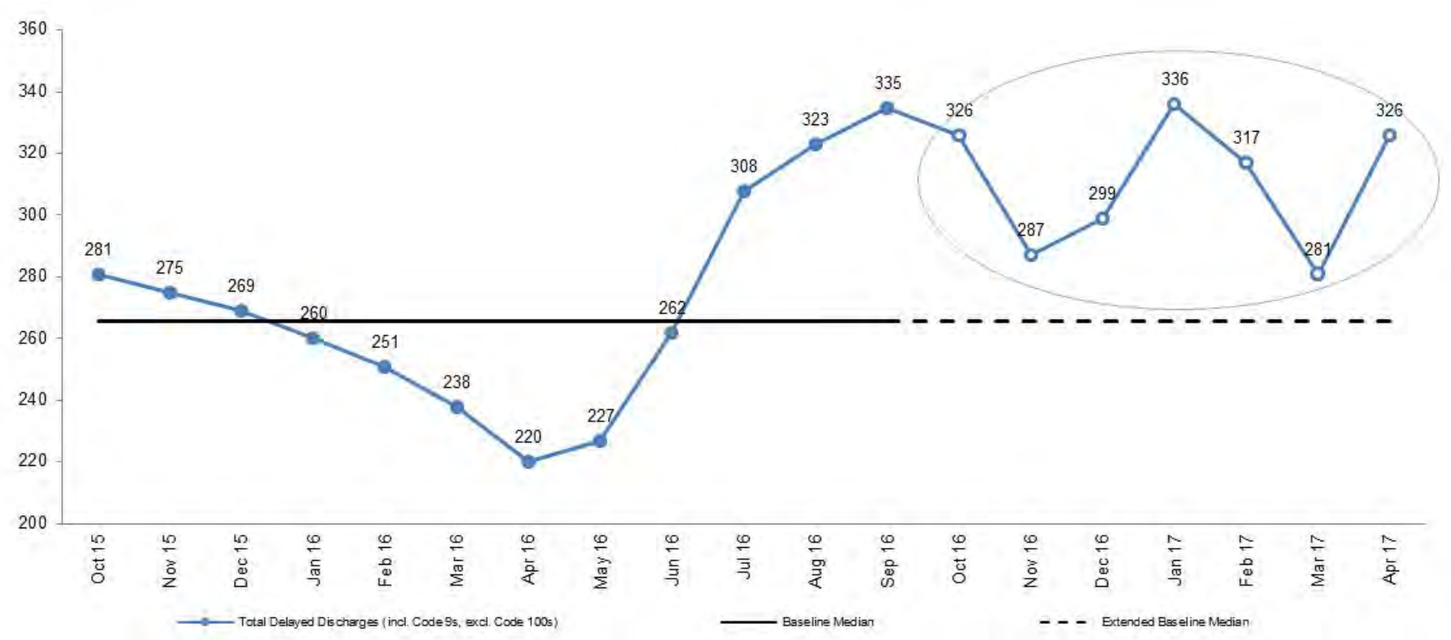
[6] Code 100 is used for commissioning/re-provisioning.

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 Better[7]

	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
City of Edinburgh				198	192	201	225	198	203	228	222	192	215
East Lothian				40	61	60	41	26	47	41	25	16	29
Midlothian				24	27	34	21	22	22	16	18	30	34
West Lothian				40	38	38	36	41	26	51	49	42	47
Total Delayed Discharges (incl. Code 9s, excl. Code 100s)	**220**	**227**	**262**	**308**	**323**	**335**	**326**	**287**	**299**	**336**	**317**	**281**	**326**

Figure 1: Census Return Data - Total Delayed Discharges (incl. Code 9s, excl. Code 100s) – Lower Count is Better



[7] 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 for NHS Lothian and East Lothian IJB (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	Mar 17	Apr 17
<=3 days (excl. Code 9s and 100s)										
City of Edinburgh	20	26	23	32	28	15	28	38	14	43
East Lothian	2	11	14	9	4	11	12	1	1	12
Midlothian	2	8	4	5	7	1	4	2	6	8
West Lothian	4	10	6	8	10	6	11	18	9	16
Total incl. Other Local Authority Areas	**29**	**55**	**47**	**55**	**49**	**33**	**55**	**61**	**30**	**80**
>3 days (excl. Code 9s and 100s)										
City of Edinburgh	153	144	155	168	148	170	188	171	162	140
East Lothian	35	47	44	31	21	35	28	24	15	17
Midlothian	15	13	25	12	13	17	9	10	20	22
West Lothian	33	23	23	23	26	17	36	24	27	24
Total incl. Other Local Authority Areas	**241**	**232**	**249**	**236**	**208**	**240**	**261**	**230**	**225**	**204**
Code 9s										
City of Edinburgh	25	22	23	25	22	18	12	13	16	32
East Lothian	3	3	2	1	1	1	1	0	0	0
Midlothian	7	6	5	4	2	4	3	6	4	4
West Lothian	3	5	9	5	5	3	4	7	6	7
Total incl. Other Local Authority Areas	**38**	**36**	**39**	**35**	**30**	**26**	**20**	**26**	**26**	**44**
Code 100s										
City of Edinburgh	23	23	27	23	25	27	26	21	22	19
East Lothian	3	5	4	2	2	1	2	2	1	1
Midlothian	4	3	3	5	5	4	3	3	4	5
West Lothian	4	6	6	5	5	6	6	6	7	6
Total incl. Other Local Authority Areas	**34**	**37**	**40**	**35**	**37**	**38**	**37**	**32**	**34**	**31**

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.

At April 2017, there were 30 delays in total at the census point 00.01Hrs on the last Thursday of the month –made up of 29 standard delays and 1 reprovisioning delay, with zero complex delays, against a target of 20.

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.	Done. Level of total unmet hours has fallen from peak of 1800 to 1500 per week. (Only 1/3 of this number relates to delayed discharges)	Implemented
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 2016	Reduction in numbers waiting for care home by at least 11 (current number of vacancies)	N/A	Implemented
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 over the last year has been capacity of care at home providers to meet demand, and this is certainly Lothian wide and indeed country wide. The actions above are mostly aimed at addressing this factor. Additional capacity in the Hospital to Home team was utilised in April, which reduced the numbers waiting in Hospital for some of the more complex Care At Home Packages.

Delayed Discharges – Edinburgh Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

For reporting at **June 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	Mar 17	0 (max)	**204** (>3 days, excl. Code 9s[8] & 100s[9])	Apr 17	Trak	Yes	Yes	RMG
		Edinburgh IJB Performance					140 (68.6% of NHS Lothian Performance)					

Summary for Committee to note or agree

- A new trajectory for the reduction of delayed discharge for the Edinburgh Partnership have been agreed with the objective of achieving a target of 50 by the end of December 2017.
- A comprehensive programme of actions to address delayed discharge for Edinburgh residents has been underway over the last year, and has been overseen by the ~~Patient~~ Flow Programme Board, which meets monthly. Progress was reviewed at the Board's March 2017 meeting, where it was agreed that the focus of the programme is reset to address a small set of priorities. The proposed priorities for agreement at the Flow Board on 30/5/17 are: ensuring the care at home contract is delivering as well as possible, improving patient flow and telecare/telehealth.
- Weekly meetings with locality managers to scrutinise performance and improve flow in relation to delayed discharge are ongoing.
- A new hospital to home service contract has now began targeting delays that current capacity cannot accommodate.

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 Better[10]

	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
City of Edinburgh				198	192	201	225	198	203	228	222	192	215
East Lothian				40	61	60	41	26	47	41	25	16	29
Midlothian				24	27	34	21	22	22	16	18	30	34
West Lothian				40	38	38	36	41	26	51	49	42	47
Total Delayed Discharges (incl. Code 9s, excl. Code 100s)	**220**	**227**	**262**	**308**	**323**	**335**	**326**	**287**	**299**	**336**	**317**	**281**	**326**

[8] 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.
[9] Code 100 is used for commissioning/re-provisioning.
[10] 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

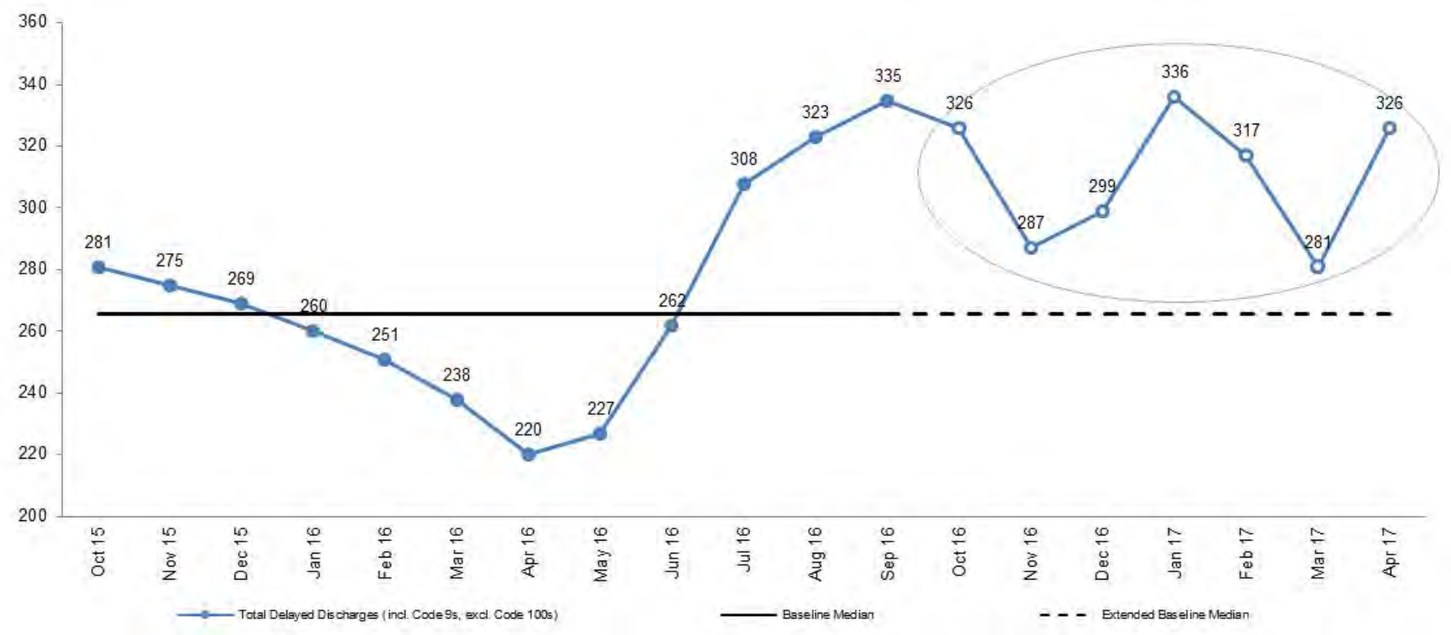


Figure 2: Census Return Data - Delayed Discharges >3 Days for NHS Lothian and City of Edinburgh IJB (excl. Code 9s & 100s) – Pre & Post-Definition Change – Lower Count is Better

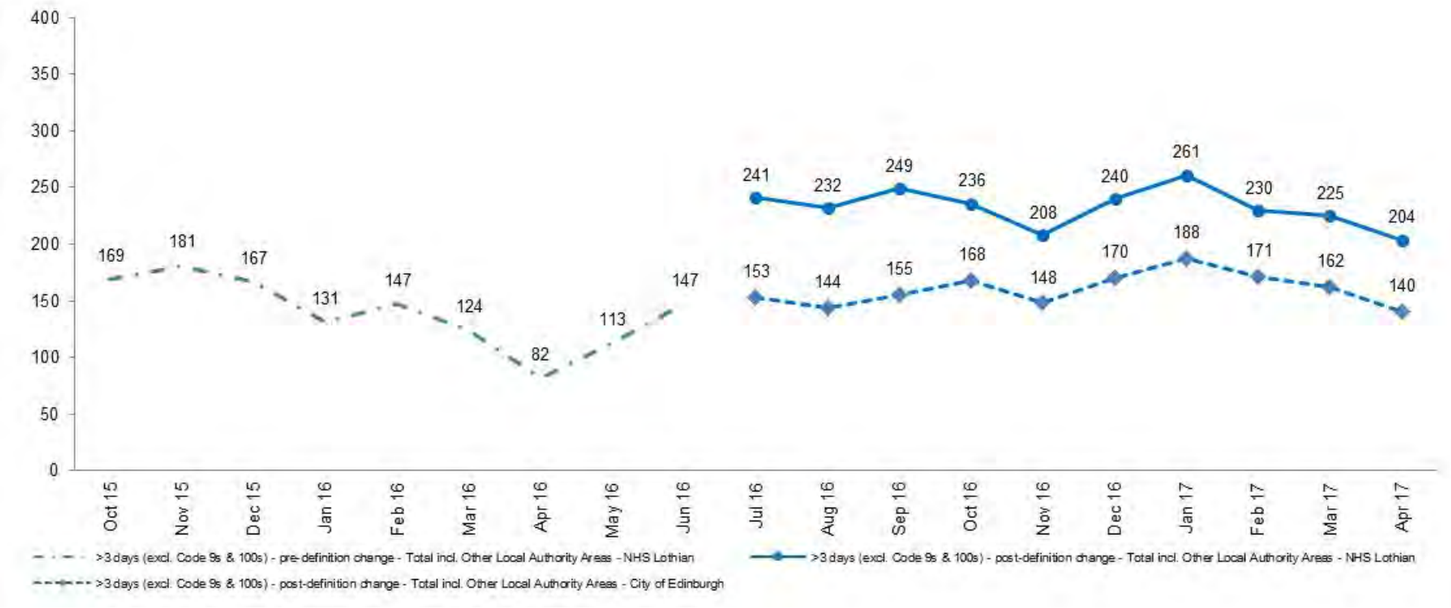


Table 2: Census Return Data - Delayed Discharges – New Methodology – Lower Count is Better

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<=3 days (excl. Code 9s and 100s)										
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East Lothian	2	11	14	9	4	11	12	1	1	12
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>3 days (excl. Code 9s and 100s)										
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Code 9s										
City of Edinburgh	25	22	23	25	22	18	12	13	16	32
East Lothian	3	3	2	1	1	1	1	0	0	0
Midlothian	7	6	5	4	2	4	3	6	4	4
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Code 100s										
City of Edinburgh	23	23	27	23	25	27	26	21	22	19
East Lothian	3	5	4	2	2	1	2	2	1	1
Midlothian	4	3	3	5	5	4	3	3	4	5
West Lothian	4	6	6	5	5	6	6	6	7	6
Total incl. Other Local Authority Areas	**34**	**37**	**40**	**35**	**37**	**38**	**37**	**32**	**34**	**31**

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
The focus of the Flow Programme moving forward will be agreed at the Board meeting on 30/5/17	30/5/17	Reductions in delayed discharge Reduced delays across the pathway Reduction in hospital admissions		• Specification of priority work streams is underway and will be discussed at the Board's next meeting on 26th April.
Overview of the whole system	Ongoing	Quicker identification of pressures and areas for targeting actions.		Work is ongoing. An interim Excel-based report has replaced the weekly overview report, focusing on 5 key points in the hospital system. A front page provides an overview including any areas where activity out with expected levels or patterns, and time series are shown for each of the five areas. A dashboard is being developed on Tableau which will enable drill down by e.g. hospital site and locality. This will enable managers to explore performance in detail. Detailed investigation of timescales within the hospital social work process has already been carried out in conjunction with the lead senior manager. Hospital OT assessments will be the next topic for in-depth analysis to identify areas for improvement

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 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 has decreased in March from 209 to 176 (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.

Reasons for Current Performance

There are several reasons for the improvement in performance, including:

- The establishment of a weekly star chamber attended by the Locality Managers, Hub Managers and colleagues from Acute Services which provides a focus on the monitoring of delays These meetings are also providing an opportunity to share information across whole system which is informs improvements.
- The MATTs are now taking place on a daily basis with a clear focus on actively pursuing individual cases through to discharge
- Clear performance targets and trajectories have been set for each locality owned by the locality managers who have the data required to manage performance

Waiting for social care support at home continues to be the most common reason for delay (86 people) followed by people waiting for care home place (51). 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 **June 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	Mar 17	0 (max)	**204** (>3 days, excl. Code 9s[11] & 100s[12])	Apr 17	Trak	Yes	Yes	EM
		Midlothian IJB Performance					22 (10.8% of NHS Lothian Performance)					

Summary for Committee to note or agree

- The performance within Midlothian remains off-target and there has been an increase on the previous month.
- The pressures continue within providing care at home services, with a provider not continuing their contract for care at home services in the west of Midlothian 31 March 2017, which has resulted in the need for the direct management of this service by the Partnership and the subsequent transfer of staff.
- As previously reported, another of the providers continues to be managed within the protocols of large scale investigation (LSI) – a manager from Midlothian Council has been seconded to provide operational management to the service.
- The ongoing work to support early discharge from acute settings to the Midlothian Community Hospital continues 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 Better[13]

	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
City of Edinburgh				198	192	201	225	198	203	228	222	192	215
East Lothian				40	61	60	41	26	47	41	25	16	29
Midlothian				24	27	34	21	22	22	16	18	30	34
West Lothian				40	38	38	36	41	26	51	49	42	47
Total Delayed Discharges (incl. Code 9s, excl. Code 100s)	**220**	**227**	**262**	**308**	**323**	**335**	**326**	**287**	**299**	**336**	**317**	**281**	**326**

[11] 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.
[12] Code 100 is used for commissioning/re-provisioning.
[13] 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

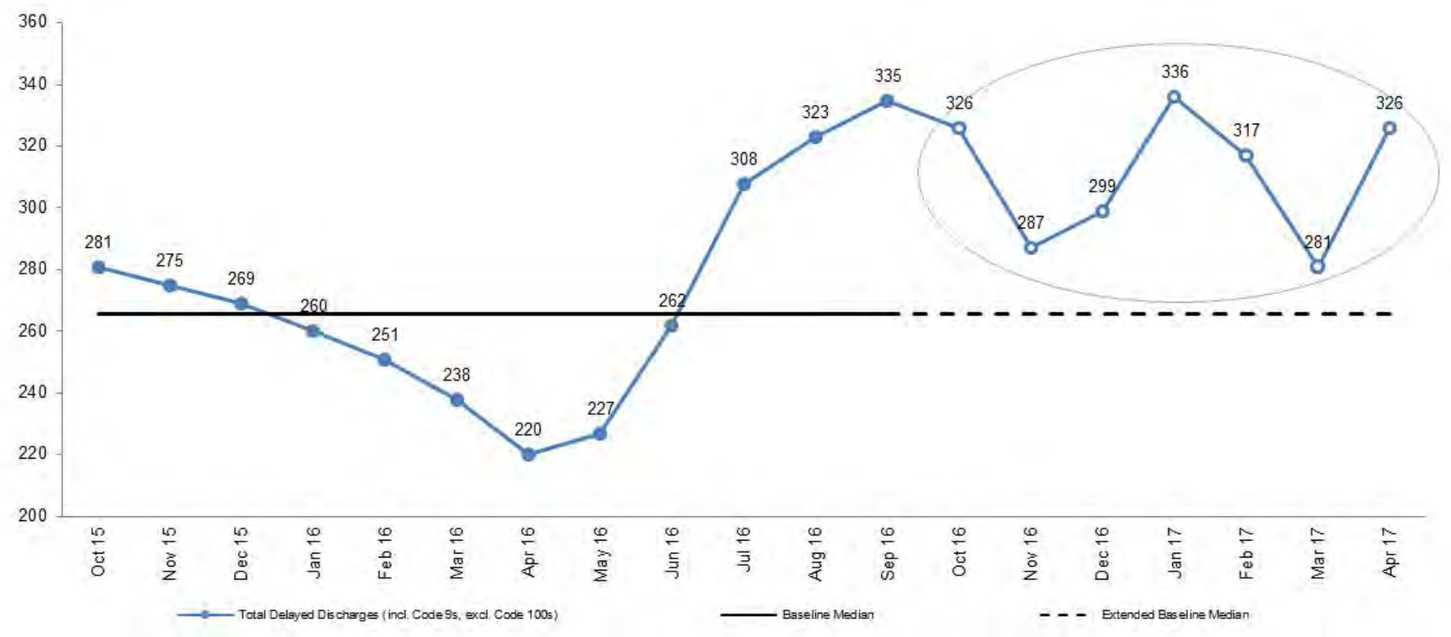

Figure 2: Census Return Data - Delayed Discharges >3 Days for NHS Lothian and Midlothian IJB (excl. Code 9s & 100s) – Pre & Post-Definition Change– Lower Count is Better

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	Mar 17	Apr 17
<=3 days (excl. Code 9s and 100s)										
City of Edinburgh	20	26	23	32	28	15	28	38	14	43
East Lothian	2	11	14	9	4	11	12	1	1	12
Midlothian	2	8	4	5	7	1	4	2	6	8
West Lothian	4	10	6	8	10	6	11	18	9	16
Total incl. Other Local Authority Areas	**29**	**55**	**47**	**55**	**49**	**33**	**55**	**61**	**30**	**80**
>3 days (excl. Code 9s and 100s)										
City of Edinburgh	153	144	155	168	148	170	188	171	162	140
East Lothian	35	47	44	31	21	35	28	24	15	17
Midlothian	15	13	25	12	13	17	9	10	20	22
West Lothian	33	23	23	23	26	17	36	24	27	24
Total incl. Other Local Authority Areas	**241**	**232**	**249**	**236**	**208**	**240**	**261**	**230**	**225**	**204**
Code 9s										
City of Edinburgh	25	22	23	25	22	18	12	13	16	32
East Lothian	3	3	2	1	1	1	1	0	0	0
Midlothian	7	6	5	4	2	4	3	6	4	4
West Lothian	3	5	9	5	5	3	4	7	6	7
Total incl. Other Local Authority Areas	**38**	**36**	**39**	**35**	**30**	**26**	**20**	**26**	**26**	**44**
Code 100s										
City of Edinburgh	23	23	27	23	25	27	26	21	22	19
East Lothian	3	5	4	2	2	1	2	2	1	1
Midlothian	4	3	3	5	5	4	3	3	4	5
West Lothian	4	6	6	5	5	6	6	6	7	6
Total incl. Other Local Authority Areas	**34**	**37**	**40**	**35**	**37**	**38**	**37**	**32**	**34**	**31**

Timescale for Improvement – Midlothian IJB

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 outwith the revised trajectory but there are actions underway to address this trend.

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
10	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	Smooth transfer of service to Midlothian Council	Transfer now complete – this resulted in some staff leaving, so further recruitment is now underway
Management support being provided to external Care at Home service to bring stability and improvements in service delivery	April 2017	Improve quality of service and create additional capacity	There is now stability within the service	No further disruption to service and provider able to take on additional clients
Recruitment campaign for additional staff over the summer months is underway, targeting local universities and colleges	May 2017	Increase short-term capacity over summer	Being monitored by the Reablement Service	Recruitment process well underway and interviews due to take place over the coming weeks
Overall review of care at home services now nearing completion – this will create blueprint for future planning and delivery of services	May 2017	Sustainable future delivery of care at home services	To be determined	Initial review document produced and consultation and engagement process now underway with key stakeholders.

Comments – Midlothian IJB

Reasons for Current Performance

The current performance is a reflection of ongoing issues 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 (though additional management support has been provided) and another provider has handed their contract back to Midlothian Council to deliver, resulting in the need to transfer staff to Midlothian Council. However, we continue to work closely with all providers to ensure a safe and consistent service is being delivered. There is currently an overall review of care at home within Midlothian and work is also underway for a procurement exercise to create a Framework Agreement that will provide greater flexibility and additional capacity – this will be ready by 1 June 2017. The continuing 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 **June 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	Mar 17	0 (max)	**204** (>3 days, excl. Code 9s[14] & 100s[15])	Apr 17	Trak	Yes	Yes	JF
		West Lothian IJB Performance					24 (11.8% 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.
- Standard delays over 3 days at 27 and over 2 weeks at 17 for end March
- We are continuing to review all delayed discharge cases to track the key issues and are addressing these within our unscheduled care plan**s**
- Regular meetings continue 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 Better[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
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East Lothian				40	61	60	41	26	47	41	25	16	29
Midlothian				24	27	34	21	22	22	16	18	30	34
West Lothian				40	38	38	36	41	26	51	49	42	47
Total Delayed Discharges (incl. Code 9s, excl. Code 100s)	**220**	**227**	**262**	**308**	**323**	**335**	**326**	**287**	**299**	**336**	**317**	**281**	**326**

[14] 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.
[15] Code 100 is used for commissioning/re-provisioning.
[16] 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

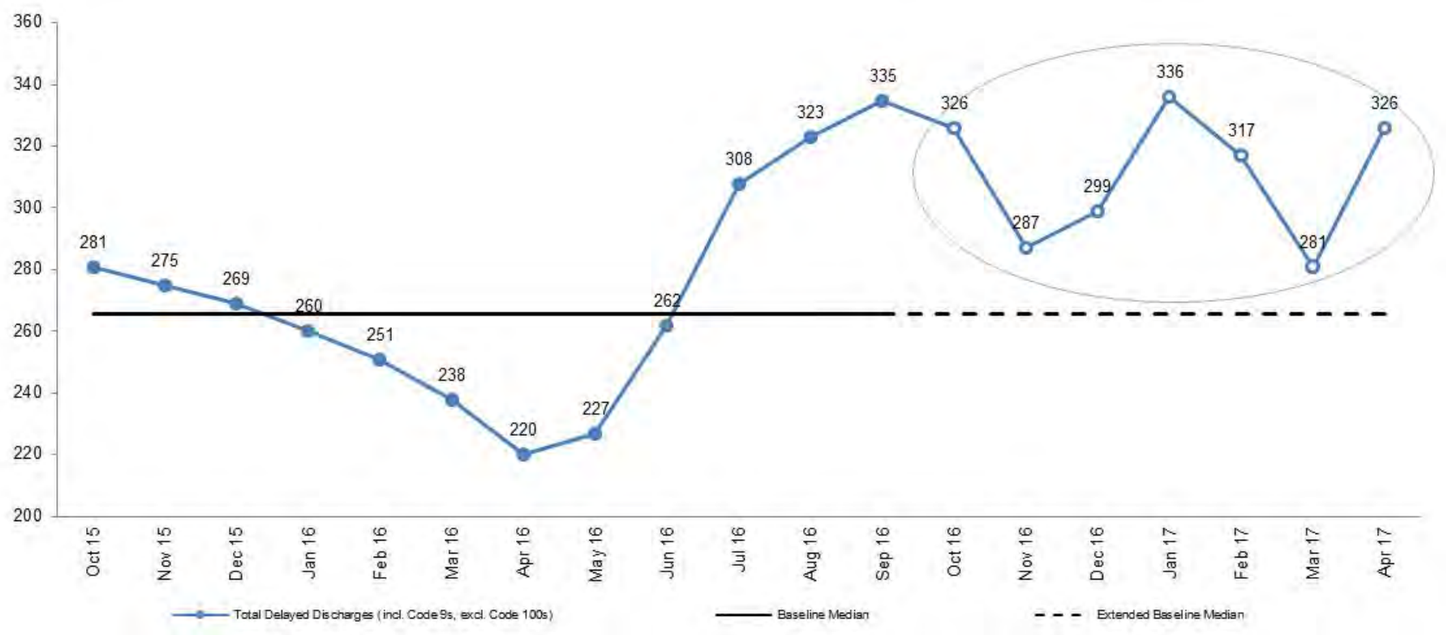

Figure 2: Census Return Data - Delayed Discharges >3 Days for NHS Lothian and West Lothian IJB (excl. Code 9s & 100s) – Pre & Post-Definition Change– Lower Count is Better

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	Mar 17	Apr 17
<=3 days (excl. Code 9s and 100s)										
City of Edinburgh	20	26	23	32	28	15	28	38	14	43
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Midlothian	2	8	4	5	7	1	4	2	6	8
West Lothian	4	10	6	8	10	6	11	18	9	16
Total incl. Other Local Authority Areas	**29**	**55**	**47**	**55**	**49**	**33**	**55**	**61**	**30**	**80**
>3 days (excl. Code 9s and 100s)										
City of Edinburgh	153	144	155	168	148	170	188	171	162	140
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Midlothian	15	13	25	12	13	17	9	10	20	22
West Lothian	33	23	23	23	26	17	36	24	27	24
Total incl. Other Local Authority Areas	**241**	**232**	**249**	**236**	**208**	**240**	**261**	**230**	**225**	**204**
Code 9s										
City of Edinburgh	25	22	23	25	22	18	12	13	16	32
East Lothian	3	3	2	1	1	1	1	0	0	0
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West Lothian	3	5	9	5	5	3	4	7	6	7
Total incl. Other Local Authority Areas	**38**	**36**	**39**	**35**	**30**	**26**	**20**	**26**	**26**	**44**
Code 100s										
City of Edinburgh	23	23	27	23	25	27	26	21	22	19
East Lothian	3	5	4	2	2	1	2	2	1	1
Midlothian	4	3	3	5	5	4	3	3	4	5
West Lothian	4	6	6	5	5	6	6	6	7	6
Total incl. Other Local Authority Areas	**34**	**37**	**40**	**35**	**37**	**38**	**37**	**32**	**34**	**31**

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 • 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.	Ongoing	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 Transformation Change Programme implemented for delivery over 2 year period Frailty Hub at implementation stage	Green
Embedding of new Care at Home contract: Performance management of providers to meet terms of contract	Ongoing	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	ongoing	Reduction in emergency admission Reduction in delayed discharge	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	Amber
Comprehensive needs assessment is in progress which will inform the IJB Commissioning Plan for Older People	Sept 2016 complete	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 1st time	Awareness sessions with MDT	Green
Provide addition MHO resource to Discharge Hub to focus on Code 9 delays	October 2016 Complete	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 lack of capacity of Care Homes and poor responsiveness of Care at Home providers continues to have an adverse impact on delayed discharges.
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.

Staff Sickness Absence

Healthcare Quality Domain: Person Centred

For reporting at **June 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
Moderate	Mar 17	Not Met	Improving	Better	2015/16	4% (max)	**5.10%**	Mar 17	Scottish Workforce Information Standard System (SWISS) - Management Information.	Yes	Yes	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

Figure 1: NHS Lothian Staff Sickness Absence (% Staff Hours Lost) - Lower % is Better

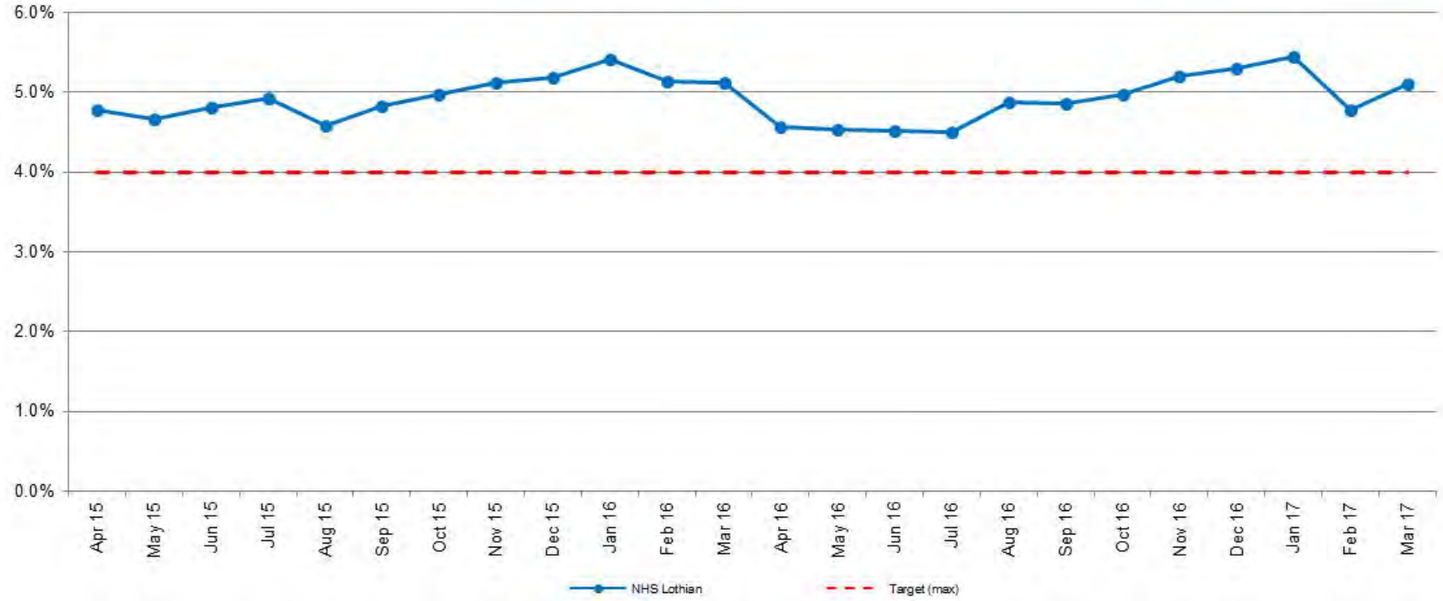


Table 1: NHS Lothian Staff Sickness Absence (% Staff Hours Lost) - Lower % is Better

	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	Feb 17	Mar 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%	4.78%	5.10%

Table 2: NHS Lothian Staff Sickness Absence (% Staff Hours Lost) - Lower % is Better

	2014/15	2015/16
NHS Scotland	5.04%	5.16%
NHS Lothian	4.71%	5.02%

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 have now been completed.	-			Completed
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			
A paper was also taken to the Staff Governance Committee at the end of March 2017 and the Committee agreed moderate assurance, based on the information that was presented to the Committee in January 2017, that systems and processes were in place to support the management of staff absence and assist with achieving the 4% target.				
A Health and Well Being Stakeholders event was held on 21st April with 35 participants and representation from most sites and job families. This is in the follow up phase and a draft Strategy paper is due in June. Clear themes came through from the event and it is likely 17/18 will be about building on what we do and changing our conversation. In parallel with that we will assess the business case for other initiatives for 18/19.				
One of the key work streams for 17 /18 absence management is to enable managers to set local absence reduction targets. The HRIS Manager has developed 3 new Tableau Dashboards enable the managers to ward / team level to set their own target reduction and to see the associated cost reduction that would achieve. They will be ready for roll out across NHSL in late May and in June.				

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.

Smoking Cessation

Healthcare Quality Domain: Equitable

For reporting at **June 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. **404** quits (min) – to be achieved **this** quarter; 50% of each quarters' target to be achieved by Pharmacy & Non-Pharmacy respectively:-	**203**	Oct - Dec 16	National Smoking Cessation database	No	Yes	AKM
						a. Non-Pharmacy & Prisons – 202 (50% of overall quarter Q1 target)	162					
						b. Pharmacy – 202 (50% of overall quarter Q1 target)	41					

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	Dec 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**	**221**	**239**	**203**	
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	158	175	162	
NHS Lothian Total – PCR Pharmacies only	27	55	81	139	94	86	79	121	63	64	41	

Figure 1: Comparison of NHS Lothian Quarterly Smoking Cessation Outcomes Against Standards, excl. 50% Target Shares (HEAT for 2014/15, & LDP for 2015/16 & 2016/17[17]) (Source: Smoking Cessation Database for 2014/15 & ISD for 2015/16) - Higher is Better

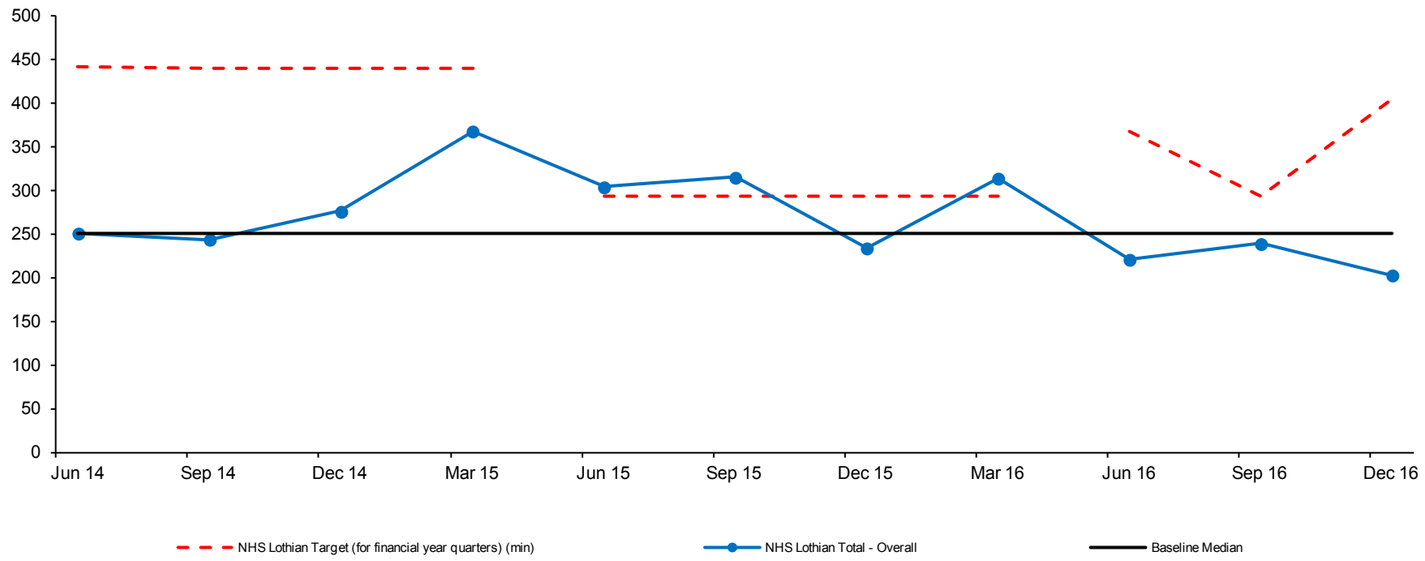
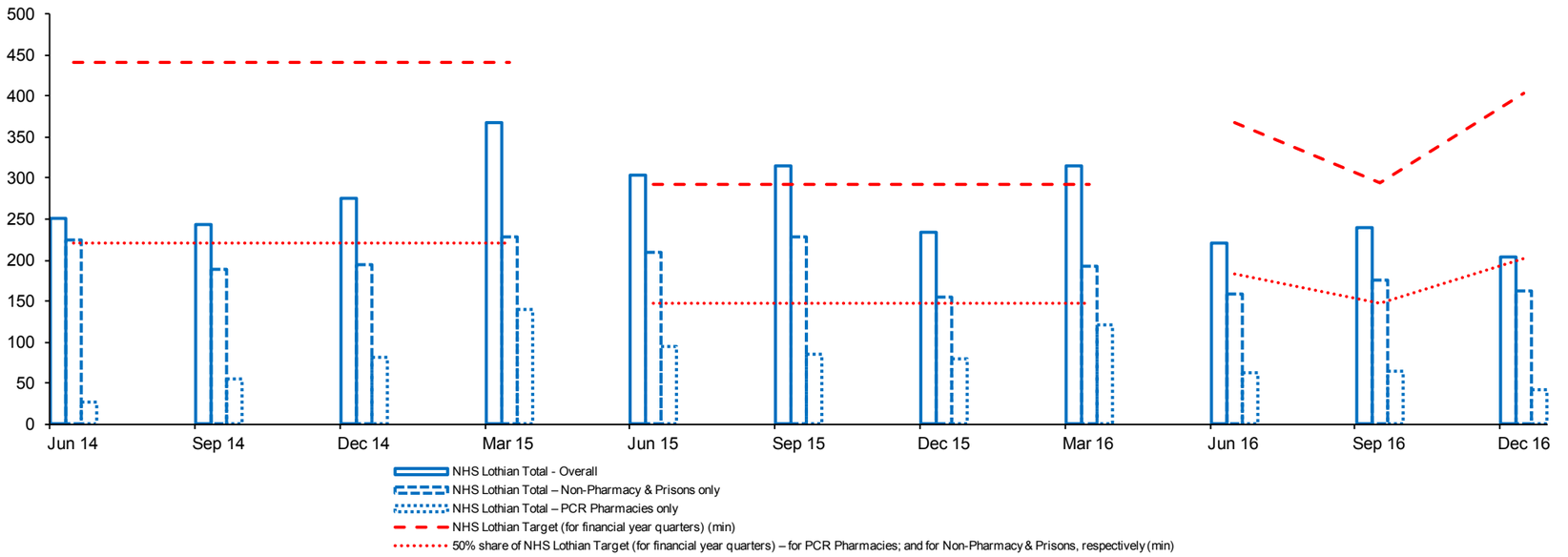


Figure 2: Comparison of NHS Lothian Quarterly Smoking Cessation Outcomes Against Standards, incl. 50% Target Shares (HEAT for 2014/15, & LDP for 2015/16 & 2016/17) (Source: Smoking Cessation Database for 2014/15 & ISD for 2015/16) - Higher is Better



[17] Current LDP standard **is 'Successful Quits in 40% most deprived areas for NHS Lothian for financial year 2015-16 (For Quit Dates per Rolling 3 Months)'**

Figure 3: NHS Lothian Quarterly Smoking Cessation Outcomes for 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

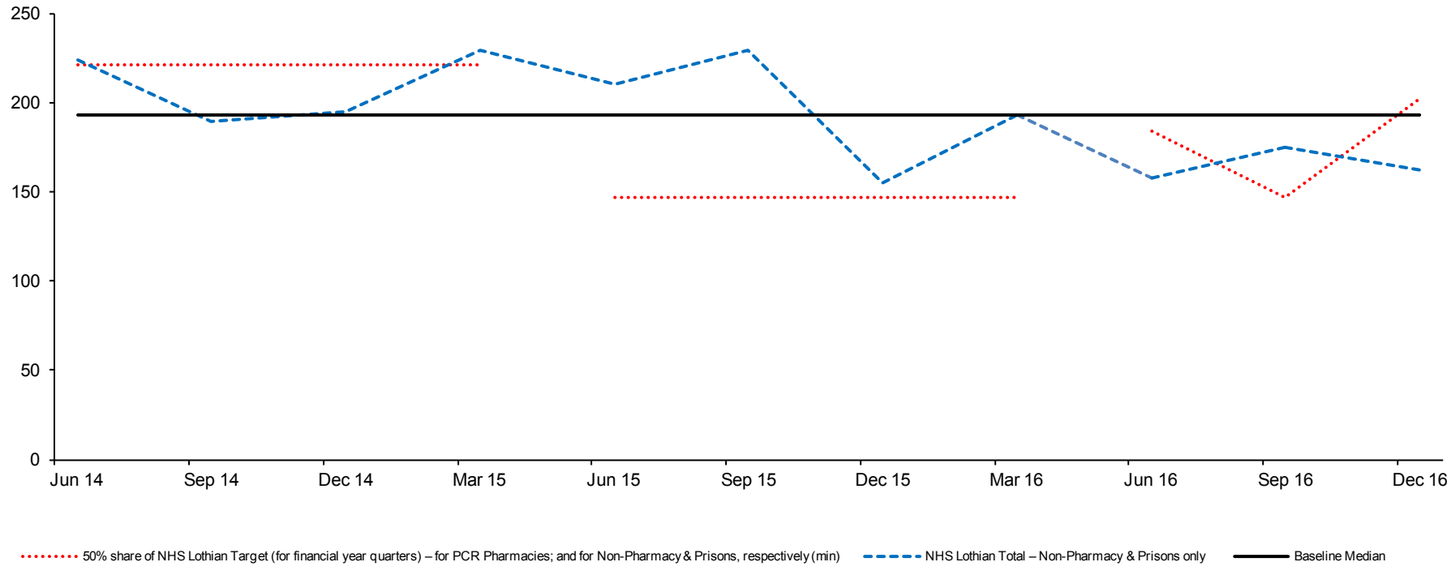
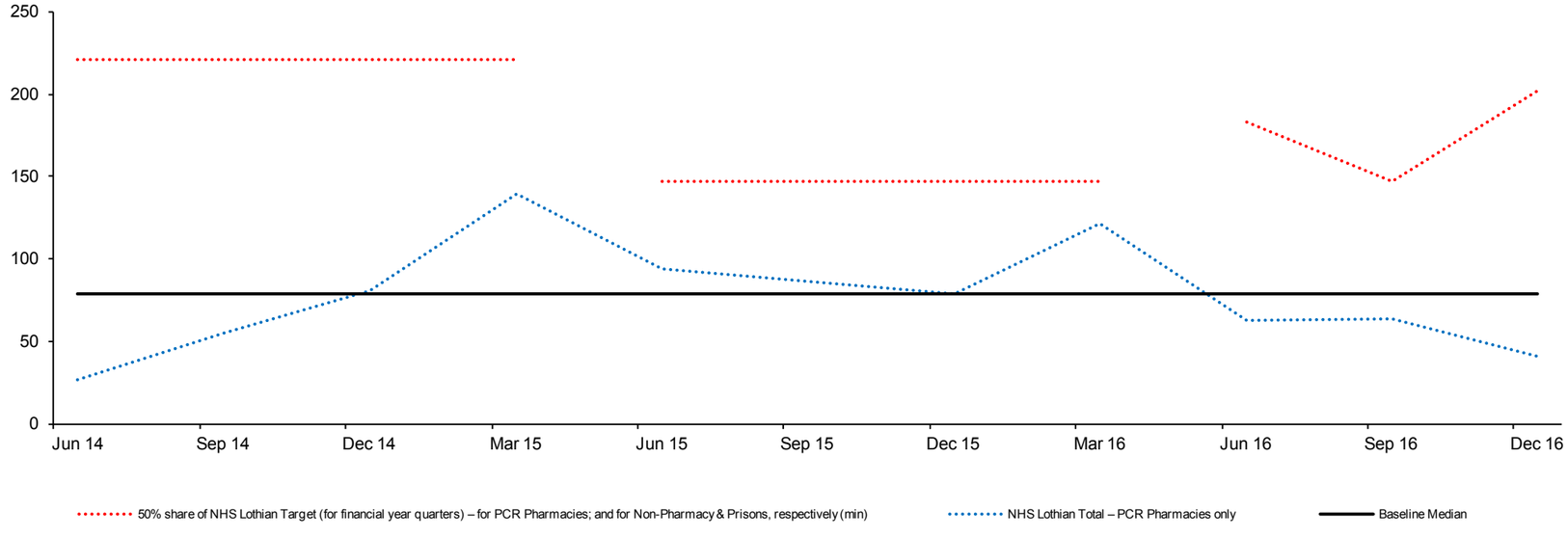


Figure 4: NHS Lothian Quarterly Smoking Cessation Outcomes for PCR-Pharmacies (HEAT for 2014/15, & LDP for 2015/16 & 2016/17) (Source: Smoking Cessation Database for 2014/15 & ISD for 2015/16) - Higher is Better



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. It should also be noted that NHS Lothian performance regarding distribution of quit attempts between Pharmacy & Non Pharmacy is significantly different from similar size health boards who aim for 70% Pharmacy and 30% non pharmacy. In Lothian the Specialist Services contribute significantly more quits than in other areas. NHS Lothian has been moving towards 50% Pharmacy and 50% non pharmacy. Although pharmacies see a larger number of clients, they have relatively lower percentage quit rates than specialist cessation services, Pharmacies in Lothian report 11% NHS Lothian, compared to 17% average at a national level.

It has been agreed that Smokefree Lothian will deliver Health Behaviour Change Training to organisations providing Money Management support. This will help raise awareness of Smokefree Lothian and support the development of referral pathways into specialist services.

Complaints: 3-Day & 20-Day Acknowledgement/Response Rate

Healthcare Quality Domain: Person Centred

For reporting at **June 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	Improving	Worse	2015/16	100% (min)	**90.0%**	Mar 17	DATIX	Yes	Yes	AMcM
20-Day: Moderate	Nov16	Not Met	Deteriorating	Worse	2015/16	80% (min)	**68.0%**	Mar 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 57% of the team's activity in March 2017. Other types of feedback include concerns, comments, enquiries and compliments.

Recent Performance – Numbers against Target/Standard

Figure 1: NHS Lothian 3-Day Formal Complaints Acknowledgment Rate – Higher % is Better

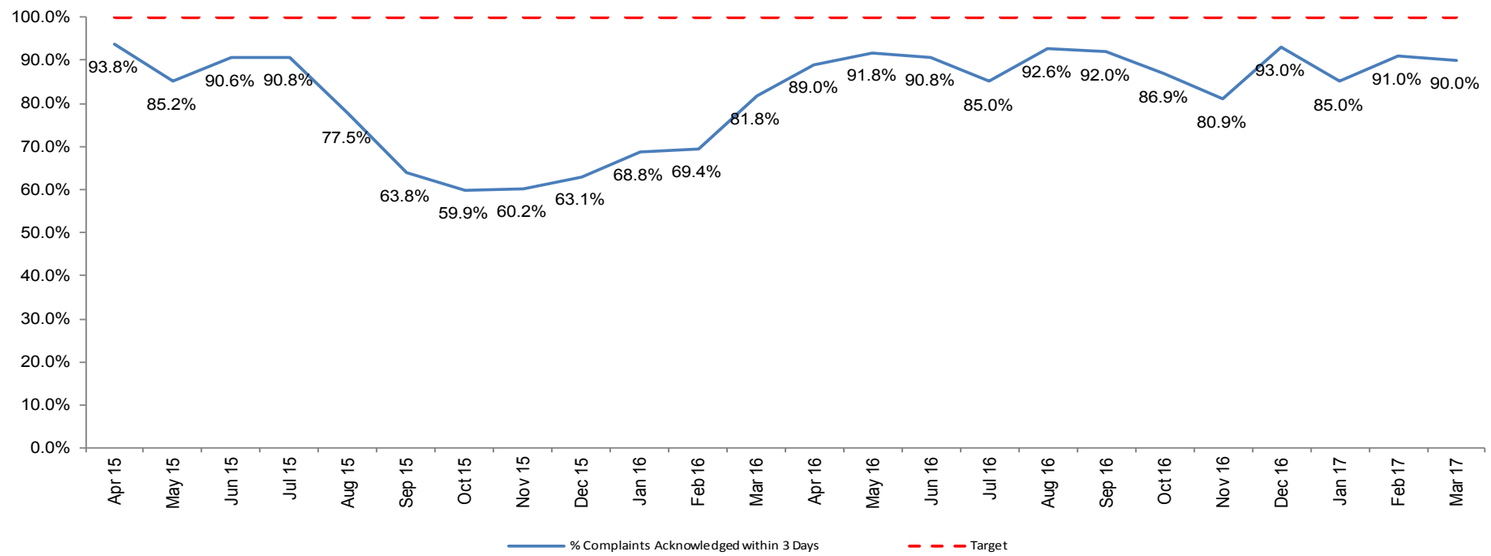


Figure 2: NHS Lothian 20-Day Complaints Response Rate – Higher % is Better

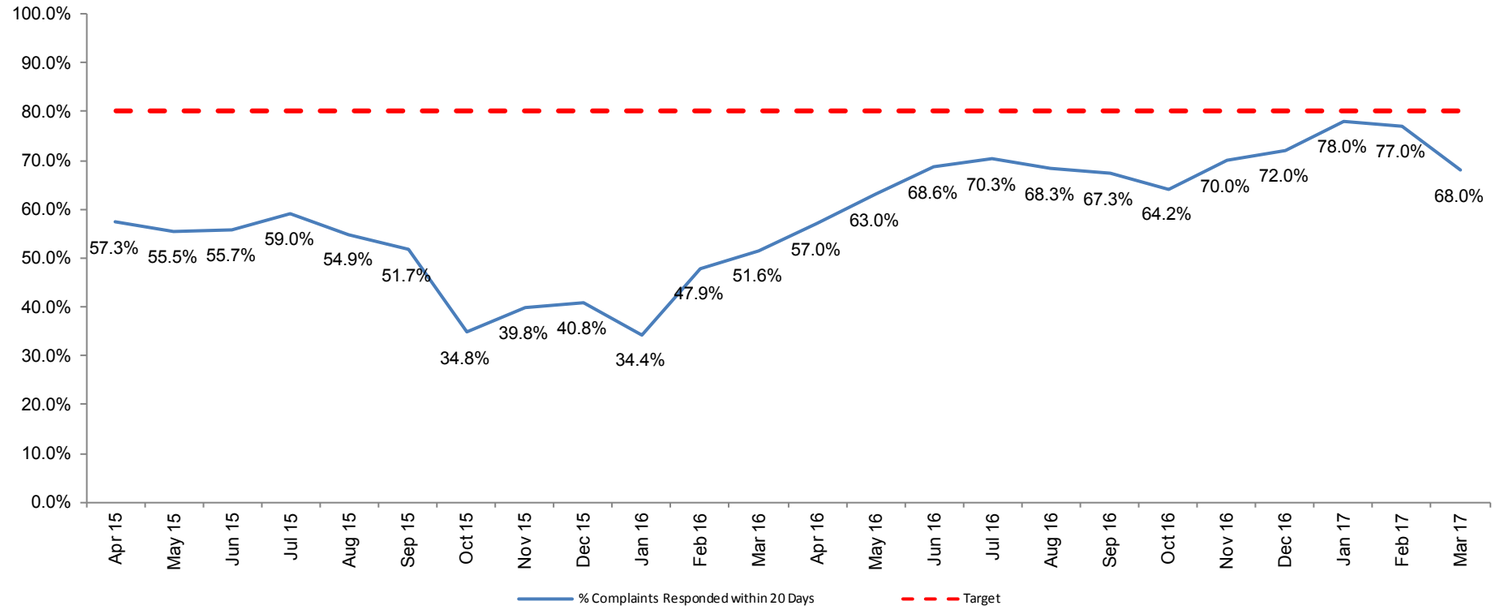


Table 1: % Complaints Acknowledged within 3 Days - Higher % is Better

	2014/15	2015/16
NHS Scotland	94.7%	93.9%
NHS Lothian	88.3%	76.3%

Published figures: source ISD

Table 2: % Complaints Responded within 20 Days - Higher % is Better

	2014/15	2015/16
NHS Scotland	69.9%	68.5%
NHS Lothian	68.7%	51.5%

Published figures: source ISD

Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:-

	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Measure	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 continue to work on improving the 3 day acknowledgement measure. This month sees drop of 1% in performance to 90 % on the previous month. To note, the Patient Experience Team saw a significant increase in the telephone calls into the department at 657 calls in March which is an increase of 19% on February (n= 534).

Work is also continuing in relation to the new Model Complaints Handling Procedure which was implemented on 1 April 2017. We now have the new model in place and the implementation plan is ongoing. This is being undertaken through a project management approach, supported by the Productivity and Efficiency Team.

The test within HMP Addiewell with regards to acknowledgement times continues to show improvements during March. 92% of Addiewell Prisoner Healthcare complaints were acknowledged within 3 days, an increase of 9% on the previous month. Both prison health care teams started to test a new Stage 1 Complaints Form from 1 April 2017 and this is working well.

Meeting with Lothian Medical Committee (LMC), Primary Care Contracts Team and Patient Experience Team and together have agreed a way forward to support the practices with the implementation of the new CHP.

As part of the wider implementation of the new CHP across the organisation a staff survey has been developed to ask clinical teams what support / local structures they will need to have in place to deliver this new CHP. The results will be shared at the Healthcare Governance Committee, Feedback & Improvement Working Group and the Complaints Improvement Project Board.

Detect Cancer Early (DCE)

Healthcare Quality Domain: Person Centred

For reporting at **June 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

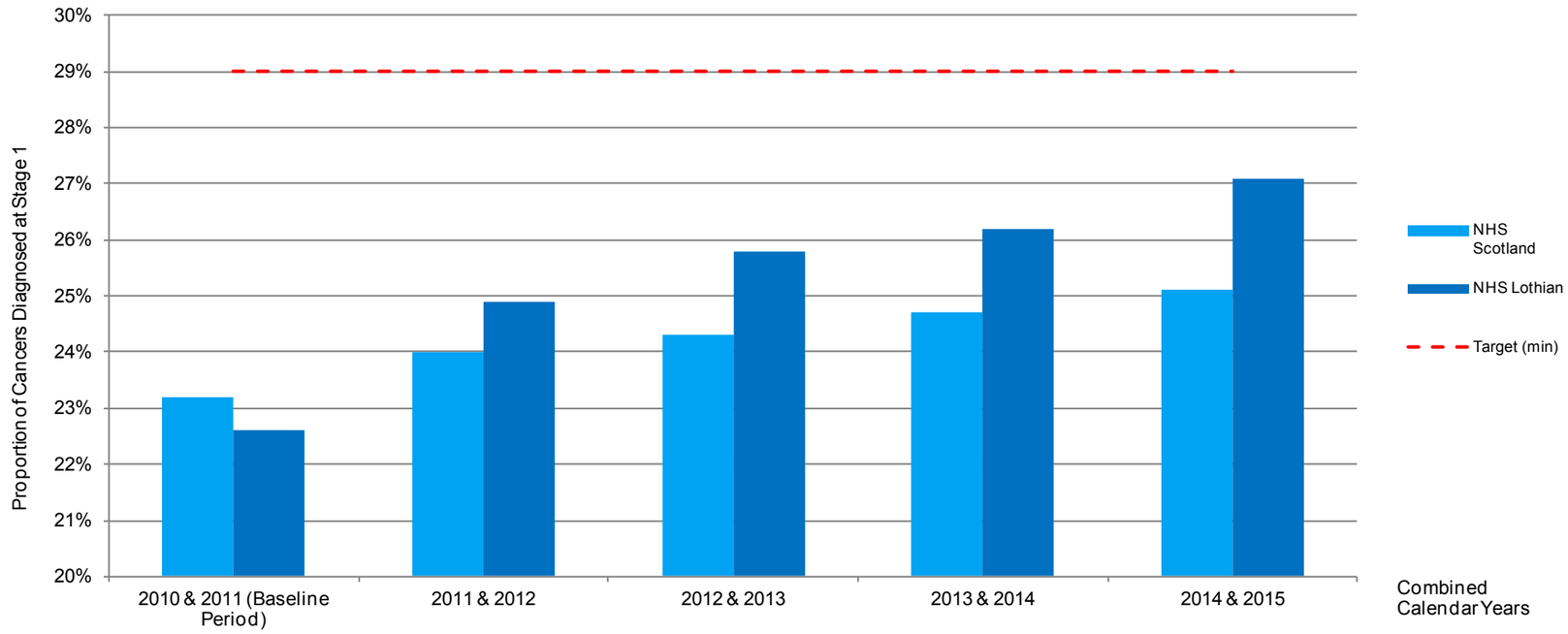
NHS Lothian's performance over time against this target has been consistently above the All Scotland position and has followed a continued upwards trajectory in detection of stage 1 combined cases, as shown in the chart below. NHS Lothian has increased the percentage of breast, colorectal and lung cancers (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



Published: Source ISD Scotland

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%

Published: Source ISD Scotland

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 **June 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[18]	Not Applicable	1. Worse 2. Worse	2014/15	TBC[19]	**1. 25.5%** **2. 64.3%**	2014/15	ISD	Yes	Yes	DS
		East Lothian IJB Performance[20]					**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[1]	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS[2]	Delivered Successfully Against the Standard[3]	% of Standard Achieved
NHS Scotland	16,661	6,660	**40.0%**		6,624	4,807	**72.6%**
NHS Lothian	2,391	609	**25.5%**		603	388	**64.3%**

[18] 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

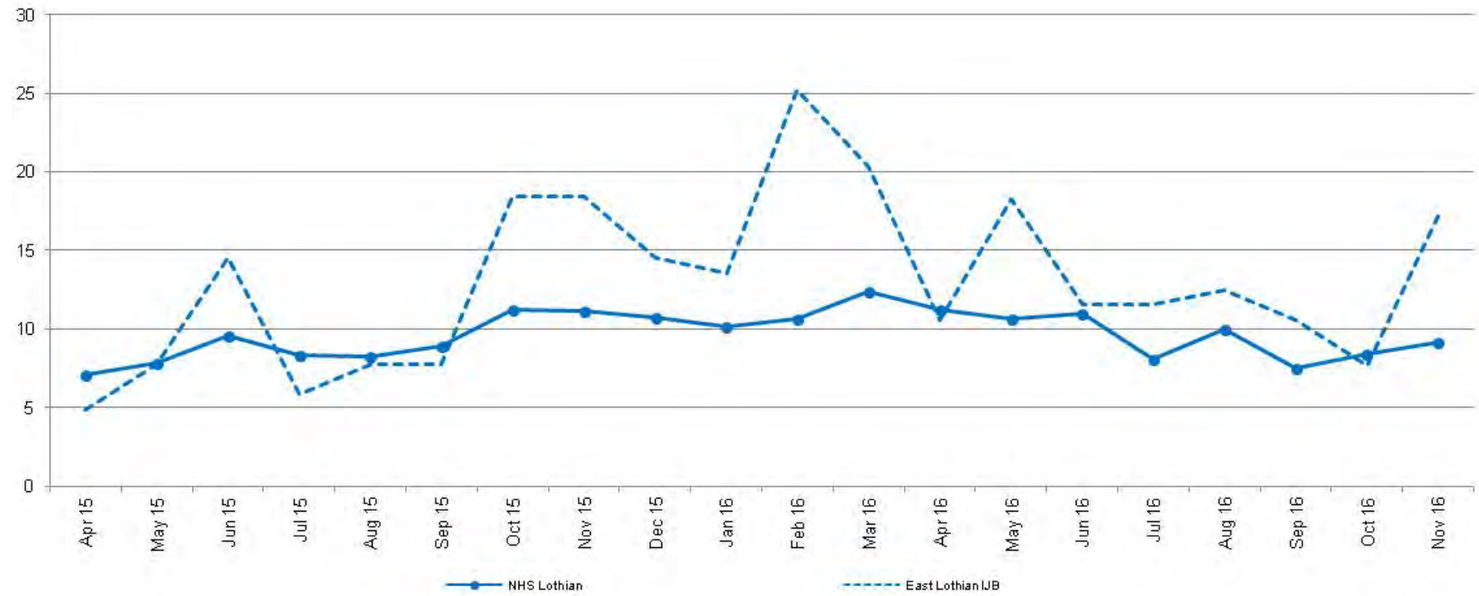
[19] Please see footnote above.

[20] 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.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[21]

	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	**7.1**	**7.9**	**9.6**	**8.3**	**8.2**	**8.9**	**11.2**	**11.1**	**10.8**	**10.2**	**10.6**	**12.4**	**11.2**	**10.6**	**11.0**	**8.1**	**9.9**	**7.5**	**8.4**	**9.1**
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	18.4	14.5	13.6	25.2	20.3	10.6	18.2	11.5	11.5	12.5	10.6	7.7	17.3
Edinburgh IJB	6.0	6.6	7.6	9.5	8.2	7.8	9.5	10.3	10.1	10.7	9.3	10.9	12.9	10.9	10.5	9.0	9.9	7.4	9.0	8.4
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	18.7	17.5	5.8	11.7	16.3	4.6	9.3	11.6	5.8	12.7	6.9	9.3	11.6
West Lothian IJB	6.7	8.4	6.7	3.9	6.7	10.1	9.0	5.6	6.7	9.0	4.5	8.4	9.5	5.6	11.1	4.5	6.7	5.6	6.7	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and East Lothian IJB, for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[22]



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

[21] 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.

[22] Please see footnote above.

Improve recording of diagnosis in TRAK. • 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
Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24th Jan 2017).	July 2016	• 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 24th Jan 2017).	TBC (ISD)	• 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.

East Lothian IJB has agreed to double the capacity for PDS using the Integrated Care Fund and this will take effect from May 2017.
Two Post Diagnostic Support officers have now been appointed and will come into full effect from 1st June 2017

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 **June 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[23]	Not Applicable	3. Worse 4. Worse	2014/15	TBC[24]	**3. 25.5%** **4. 64.3%**	2014/15	ISD	Yes	Yes	RMG
		Edinburgh IJB Performance[25]					**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 standards[26].

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[1]	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS[2]	Delivered Successfully Against the Standard[3]	% of Standard Achieved
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NHS Lothian	2,391	609	**25.5%**		603	388	**64.3%**

[23] 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

[24] Please see footnote above.

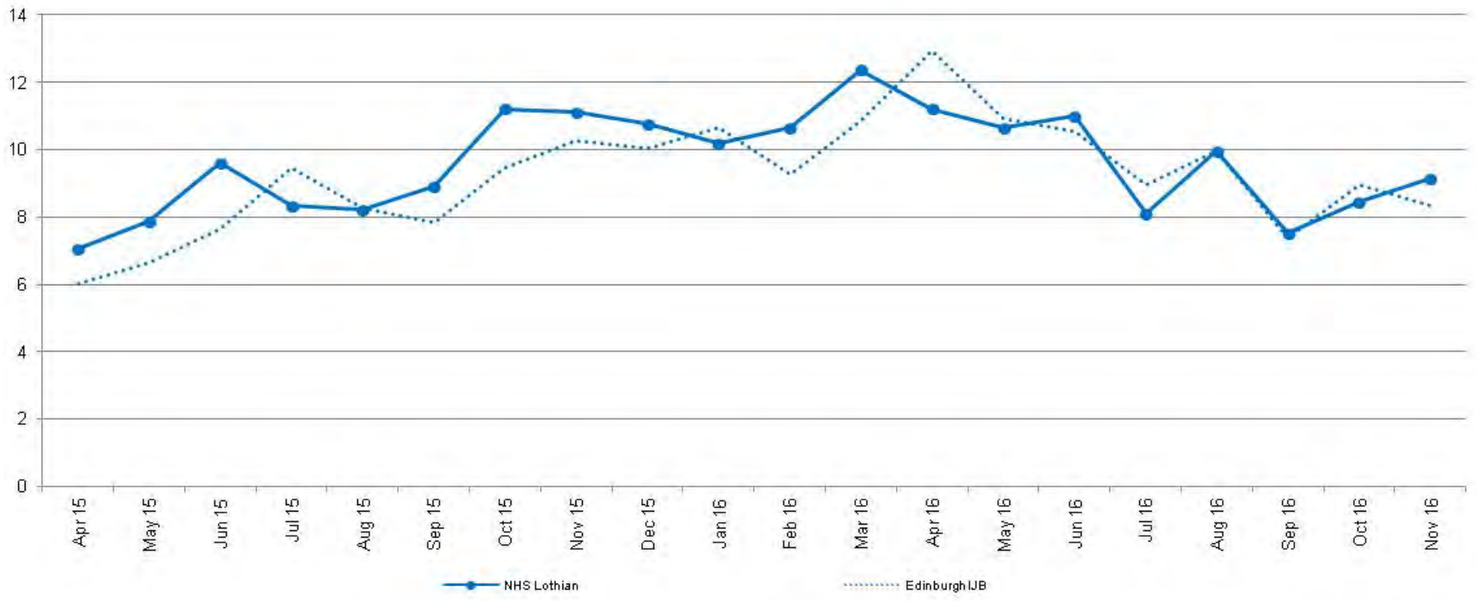
[25] For a case to be counted in an IJB, that case must have a patient postcode of residence within the IJB and have been included in a submission from the Health Board (HB), within whose bounds the IJB resides. E.g. if an NHS Lothian HB submission includes a patient with an Edinburgh postcode, they 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.

[26] Estimated and Projected Diagnosis Rates for Dementia in Scotland:2014 -2020

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[27]

	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	**7.1**	**7.9**	**9.6**	**8.3**	**8.2**	**8.9**	**11.2**	**11.1**	**10.8**	**10.2**	**10.6**	**12.4**	**11.2**	**10.6**	**11.0**	**8.1**	**9.9**	**7.5**	**8.4**	**9.1**
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	18.4	14.5	13.6	25.2	20.3	10.6	18.2	11.5	11.5	12.5	10.6	7.7	17.3
Edinburgh IJB	6.0	6.6	7.6	9.5	8.2	7.8	9.5	10.3	10.1	10.7	9.3	10.9	12.9	10.9	10.5	9.0	9.9	7.4	9.0	8.4
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	18.7	17.5	5.8	11.7	16.3	4.6	9.3	11.6	5.8	12.7	6.9	9.3	11.6
West Lothian IJB	6.7	8.4	6.7	3.9	6.7	10.1	9.0	5.6	6.7	9.0	4.5	8.4	9.5	5.6	11.1	4.5	6.7	5.6	6.7	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and Edinburgh IJB, for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[28]



Timescale for Improvement – Edinburgh Integration 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 Integration 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, fluctuating between 9 and 11 in the last year.	Completed
Improve recording of diagnosis in TRAK. • 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.

[27] 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.

[28] Please see footnote above.

Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24th Jan 2017).	July 2016	• 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 24th Jan 2017).	TBC (ISD)	• Allow more accurate evaluation of performance against the standard at Board and partnership level.		

Comments – Edinburgh Integration Joint Board (IJB)

Edinburgh Health and Social Care Partnership Strategic Plan Action 23A – improving support for people with dementia, identifies dementia post diagnostic support as a key area.

Data collected for ISD utilises the date of the dementia diagnosis as a proxy for the referral date rather than actual date referred for post diagnostic support. This causes the rate of referral data to fluctuate month on month. There is a data lag as the June 2017 report only has figures available up to November 2016.

Post diagnostic support is mainly delivered through current contract with Alzheimer Scotland for the Edinburgh Post Diagnostic Support Service which includes a total of 6 WTE link workers based in the 4 Edinburgh localities. Funded through the Integrated Care Fund until 31 March 2018. 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.

Awaiting further ISD guidance to report on Edinburgh IJB rates and develop reporting on rates within 4 Edinburgh locality areas. 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
Improving recording of diagnosis 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. 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. These factors have impacted on published yearly returns.

Dementia – Midlothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Person Centred

For reporting at **June 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[29]	Not Applicable	5. Worse 6. Worse	2014/15	TBC[30]	**5. 25.5%** **6. 64.3%**	2014/15	ISD	Yes	Yes	EM
		Midlothian IJB Performance[31]					**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[1]	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS[2]	Delivered Successfully Against the Standard[3]	% of Standard Achieved
NHS Scotland	16,661	6,660	**40.0%**		6,624	4,807	**72.6%**
NHS Lothian	2,391	609	**25.5%**		603	388	**64.3%**

[29] 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

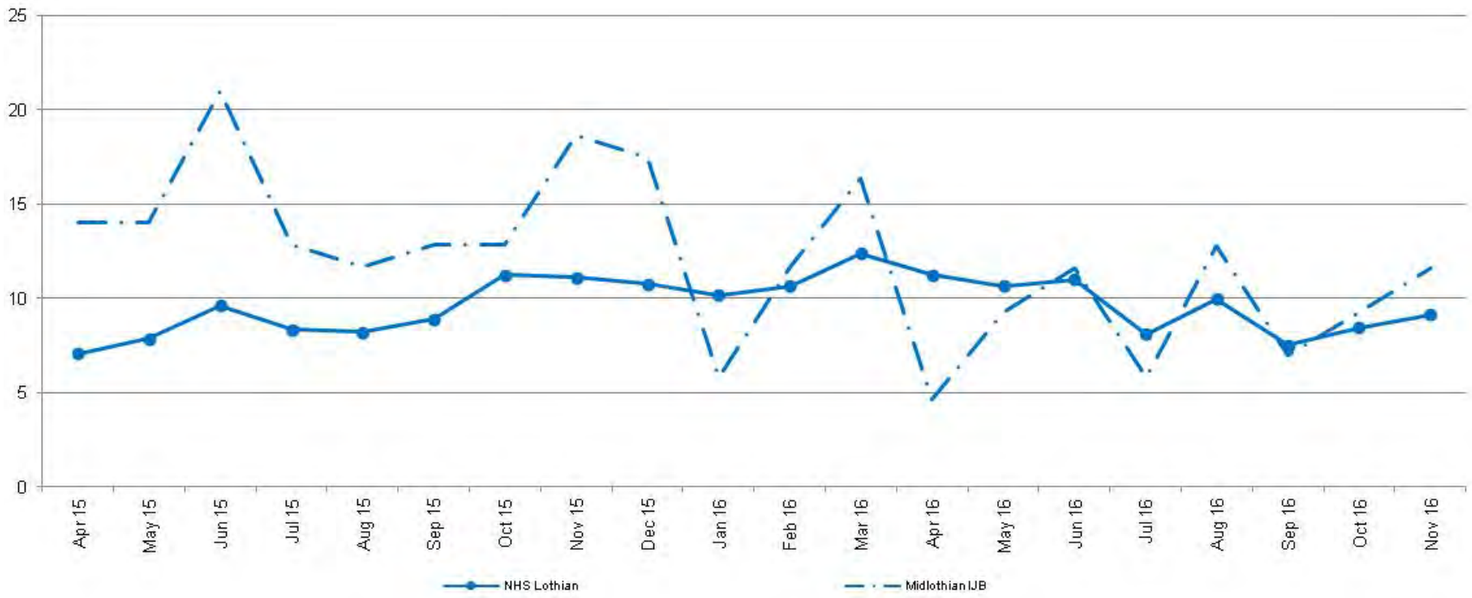
[30] Please see footnote above.

[31] 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.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[32]

	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	**7.1**	**7.9**	**9.6**	**8.3**	**8.2**	**8.9**	**11.2**	**11.1**	**10.8**	**10.2**	**10.6**	**12.4**	**11.2**	**10.6**	**11.0**	**8.1**	**9.9**	**7.5**	**8.4**	**9.1**
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	18.4	14.5	13.6	25.2	20.3	10.6	18.2	11.5	11.5	12.5	10.6	7.7	17.3
Edinburgh IJB	6.0	6.6	7.6	9.5	8.2	7.8	9.5	10.3	10.1	10.7	9.3	10.9	12.9	10.9	10.5	9.0	9.9	7.4	9.0	8.4
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	18.7	17.5	5.8	11.7	16.3	4.6	9.3	11.6	5.8	12.7	6.9	9.3	11.6
West Lothian IJB	6.7	8.4	6.7	3.9	6.7	10.1	9.0	5.6	6.7	9.0	4.5	8.4	9.5	5.6	11.1	4.5	6.7	5.6	6.7	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and Midlothian IJB, for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[33]



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

[32] 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.

[33] Please see footnote above.

Improve recording of diagnosis in TRAK. • 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
Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24th Jan 2017).	July 2016	• 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 24th Jan 2017).	TBC (ISD)	• Allow more accurate evaluation of performance against the standard at Board and partnership level.		

Comments – Midlothian Integrated Joint Board (IJB)

Reasons for Current Performance
The performance in Midlothian has continued to improve and this has been supported by the Dementia Service entering a settled phase in terms of staffing. The recent appointment of 2 psychiatry of old age consultants to replace a recent retirement has ensured the service is now back up medical staffing to support the service.

Dementia – West Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Person Centred

For reporting at **June 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[34]	Not Applicable	7. Worse 8. Worse	2014/15	TBC[35]	**7. 25.5%** **8. 64.3%**	2014/15	ISD	Yes	Yes	JF
		West Lothian IJB Performance[36]					**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[1]	Number of People Referred to a PDS Service	% of New Diagnosed Incidences Referred to PDS	Part 2:-	Total Referred to PDS[2]	Delivered Successfully Against the Standard[3]	% of Standard Achieved
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[34] 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

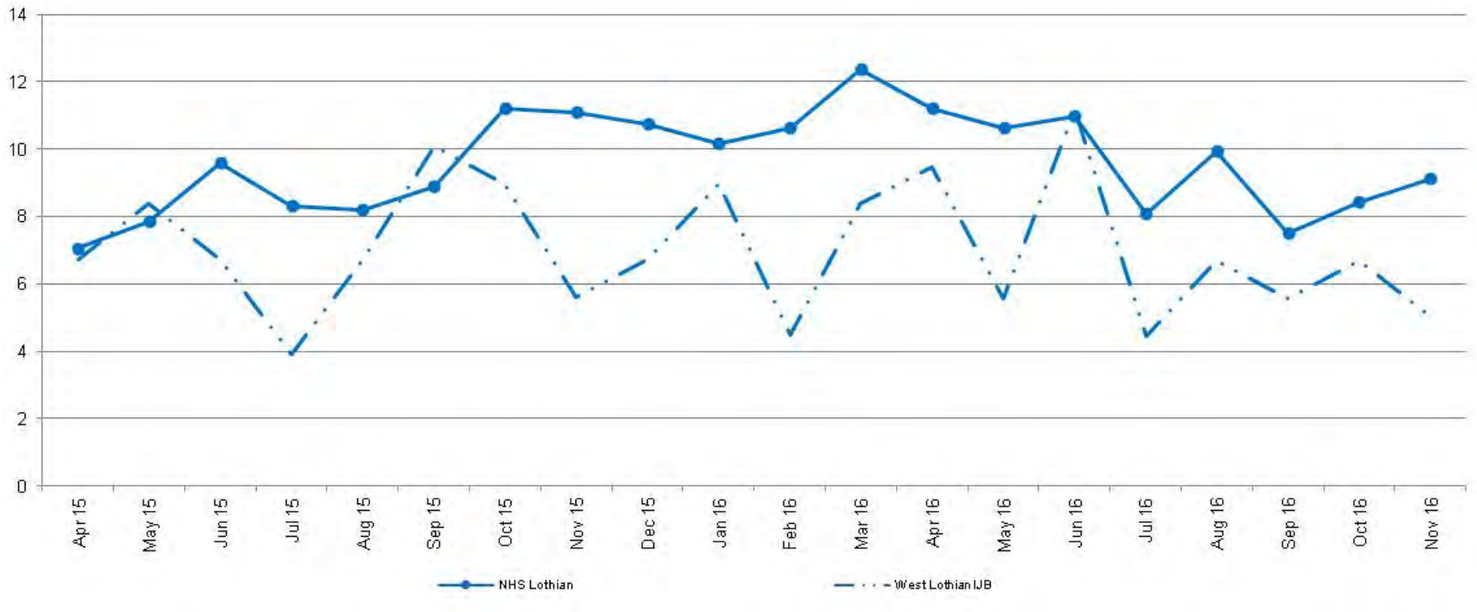
[35] Please see footnote above.

[36] 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.

Table 2: Rate of Referral to PDS in each month for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[37]

	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	**7.1**	**7.9**	**9.6**	**8.3**	**8.2**	**8.9**	**11.2**	**11.1**	**10.8**	**10.2**	**10.6**	**12.4**	**11.2**	**10.6**	**11.0**	**8.1**	**9.9**	**7.5**	**8.4**	**9.1**
East Lothian IJB	4.8	7.7	14.5	5.8	7.7	7.7	18.4	18.4	14.5	13.6	25.2	20.3	10.6	18.2	11.5	11.5	12.5	10.6	7.7	17.3
Edinburgh IJB	6.0	6.6	7.6	9.5	8.2	7.8	9.5	10.3	10.1	10.7	9.3	10.9	12.9	10.9	10.5	9.0	9.9	7.4	9.0	8.4
Midlothian IJB	14.0	14.0	21.0	12.8	11.7	12.8	12.8	18.7	17.5	5.8	11.7	16.3	4.6	9.3	11.6	5.8	12.7	6.9	9.3	11.6
West Lothian IJB	6.7	8.4	6.7	3.9	6.7	10.1	9.0	5.6	6.7	9.0	4.5	8.4	9.5	5.6	11.1	4.5	6.7	5.6	6.7	5.0

Figure 1: Rates of Referral to PDS in each month for NHS Lothian and West Lothian IJB, for those Diagnosed with Dementia - Source: ISD **– Higher Rate is Better**[38]



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. West Lothian has recently decided to invest in PDS and enhance its provision. This is being undertaken in an attempt to meet increasing demand.	Completed

[37] 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.

[38] Please see footnote above.

Improve recording of diagnosis in TRAK. • 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
Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area. (This was published on 24th Jan 2017).	July 2016	• 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 24th Jan 2017).	TBC (ISD)	• 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 – has looked 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 has concluded and will result in an increase in resourcing. Much of that resourcing will focus on ensuring that waiting times are reduced and not re-established.

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 **June 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:-

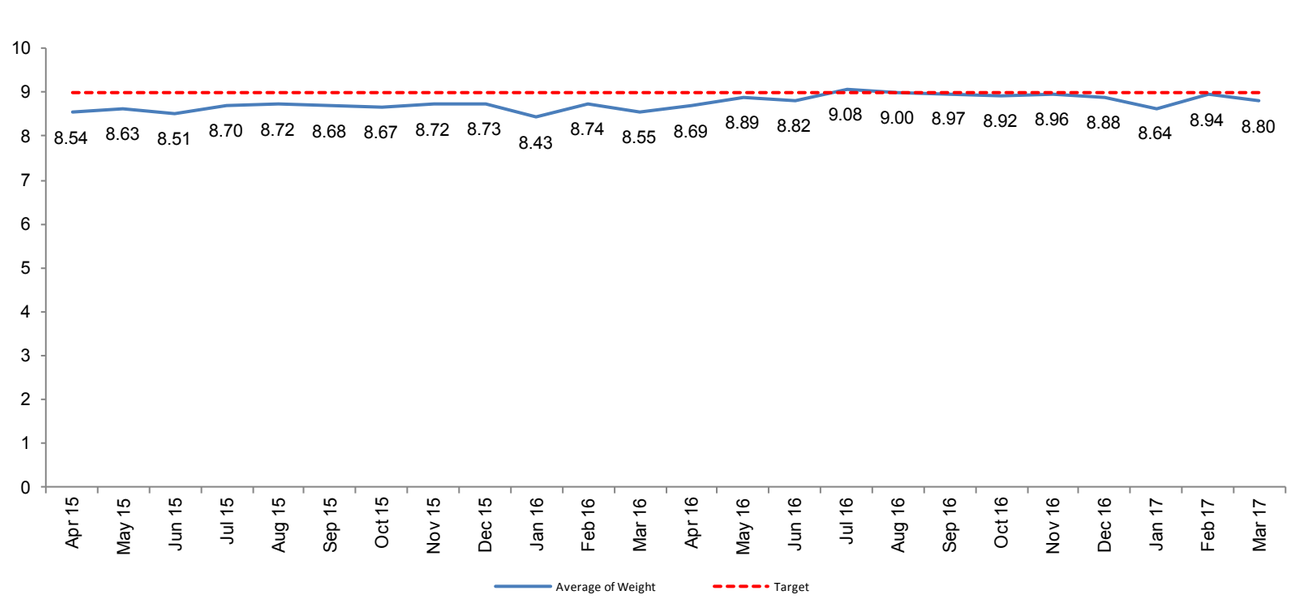
Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard	Trend	Published NHS Lothian vs. Scotland	Date of Published NHS Lothian vs. Scotland	Target/Standard	Latest Performance	Reporting Date	Data Source	Data Updated since Last Month?	Narrative Updated since Last Month?	Lead Director
Limited	Nov 16	Not Met	Improving	Not Applicable	Not Applicable	9.0/10 (min)	8.80	Mar 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. All data (currently in draft format) for In-patient TTT can be accessed successfully on Tableau. Refreshed weekly.	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 16th 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.	Although this has been met it is a continuous process.	Met

		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.		
Discussions with Senior Charge Nurses / Clinical Nurse Managers to highlight return rates and consider local actions to improve responses.	June 2016	To share best practice and carry out quality improvement actions to enhance patient experience.	Improvements within patient experience and examples include improving noise at night.	Met
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
Supplies of TTT questionnaires across all areas	June 2017	Seeking approved suppliers through procurement and reviewing volumes required Impact regards increase in Care Assurance Standards across all the hospital sites who will not be doing TTT >12 wards in the next three months	Review and option for cost effective alternative	
Continued support for increase response rate raised via the Nurse Director's group	12.04.17	Increase response rate		

Comments

Patient Experience Team continue to work alongside IT analytical services to provide a seamless, robust data reporting mechanism via Tableau dashboard, accessible from 22 May 2017.
A&E remain low and we are working with the relevant senior managers and senior charge nurses to see how we can improve return rates.
TTT Template for Royal Hospital for Sick Children is now completed and will be supported via the Patient Experience Team.
To further raise awareness a short presentation detailing TTT and valuing patient feedback has been developed for Training and Corporate Induction.

Recognising that TTT is just once source of feedback, it has been discussed and agreed that the Healthcare Governance paper will also report on the feedback via Care Opinion (previously Patient Opinion), Care Assurance Standards and there are other local examples of feedback that the clinical teams undertake independently that have not previously been reported. As of May 2017. the team at the Royal Infirmary of Edinburgh have agreed to respond to all Care Opinion posts that relate to this site.

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
14th Jun 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 31 st March 2009.
Surveillance Endoscopy (past due date)	No patient should wait past their planned review date for a surveillance endoscopy.
IVF (12 months)	The Scottish Government have set a target that at least 90% of eligible patients will commence IVF treatment within 12 months. This is due for delivery by 31 March 2015.
Drug & Alcohol Waiting Times (3 weeks)	The Scottish Government set a target that by June 2013, 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. This was one of the national HEAT (Health improvement, Efficiency, Access, Treatment) targets, number A11. This target was achieved in June 2013 and has now become a Local Delivery Plan (LDP) standard - that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%).
Detecting Cancer Early (% diagnosed)	The DCE HEAT standard is for NHS Scotland to achieve a 25% improvement in the percentage of breast, colorectal and lung cancer cases (combined) diagnosed at stage 1. This is to be achieved by the combined calendar years of 2014/2015 and is the equivalent of a national rate of stage 1 diagnosis for breast, colorectal and lung cancer (combined) of 29.0%.
Staff Sickness Absence Levels (<=4%)	4% Staff Hours or Less Lost to Sickness
Cardiac Arrest	50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2015 from February 2013 (1.9 per 1,000), baseline.
Falls with Harm	"Harm" is 'Moderate, Major Harm or Death'. Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level. 20% reduction in inpatient falls and associated harm, on a baseline median of 30 per month, by March 2016.
Hospital Standardised Mortality Ratios (HSMR)	HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.
48 Hour GP Access - access to healthcare profession; or GP appointment.	48 hour access or advance booking to an appropriate member of the GP team (90%) - Patients can speak with a doctor or nurse within 2 working days; or Patients are able to book an appointment 3 or more working days in advance.
Alcohol Brief Interventions (ABIs)	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.
Hospital Scorecard - Standardised Surgical Readmission rate within 7 days	This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Surgical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Standardised Medical Readmission rate within 7 days	This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Medical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Average Surgical Length of Stay - Adjusted	Ratio of 'observed' length of stay over 'expected' length of stay. This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).
Hospital Scorecard - Average Medical Length of Stay - Adjusted	Ratio of observed length of stay over expected length of stay. This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).
Complaints (3-Day; & 20-Day)	3-Day Response [Acknowledgement] Rate – 100% formal acknowledgement within 3 working days; & 1. 20-Day Response Rate – 85% of complaints responded to within 3 days.
Dementia	1. To deliver expected rates of dementia diagnosis; 2. All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.

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

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

NHS LOTHIAN

Board Meeting
21 June 2017

2.4

Director of Finance

2017/18 FINANCIAL PERFORMANCE – 31ST MAY 2017

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an overview of the financial position at period 2 based on the latest financial information.

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

2 Recommendations

2.1 Members of the Board are asked to:

- **Consider** the financial position as at May 2017 which reports a deficit of £4.8m, after phasing in two months of the £10m reserves identified in the Financial Plan;
- **Note** that the reported overspend is slightly lower than the financial plan trajectory but this is not consistent across the Business Units. Despite this relative improvement against an imbalanced plan, the overspend position is significant and gives cause for concern.

3 Discussion of Key Issues

2017/18 NHS Lothian Financial Plan

3.1 The 17/18 LDP that was submitted to the Scottish Government at the end of March and the subsequent Financial Plan to the Board in April showed an outstanding £22.4m gap to be closed in order to achieve breakeven by the end of the year.

3.2 A total overspend of £4.8m has been reported in the first two months of the year. Financial performance in period 2 has seen a deterioration compared with April; however the first two months in the financial year can produce a degree of variation between months.

3.3 Comparing the month 2 position to the expected outturn per the Financial Plan, the overspend position is £457k lower than anticipated (based on a pro rata share of the financial plan overspend, adjusted for timing of efficiency savings). However this is not consistent across all the individual business units. Table 1 gives a summary comparison at month 2 compared to the Financial Plan and 16/17 outturn position by business unit, with more detail provided in Appendix 3.

3.4 Work is ongoing to understand variation from this trajectory; early indications are that within UHSS there may be waiting times costs which could be set against additional funding once this is allocated by the Scottish Government (this funding has yet to be received). Within the Edinburgh Partnership a review of the available resources is currently being undertaken to support achievement of financial balance.

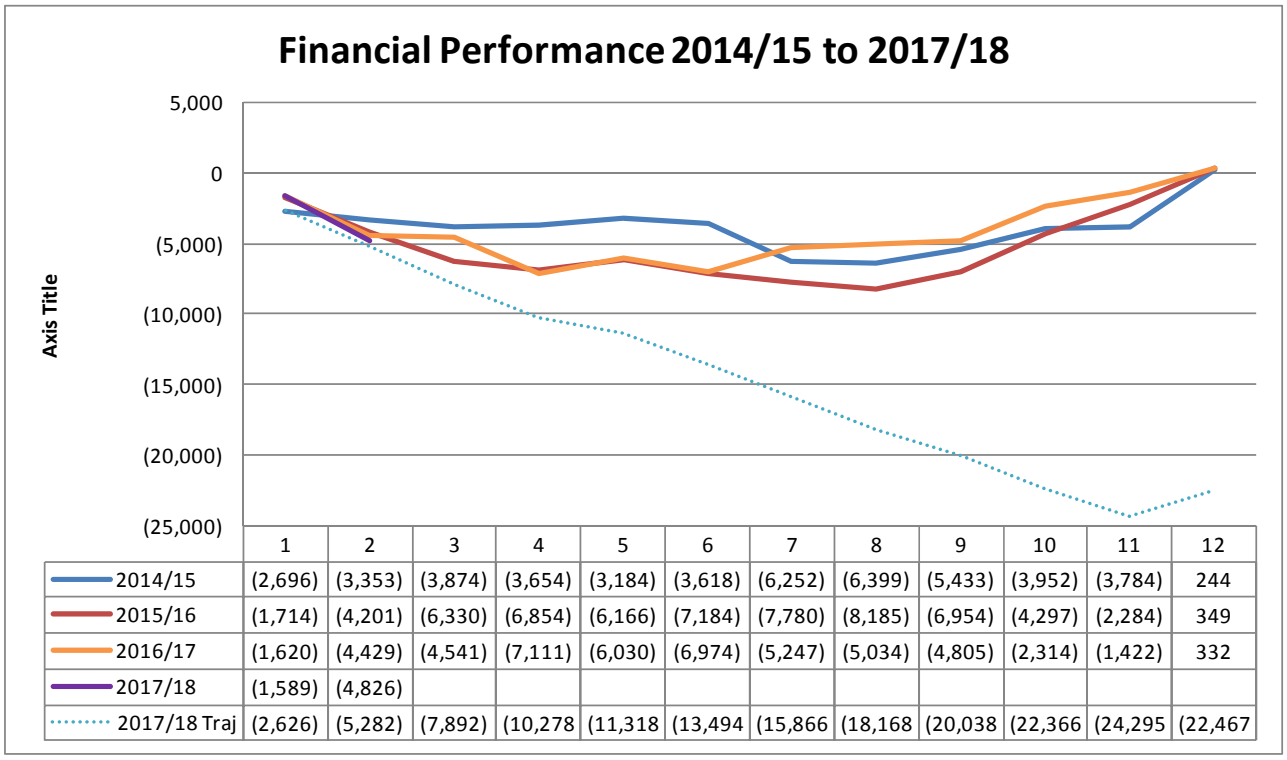
3.5 The Quarter 1 review will present the first key opportunity of 2017/18 to review the detail of the financial position across NHS Lothian, and the options available to meet the statutory target of breakeven. Meetings are now scheduled and a formal update on the revised forecast and any other supporting actions for cost reduction will be presented to the Finance and Resources Committee at its meeting of the 20th September.

Table 1: Comparison to Financial Plan

Business Unit	16/17 Year End Outturn £'000	17/18 Financial Plan £'000	Expected YTD M2 Outturn £'000	M2 YTD Outturn £'000	M2 YTD Comparison £'000
UHSS	(9,312)	(17,044)	(3,117)	(2,889)	228
REAS	(1,155)	(811)	(157)	(286)	(129)
East Lothian Partnership	(1,759)	49	8	(252)	(260)
Edinburgh Partnership	(1,660)	(4,019)	(670)	(1,472)	(802)
Midlothian Partnership	(867)	164	27	(131)	(159)
West Lothian Hsc Partnership	(917)	(721)	(157)	45	201
Facilities And Consort	239	1,036	(1,033)	(397)	637
Corporate Departments	1,520	(1,759)	(311)	102	413
Strategic Services	9,373	643	107	(180)	(287)
Inc + Assoc Hlthcare Purchases	(5,196)	(6,055)	(1,009)	(816)	193
Research & Teaching	(1,639)	(1,307)	(218)	(218)	0
Reserves	11,704	7,357	1,246	1,667	421
Total	332	(22,467)	(5,282)	(4,826)	457

3.6 Whilst the table above shows an improved position on Plan, the requirement for NHS Lothian to deliver against its statutory breakeven target remains, and in this context the overspend to date gives significant cause for concern.

3.7 The chart below compares the cumulative run rate to previous years and also shows the forecast trajectory for 17/18. The total overspend position to P2 shows a slight deterioration in 2017/18 compared to other years but slightly better than forecast based on the trajectory.



	1	2	3	4	5	6	7	8	9	10	11	12
2014/15	(2,696)	(3,353)	(3,874)	(3,654)	(3,184)	(3,618)	(6,252)	(6,399)	(5,433)	(3,952)	(3,784)	244
2015/16	(1,714)	(4,201)	(6,330)	(6,854)	(6,166)	(7,184)	(7,780)	(8,185)	(6,954)	(4,297)	(2,284)	349
2016/17	(1,620)	(4,429)	(4,541)	(7,111)	(6,030)	(6,974)	(5,247)	(5,034)	(4,805)	(2,314)	(1,422)	332
2017/18	(1,589)	(4,826)										
2017/18 Traj	(2,626)	(5,282)	(7,892)	(10,278	(11,318	(13,494	(15,866	(18,168	(20,038	(22,366	(24,295	(22,467

Financial Position as at May 2017

3.8 In period 2, NHS Lothian overspent by £3,237k, bringing the year to date position to £4,826k overspend against the Revenue Resource Limit. A summary of the position is shown in Table 2 below and in more detail in Appendix 1 and by operational unit in Appendix 2.

Table 2: Financial Position to 31st May 2017

	Mth 1	Mth 2	YTD
	£000	£000	£000
Pay	(1,889)	(1,685)	(3,574)
Non Pay	1,289	(2,126)	(837)
GP Prescribing	(339)	(419)	(758)
Income	(289)	69	(220)
Legacy Efficiency Target	(361)	(743)	(1,104)
Total	**(1,589)**	**(4,904)**	**(6,493)**
Reserves Flexibility	0	1,667	1,667
Total	**(1,589)**	**(3,237)**	**(4,826)**

3.9 Pay expenditure is the most significant driver of the position to date, with Nursing and Medical staffing representing the main elements of the year to date overspend.

3.10 Junior Medical costs continue to be one of the main areas of overspend for the organisation with a variance of £1.3m reported after 2 months. Other medical pressures relate to ongoing locum and agency usage particularly in Ophthalmology and LUCS along with continued financial pressure relating to medical staffing for Eskbridge S2C Practice in East Lothian. In addition, as part of the paediatric review additional medical posts were established and these continue to be a financial pressure to the service.

3.11 Nursing staffing is another of the main drivers of the pay overspend to date. The average cost of Nursing has increased by 2.2% from last year, greater than the anticipated 1.5% to cover pay uplift and apprenticeship levy, which is an additional cost for all staff groups. The main areas of Nursing overspend are reported in St John's Hospital where agency usage remains high. In addition the Western General Hospital has overspent across specialities but in particular Cancer and GI are reporting the largest pressures. Edinburgh Partnership Older Peoples Services also continue to report a nursing overspend but with some improvement on last year.

3.12 GP Prescribing is reporting an overspend of £834k for the year to date. As there is no updated volume or price information available at present for 2017/18, the variance reported to date reflects 2 months worth of the £5m financial plan pressure, offset by some other prescribing benefits. This position will be reviewed for period 3 once information on this financial year becomes available.

3.13 Cumulatively, non pay shows an overspend of £1.1m legacy savings target being phased in monthly. This is an ongoing issue for a number of Business Units that have been unable to resolve this last year. Other main areas of non pay pressure relate to Patient Service Agreements (£612k), Drugs (£235k), and Equipment costs (£232k). Expenditure on drugs and medical supplies in particular are significantly higher in month 2 than the level reported in month 1 (Drugs higher by £1.2m and Medical Supplies higher by £1.7m). This increase is being investigated to establish if this is a spike or a trend which would then have a significant impact on forecast positions, in particular on drugs expenditure. A fuller review of the implications from this will feature as part of the detailed Quarter 1 review.

Efficiency & Productivity

3.14 The financial plan presented recovery actions totalling £25.5m of which £2.2m was anticipated to be delivered in the first 2 months. Actual delivery reported to date is £500k. Table 3 below shows this position by Business Unit and presents those areas that are behind the projected savings trajectory. It should be noted that savings from Prescribing are not shown as delivered at this stage across Partnerships and will be a key reason for the apparent shortfall in these areas. Details on delivery are reliant on receiving data for this year.

3.15 Given the levels of efficiency recorded so far, the Quarter 1 review will require all Business Units to review year end projections for recovery actions, and to set out additional plans in support of achieving breakeven, and closing the remaining gap of £22.4m.

Table 3: Financial Recovery Plan Delivery

	17/18 Planned Savings £000's	YTD Planned £000's	YTD Achieved £000's	Shortfall in Delivery £000's
University Hosp Support Services	8,930	1,212	161	(1,051)
East Lothian Partnership	1,140	131	100	(31)
Edinburgh Partnership	3,105	284	0	(284)
Midlothian Partnership	1,100	79	0	(79)
West Lothian Hsc Partnership	2,621	288	105	(183)
Reas	130	0	0	0
Facilities & Consort	7,235	0	69	69
Corporate Services	1,546	260	66	(195)
Total	**25,807**	**2,254**	**500**	**(1,754)**

4 Key Risks

4.1 Non delivery of recovery actions by individual Business Units to the value required identified in the financial plan is one of the main risks continuing to face the organisation. This risk reduces however as progress is made towards the year end.

5 Risk Register

5.1 There is nothing further to add to the Risk Register at this stage, although this will be reassessed following the Quarter 1 review.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 The implementation of the financial plan and the delivery of a breakeven outturn may require service changes. As this particular paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

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Director of Finance
13th June 2017
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List of Appendices

Appendix 1 - NHS Lothian Income & Expenditure Summary 31st May 2017
Appendix 2 – NHS Lothian Summary by Operational Unit to 31st May 2017
Appendix 3 - Comparison of Financial Plan to Month 2 Position

Appendix 1

NHS Lothian Income & Expenditure Summary to May 2017

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	243,328	41,623	42,769	(1,146)	(386)
Nursing	385,597	64,961	66,590	(1,629)	(932)
Administrative Services	92,072	15,168	15,267	(98)	(1)
Allied Health Professionals	61,310	10,329	10,646	(318)	(122)
Health Science Services	36,139	6,181	5,998	183	79
Management	8,749	1,492	1,349	143	85
Support Services	59,046	9,572	10,007	(435)	(257)
Medical & Dental Support	11,535	1,922	1,975	(53)	(25)
Other Therapeutic	25,571	4,658	4,682	(24)	(9)
Personal & Social Care	3,022	511	537	(26)	(5)
Other Pay	(3,775)	(36)	135	(171)	(113)
Pay	**922,593**	**156,382**	**159,956**	**(3,574)**	**(1,685)**
Drugs	119,254	19,946	20,181	(235)	(275)
Medical Supplies	84,529	14,389	14,393	(4)	(565)
Maintenance Costs	5,284	729	827	(97)	(77)
Property Costs	39,338	6,622	6,101	521	356
Equipment Costs	26,344	4,096	4,329	(232)	(375)
Transport Costs	8,742	1,521	1,562	(41)	(138)
Administration Costs	123,469	14,374	14,479	(105)	(192)
Ancillary Costs	11,392	1,921	1,822	99	(2)
Other	24,501	(2,073)	(2,111)	37	36
Service Agreement Patient Serv	95,375	17,876	18,488	(612)	(656)
Savings Target Non-pay	(7,343)	(1,104)	0	(1,104)	(743)
Non-pay	**530,883**	**78,297**	**80,071**	**(1,774)**	**(2,632)**
Gms2 Expenditure	120,500	17,572	17,739	(167)	(236)
Other Primary Care Expenditure	87	15	17	(3)	(1)
Pharmaceuticals	156,149	25,933	26,691	(758)	(419)
Primary Care	**276,739**	**43,520**	**44,447**	**(927)**	**(656)**
Other	**(1,338)**	**(218)**	**(220)**	**2**	**(1)**
Income	**(1,766,411)**	**(45,080)**	**(44,860)**	**(220)**	**69**
CORE POSITION	**(37,534)**	**232,901**	**239,394**	**(6,493)**	**(4,904)**
Additional Reserves Flexibility	1,667	1,667	0	1,667	1,667
TOTAL	**(37,534)**	**234,568**	**239,394**	**(4,826)**	**(3,237)**

NB. The above table relates to Core Services only. There is £37.534 m of Non Core Budget not shown above that balances the annual budget to zero.

Appendix 2
NHS Lothian Summary by Operational Unit to May 2017

Description	University Hosp Support Serv (£k)	Reas (£k)	East Lothian Partnership (£k)	Edinburgh Partnership (£k)	Midlothian Partnership (£k)	West Lothian Hsc Partnership (£k)	Facilities And Consort (£k)	Corporate Services (£k)	Strategic Services (£k)	Inc + Assoc Hlthcare Purchases (£k)	Reserves (£k)	Research + Teaching (£k)	Total (£k)
Annual Budget	**672,365**	**76,939**	**85,063**	**290,692**	**61,519**	**140,148**	**147,643**	**95,328**	**27,369**	**(1,640,241)**	**15,426**	**(9,787)**	**(37,534)**
Medical & Dental	(959)	17	(209)	7	9	69	(0)	(15)	(9)	0	0	(55)	**(1,146)**
Nursing	(814)	(125)	(124)	(351)	(53)	(86)	(6)	(23)	(58)	0	0	10	**(1,629)**
Administrative Services	67	(25)	12	(59)	(9)	27	(32)	(85)	(7)	0	0	13	**(98)**
Allied Health Professionals	(213)	(57)	0	(67)	(6)	36	(4)	(3)	(1)	0	0	(2)	**(318)**
Health Science Services	92	(1)	2	70	0	1	0	5	17	0	0	(3)	**183**
Management	(19)	0	13	61	0	1	13	85	(11)	0	0	(1)	**143**
Support Services	(45)	32	(13)	7	(0)	(9)	(346)	(18)	(36)	0	0	(8)	**(435)**
Medical & Dental Support	(85)	0	0	0	0	42	0	(9)	0	0	0	0	**(53)**
Other Therapeutic	11	(24)	22	(19)	0	27	0	(28)	0	0	0	(13)	**(24)**
Personal & Social Care	(14)	(28)	5	(5)	(5)	0	(0)	28	0	0	0	(6)	**(26)**
Other Pay	(21)	(2)	(15)	(10)	(4)	0	(17)	(103)	0	(0)	0	0	**(171)**
Pay	**(2,001)**	**(213)**	**(307)**	**(367)**	**(67)**	**108**	**(391)**	**(166)**	**(105)**	**(0)**	**0**	**(65)**	**(3,574)**
Drugs	(212)	(8)	(12)	(5)	(4)	8	(1)	13	(14)	0	0	(1)	**(235)**
Medical Supplies	297	(6)	(44)	(225)	(11)	(15)	(12)	15	(0)	0	0	(4)	**(4)**
Maintenance Costs	(59)	(53)	(2)	(5)	6	(25)	46	(6)	(0)	0	0	(0)	**(97)**
Property Costs	(5)	(0)	(51)	16	(10)	34	536	1	(0)	0	0	(0)	**521**
Equipment Costs	(225)	7	(11)	(2)	(10)	3	22	(35)	19	0	0	(1)	**(232)**
Transport Costs	(30)	1	(5)	57	13	13	(69)	(12)	(5)	(2)	0	(2)	**(41)**
Administration Costs	55	8	177	(90)	(22)	156	(499)	107	(149)	(0)	0	(15)	**(270)**
Ancillary Costs	33	(4)	(4)	(18)	(5)	3	101	(7)	(0)	0	0	(0)	**99**
Other	8	1	81	(209)	0	(22)	62	117	0	0	0	0	**37**
Service Agreement Patient Serv	(6)	55	(54)	33	1	77	(182)	(0)	72	(331)	0	(112)	**(447)**
Savings Target Non-pay	(722)	(31)	2	(312)	0	(1)	0	(41)	(0)	0	0	0	**(1,104)**
Non-pay	**(866)**	**(29)**	**79**	**(759)**	**(41)**	**232**	**2**	**154**	**(77)**	**(333)**	**0**	**(135)**	**(1,774)**
Gms2 Expenditure	(1)	(3)	(41)	31	17	(169)	0	(0)	0	0	0	0	**(167)**
Other Primary Care Expenditure	(3)	0	0	0	0	0	0	0	0	0	0	0	**(3)**
Pharmaceuticals	0	(43)	29	(438)	(66)	(240)	0	0	0	0	0	0	**(758)**
Primary Care	**(3)**	**(46)**	**(12)**	**(407)**	**(49)**	**(409)**	**0**	**(0)**	**0**	**0**	**0**	**0**	**(927)**
Other	**0**	**0**	**0**	**(3)**	**0**	**1**	**(0)**	**4**	**0**	**0**	**0**	**0**	**2**
Income	**(19)**	**3**	**(12)**	**64**	**27**	**113**	**(7)**	**111**	**2**	**(483)**	**0**	**(17)**	**(220)**
CORE POSITION	**(2,889)**	**(286)**	**(252)**	**(1,472)**	**(131)**	**45**	**(397)**	**102**	**(180)**	**(816)**	**0**	**(218)**	**(6,493)**
Additional Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	1,667	0	**1,667**
TOTAL	**(2,889)**	**(286)**	**(252)**	**(1,472)**	**(131)**	**45**	**(397)**	**102**	**(180)**	**(816)**	**1,667**	**(218)**	**(4,826)**

NB. The above table relates to Core Services only. There is £37.534 m of Non Core Budget not shown above that balances the annual budget to zero

Appendix 3

Comparison of Financial Plan to Month 2 Position

Business Unit	16/17 Year End Outturn £'000	17/18 Financial Plan £'000	Expected YTD M2 Outturn £'000	M2 YTD Outturn £'000	M2 YTD Comparison £'000
Acute Divisional Management	(4,898)	(3,752)	(842)	(1,157)	(315)
Diagnostics, A+T, Crit Care	(4,330)	(5,140)	(857)	(773)	84
Luhs Ahp Services	(222)	(326)	(54)	(33)	22
Outpatients And Assoc Services	(49)	(1,131)	(189)	73	261
Royal Infirmary Edinburgh Site	(228)	(2,961)	(518)	(0)	518
St Johns Hospital Site	(2,004)	(2,357)	(394)	(519)	(125)
Western General Hospital Site	1,520	262	44	(265)	(308)
Women + Children Services	900	(1,638)	(306)	(215)	91
UHSS Total	**(9,312)**	**(17,044)**	**(3,117)**	**(2,889)**	**228**
East Lothian Partnership Total	**(1,759)**	**49**	**8**	**(252)**	**(260)**
Edinburgh Partnership Total	**(1,660)**	**(4,019)**	**(670)**	**(1,472)**	**(802)**
Midlothian Partnership Total	**(867)**	**164**	**27**	**(131)**	**(159)**
West Lothian Hsc Partnership Total	**(917)**	**(721)**	**(157)**	**45**	**201**
REAS Total	**(1,155)**	**(811)**	**(157)**	**(286)**	**(129)**
Facilities Management	1,309	3,760	(510)	17	526
Facilities Pfi Contract	(1,070)	(2,724)	(524)	(413)	110
Facilities And Consort Total	**239**	**1,036**	**(1,033)**	**(397)**	**637**
Chief Executive Management Cst	(15)	20	3	7	4
Chief Quality Officer Dept	36	(457)	(76)	(12)	64
Ehealth	(696)	(670)	(87)	(211)	(124)
Finance	447	226	44	6	(39)
Human Resources	289	(414)	(69)	90	159
Medical Directors Office	296	(23)	(4)	24	28
Nursing	96	(77)	(46)	130	176
Pharmacy	802	38	6	27	20
Planning	187	(185)	(31)	46	77
Public Health	78	(217)	(52)	(4)	48
Corporate Departments Total	**1,520**	**(1,759)**	**(311)**	**102**	**413**
Finance General	(180)	(261)	(44)	1	44
Programmes	30	(1,512)	(252)	82	334
Property & Asset Management	8,808	4,433	739	1	(738)
Provisions & Claims	715	(2,017)	(336)	(264)	72
Strategic Services Total	**9,373**	**643**	**107**	**(180)**	**(287)**
Inc + Assoc Hlthcare Purchases	**(5,196)**	**(6,055)**	**(1,009)**	**(816)**	**193**
Research & Teaching	**(1,639)**	**(1,307)**	**(218)**	**(218)**	**0**
Reserves	**11,704**	**7,357**	**1,246**	**1,667**	**421**
Total	**332**	**(22,467)**	**(5,282)**	**(4,826)**	**457**

NHS LOTHIAN

NHS Lothian Board

21 June 2017

Deputy Chief Executive

2.5

SCHEDULED CARE ACCESS PERFORMANCE, 2017/18 TRAJECTORIES AND ALLOCATION OF FUNDING

1 Purpose of the Report

1.1 The purpose of this report is to provide the NHS Lothian Board with an updated position on NHS Lothian's Outpatient (OP) and Inpatient and Daycase (IPDC) Treatment Time Guarantee (TTG) performance, at end March 2017.

1.2 Provide detail of Outpatient and In-patient/Day case Trajectories for 2017/18.

1.3 An update on the process of clinical risk assessment of specialties, and the use of this process to allocate non recurring access performance funding received by the Scottish Government.

2 Recommendations

2.1 The Board are asked to:

2.2 **Note** the end of year (March 2017) outpatient performance of 15,487 outpatients waiting over 12 weeks for a new appointment against a trajectory of 20,009.

2.3 **Note** the end of year (March 2017) In-Patient/Day Case (IPDC) performance of 1,362 patients waiting over 12 weeks for an IPDC procedure against a trajectory of 1,057.

2.4 **Recognise** that the end of March position was attained through the continuation of waiting list initiatives at the same level as 2015/16, use of Golden Jubilee National Hospital, and the use of non-recurring funding used to purchase additional capacity in the independent sector and medical locums.

2.5 **Note** the 2017/18 Out-Patient and In-Patient/Day Case trajectories.

2.6 **Discuss** the person centred approach for prioritising resources aligned to clinical risk

2.7 **Discuss** the pilot project with NHS 24 to develop a 'keeping in touch' model for long waiting patients, and a demand management model for patients with a negative clinical investigation.

2.8 **Agree** that detailed investment profile against the available non recurring funding from the Scottish Government will be brought to the Board in August, along with the anticipated impact on performance.

3 Discussion of Key Issues

2016/17 Performance and use of the Independent Sector

3.1 In March 2016 the decision was taken to cease use of Independent sector in the light of the board's projected financial deficit as identified in the NHS Lothian 2016/17 Financial Plan.

3.2 DCAQ analysis undertaken in 2016 highlighted a number of specialties where there was a significant capacity deficit against predicted demand. This gap was managed in previous years through a combination of waiting list initiatives and independent sector activity.

3.3 The trajectory for projected performance to end March 2017 was estimated by aggregation of individual service projections. These projections were developed based on detailed Demand and Capacity analysis and including efficiency opportunity benefits as well as the continuation of in-house waiting list initiative clinics at the same level as 2015/16 and where appropriate continued use of Golden Jubilee National Hospital.

3.4 Following discussion with Scottish Government on 22 September 2016, it was agreed that NHS Lothian would re-engage with the independent sector in order to address deteriorating performance. Investment of c.£6m was agreed through a combination of Scottish Government (£2m) and benefits identified in year through NHS Lothian (£4m). This investment was targeted at a range of specialties on a See & Treat basis.

3.5 Specialties were identified through assessing clinical risk, based on the rate of incidence in cancer exclusion, diagnosis or treatment, other specialties were prioritised based on *total volume waiting >12 weeks.*

3.6 The 2016/17 outpatient trajectory was adjusted from 20,009 to an end March position of 17,414, based on this additional non recurring funding.

3.7 At March 2017 the number of outpatients waiting in excess of 12 weeks for a new appointment was under trajectory at 15,487. This was 1927 patients under the revised trajectory. This was mainly due to the 'backloaded' phasing of independent sector capacity, late benefit of capacity in The Edinburgh Clinic (TEC) for vascular, impact of focus on long waits and housekeeping.

3.8 The 2016/17 IPDC Treatment Time Guarantee trajectory was not adjusted, as additional capacity was on a see and treat basis. At March 2017 the number of IPDC's waiting longer that 12 weeks was 1362 against a trajectory of 1057.

3.9 Orthopaedics and Urology were the key specialties that were significantly above trajectory and were the main drivers of the variance between performance and trajectory. All other services are in line with their trajectory with exception of cleft palate and neurosurgery.

Projected Performance 2017/18

3.10 The projected performance for 2017/18 is based on the continuation of Waiting List Initiatives (WLIs) at the same level of 2016/17, at a cost of circa £2m, use of Golden Jubilee National Hospital, as well as ongoing use of unfunded locums in ophthalmology.

3.11 Just as financial forecasts are presented at quarterly review and amended on a monthly basis, performance trajectories should be dynamic and revised in recognition of changes to

demand and capacity on an ongoing basis. Developing a trajectory for 12 months ahead has an inherent risk as the only known demand and capacity is 12 weeks (demand) and 6 weeks (capacity) – the rest is based on historic patterns.

3.12 Each service has developed both OP and IPDC trajectories based on established DCAQ methodology.

3.13 Projected performance is expressed in terms of numbers waiting over 12 weeks however it should be recognised that this is an indicator of overall increase in waiting list size and increasing length of wait, resulting in increased clinical risk.

Table 1- Projected Outpatients waiting greater than 12 weeks to March 2018

Final Trajectories	April	May	June	July	August	September	October	November	December	January	February	March
Outpatient incl. WLI	16542	18740	20790	24743	27722	29495	31725	33569	36164	37122	38780	40056

3.14 The projected performance at end March 2018 is 40,056 outpatients waiting greater than 12 weeks. This is based on the continuation of existing locums, use of Golden Jubilee National Hospital and maintained levels of waiting list initiatives. These figures assume no further investment in independent sector capacity.

Table 2- Projected patients waiting greater than 12 weeks on an IPDC treatment to March 2018

Final Trajectories	April	May	June	July	August	September	October	November	December	January	February	March
Inpatient incl. WLI	1457	1648	1932	2098	2335	2550	2663	3027	3466	3579	3719	3966

3.15 The projected performance at end March 2018 is 3933 patients waiting greater than 12 weeks for an IPDC treatment. This is based on the continuation of existing locums, use of Golden Jubilee National Hospital and maintained levels of waiting list initiatives**.**

Risks Associated with Increasing Waiting Times for New Out-Patient Appointment

3.16 As demand for some services significantly exceed capacity, the waits for new routine out-patient appointments will continue to rise. Current waiting times are detailed in Appendix 1.

3.17 New referrals have a clinical triage undertaken which categorises patients as Urgent Suspicion of Cancer (USOC), Urgent and Routine. Within each of these categories patients are triaged into the most appropriate sub-specialty queue, and each sub specialty queue will have a different level of clinical risk associated with it.

3.18 The Medical Director and Chief Officer for Acute services currently are looking at how risk can be best categorised and reduced based on *subspecialty* queues.

3.19 A revised communications strategy has been established to ensure that both patients and referrers are appropriately informed in relation to the length of waits. This includes an 'added to outpatient waiting list' letter that informs patients that their referral has been received and that some services waits are above the 12 weeks standard, the letter also contains a link to *RefHelp* waiting time information. The publication of current waiting times on *RefHelp* are also available to GPs' at time of referral. Despite these actions, there is an

ongoing concern about how NHS Lothian can maintain contact with patients on our waiting list to establish if their condition has changed. See section 3.30.

3.20 A concurrent pilot of 'text reminder' and patient focussed booking is being developed to evaluated impact on Did Not Attend (DNA) rates.

Assessing Clinical Risk

3.20 Clinical risk has been identified in relation to two key dimensions:

- Probability that due to length of wait the patient condition deteriorates.
- Probability that due to length of wait significant diagnosis is delayed

3.21 The impact on length of wait and consequent impact on clinical risk has been assessed on a specialty basis and is presented below in Table 3

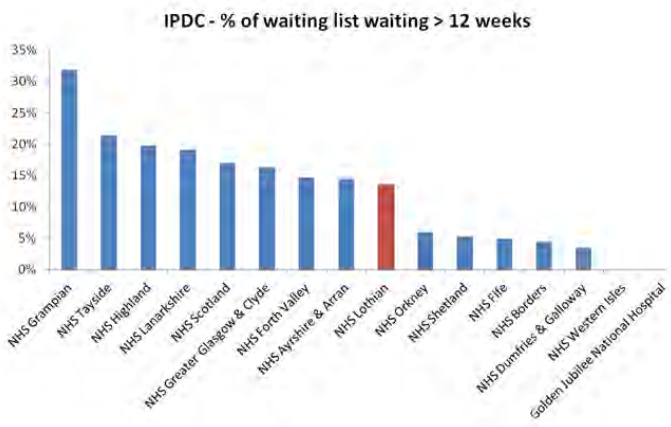
Table 3.Clinical Risk Assessment

			Risk Rating			
Specialty	**The No. of weeks which 9 out of every 10 patients had been seen (at 03/05/17)**	**Predicted No. of patients waiting > 12 weeks end of March 2018**	**Risk based on length of current length of wait for 90% of patients (at 03/05/17) (1-5)**	**Probability of clinical risk (e.g. cancer) (1-5)**	**Risk based on predicted volume waiting > 12 weeks at March 18. (1-5)**	**Risk score (3-15)**
GI Diagnostics*	25	2607	5*	5	5	15
Gastroenterology	68	6790	5	5	5	15
Colorectal	42	2345	4	4	3	11
ENT (pead)	52	935	5	3	2	10
Dermatology	24	4632	2	4	4	10
Vascular	47	1142	4	3	2	9
Urology Diagnostics*	19	761	4*	3	2*	9
Urology	19	2145	2	4	3	9
Orthopaedics	33	4,103	3	2	4	9
Ophthalmology	18	6375	2	2	5	9
General Surgery	27	2306	3	3	3	9
ENT (adult)	23	5333	2	2	5	9
Breast	4	0	1	4	1	6
Paed. General Surgery	-	5	1	3	1	5

**Score reflects 6 week target for diagnostics.*

3.22 **Performance in Relation to National Peers**

Peer Performance Graphs



3.23 NHS Lothian's corporate objectives for 2017/18 stated the Board's intention to perform comparably with other Health Boards. This takes into account the challenges faced nationally in matching capacity with demand.

Allocation of Access Funding 2017/18

3.24 At end May the cabinet secretary announced non-recurrent funding of £50m to support Access performance; the NHS Lothian share of this additional resource is expected to be £7.378m. Allocation of this funding will be in two tranches, with 75% to be released following submission of a "2017/18 LDP Risk Assessment and Improvement Plan"; the balance to be released in September. Correspondence from Scottish Government has outlined expectations in relation to the use of this funding across the whole patient pathway (including diagnostics and TTG), and that trajectories are developed showing a progressive improvement in performance to March 2018 and that patients waiting a long time are treated. The expectation is that March 2017 is used as baseline for this trajectory. Improvement plans should also take account of regional capacity in order to minimise requirement for use of independent sector. Our proposal is that this non recurring allocation is used to treat patients assessed at highest risk, and this may not always be longest waiting patients.

3.25 It is estimated that ongoing use of Waiting List Initiatives will require investment of c.£2m against this allocation. As outlined above, it is intended to use this funding to further manage high clinical risk services, however given recognised constraints on expansion of internal capacity it is likely that these plans will include an element of independent sector. External Provider Office (EPO) and Procurement colleagues have begun exploratory discussions with providers in order to identify available capacity. As highlighted previously, engaging providers on a longer term basis with appropriate notice will provide opportunities to deliver best value; these elements remain challenging in the context of non-recurrent funding and the recent withdrawal from existing arrangements (resulting in contractors downsizing their own workforce arrangements). Formal contract awards will not be progressed until prioritised action plans are agreed.

3.26 The risk matrix detailed in section 3.21 will form the basis for prioritisation of resources against proposed action plans. Services have been asked to consider options and tests of change that could offer sustainable solutions to capacity deficits.

3.27 Building on the risk matrix, an innovative programme of keeping in touch will be developed for our longest waiting patients.

3.28 NHS 24 are working with us to develop a pilot of an administrative and clinical triage model. The Scottish Government will support the funding of this, as part of their access improvement funding. This will initially be tested within Gastroenterology (GI) and endsoscopy where we have identified our highest risk patient queues and have significant volumes of long waiting patients. The pilot will have agreed contact points for long waiting patients, and through agreed algorithms patients will be assessed as to whether they still require their appointment, can safely wait for next contact or appointment or whether they require their appointment to be expedited. It is proposed that the purchase of non recurring capacity in the independent sector will give the required capacity to support patients who require their appointment to be expedited.

3.29 NHS Fife and Borders have been contacted to ask if they have capacity to help support any of our pressurised services or whether they are anticipating using independent sector capacity. NHS Borders have advised that they are unable to offer material capacity currently but that they would potentially be purchasing additional non recurring capacity for dermatology; both procurement departments are collaborating to negotiating best costs.

3.30 IR35 tax changes has had an impact on the availability of some locums, this has been particularly evident in dermatology who have a gap of 3 WTE vacancies plus 2.5 WTE maternity leave Consultant posts, and have been unable to secure locums to cover this substantial gap, and have been unable to substantively recruit. Similarly in ophthalmology, where one of the two locums in post is leaving. Alternative staffing options are being pursued.

3.31 The use of shared models such as Medinet are being taken forward with procurement with advice from CLO regarding their compliance with IR35 regulations. Issues arising in relation to changes to HMRC regulations have necessitated a review of the Board's use of contractors who provide services within NHS facilities. This may impact on plans to engage with Medinet and other service providers whose main provision is workforce. Alternative options are being explored in conjunction with actions to clarify previous arrangements going forward.

3.32 Details of proposed investment profile will be finalised throughout June and July, and will be brought to the August Board meeting, along with the anticipated impact on the performance trajectories.

3.33 Integral to the investment profile is The Modern Out Patient Programme, Theatre Improvement Programme and through the DCAQ individual service plans aim to redesign services to reduce demand and increase capacity.

3.34 The Modern Outpatient Programme has been launched by the Scottish Government. This is a three year programme. Tracey Gillies has been nominated to lead the programme for NHS Lothian. Key deliverables of the programme include:-

- Strengthening knowledge exchange and self-management within the community with patients at the centre

- Accessing decision support, care planning and care services in the community wherever safe and appropriate
- Emphasising competency-based roles in secondary care, to focus Consultant resource on more complex patients, and recognising the role of the GP as the 'expert clinical generalist' and raising the profile and enhancing the role of the wider multidisciplinary team of community based practitioners
- Optimising e-Health and digital opportunities at the primary/secondary interface as the norm
- Reducing widespread variation in secondary care return appointments and review processes, wherever clinically appropriate.

3.35 The programme aims to reduce the number of hospital based outpatient appointments by up to 400,000 by 2020 across Scotland, including reversing the year on year increase. The Lothian element of this is around 55,000 which equates to 2.8% of the total attendances in a year.

3.36 There is an established programme of work in place to deliver modernisation for outpatients. Some key pieces of innovation underway are detailed below:-

- Nurse Led Faecal Calprotectin Clinics, initial impact of reduce number of new appointments required in consultant clinics by 31%
- Rapid Access Respiratory Clinic, where a reduction of 2 bed days were saved for each patient during the pilot period. This clinic will now be embedded and extended to two appointments/week.
- Cardiology clinic redesign which has resulted in advice only clinics being established, standardised clinic templates and central booking to optimise capacity utilisation.

3.37 The Theatre Improvement Programme is being managed through a formal project management approach, with an aim of increasing utilisation of theatre sessions to 90%, use of hours within sessions (95%), reduce cancellations to 8% and increase productivity through a combination of these measures.

3.38 Quarter 4 2016/17 saw use of theatre sessions rise to 91.9% and cancellation rate reduce from 9.7% in 2015/16 to 8.9% in 2016/17 (this is below the national average of 8.9%)

4 Resource Implications

4.1 Continuation of waiting list initiatives as a cost of circa £2m.

4.2 Other investment costs being finalised, this includes; service redesign, NHS 24 "keeping in touch" pilot, and the use of the independent sector – note; the access funding released from the Scottish Government is non recurring.

5 Risks and Assumptions

5.1 Table 4, below, outlines the risks associated with outpatient performance.

Table 4 – Summary of Key Risks

Risk	Mitigation
That patients condition deteriorates whilst awaiting an appointment/treatment in excess of 12 weeks	Prioritisation of any available funding to highest risk patient groups Pilot of keeping in touch with NHS 24 Focus on 31 and 62 day cancer performance, with enhanced management oversight
That the volume of patient enquiries and complaints rises due to increasing waits, impacting on Board reputation	Being open and honest with referrers and patients about current waiting times through 'refHelp' waiting time information Pilot of keeping in touch with NHS 24
That the subspecialty queues that clinically have greatest risk are not directly impacted on by waiting list initiatives or any use of independent sector	Close working with clinical services to consider how patients are triaged to waiting list initiatives and independent sector, this may require creating capacity for higher risk patients through triaging lower risk patients to waiting list initiatives and independent sector
That additional activity will not deliver the predicted improvement in performance against Access standards e.g substantive resignations/absences above norm	This will be monitored in line with the board's overall Waiting Times management. Weekly communication with SG colleagues

6 Risk Register

6.1 Management of Access performance should remain a significant risk on the division's Risk register.

7 Health and Other Inequalities

7.1 Individuals with poorer or limited access to primary care services will find it more difficult to receive information about any deteriorating symptoms and may be more likely to delay seeking advice. There is a disadvantage to those with chronic non malignant diseases requiring specialist care who will wait longer for diagnosis and may also wait longer for treatment to be stabilised if return outpatient waiting times are longer. Patients without sick pay who are unable to work will also be disadvantaged.

8 Involving People

8.1 The Board shares performance reporting against Access and other relevant targets with local partnership forums and makes its monthly monitoring information available under non routine FOI requests from other stakeholders.

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08/06/2017

Appendices to the report
Appendix 1 – Current Length of Outpatient Waits (RefHelp)

NHS Lothian Outpatient Waiting Times

90% of patients waited *n* weeks or less from referral to new outpatient appointment

The following table shows the number of weeks by which 9 out of every 10 patients on an NHS Lothian outpatient waiting list had been seen in the previous month. This is not the length of time a patient will wait, but the time within which we might expect a patient to be seen. The majority of patients will wait less than the number of weeks given in the table.

		90% of Patients seen within (weeks)	
National Specialty	**Sub Specialty**	**Adult (16 and over)**	**Paediatric (Under 16)**
Anaesthetics	Anaesthetics	10	*
Cardiac Surgery	Cardiac Surgery	*	
Cardiology	Cardiology	12	*
Clinical Genetics	Clinical Genetics		*
Clinical Oncology	Clinical Oncology	4	
Community Reproductive & Sexual Heal..	Sexual & Reproductive Health	11	*
Dermatology	Dermatology	25	32
Diabetes	Diabetes	9	*
Ear Nose and Throat	Ear Nose and Throat	22	54
Endocrinology	Endocrine	8	*
Endocrinology & Diabetes	Metabolic Diseases		*
Gastroenterology	Diagnostic Procedure	9	
	Gastroenterology	62	*
General Medicine	Ambulatory Care	1	
	General Medicine	9	
	Stroke Medicine	1	
General Surgery	Colorectal Surgery	41	
	Edinburgh Breast Unit	4	
	General Surgery (excl Vascular)	37	
	Transplant Surgery	*	
GP other than Obstetrics	GP Other than Obstetrics	*	
Gynaecology	Fertility and Rep Endocrine Centre	13	*
	Gynaecology	12	*
Haematology	Haematology	7	*
Infectious Diseases	Infectious Diseases	5	*
Maxillofacial	Maxillofacial Surgery	11	*
Medical Oncology	Medical Oncology	3	*
Medicine of the Elderly	Medicine of the Elderly	7	
Neurology	Neurology	13	15
Neurosurgery	Neurosurgery	18	*
Ophthalmology	Ophthalmology	18	25
Orthopaedic Surgery	Orthopaedics	33	15
	Scoliosis		*
Paediatric Medicine	Paediatric Medicine	*	17
Paediatric Surgery	Paediatric Surgery		11
Palliative Medicine	Palliative Medicine	*	
Plastic Surgery	Plastic Surgery	11	9
Rehabilitation Medicine	Rehabilitation Medicine	10	*
Renal Medicine	Renal Medicine	*	*
Respiratory Medicine	Respiratory Medicine	13	8
	Sleep Medicine	12	
Rheumatology	Rheumatology	10	*
Thoracic Surgery	Thoracic Surgery	8	
Urology	Diagnostic Procedure (Urology)	16	
	Urology	18	*
Vascular Surgery	Vascular Surgery	50	

The number of weeks waited has been supressed for specialties where the number of completed waits was fewer than 50 patients in the month. This is indicated by * in the table above.
Data Source: TRAK, NHS Lothian.

Last updated: 16 May 2017

Completed Waits in April 2017

NHS LOTHIAN

Board Meeting
Wednesday 21st June 2017

2.6

Director of Public Health & Health Policy

EQUALITIES AND RIGHTS OUTCOMES AND MAINSTREAMING REPORT

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve this report for publication.

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

2 Recommendations

2.1 To endorse the contents of the attached reports.

2.2 To endorse the next steps set out within the Main Report.

3 Discussion of Key Issues

3.1 This report is a summary of progress in work on NHS Lothian's Equality and Rights Outcomes Report, which was published in 2013 after approval by the Board on 27th March 2013. This report also sets out what we have learned about Mainstreaming Equalities and Human Rights. The public sector equality duty sets out the minimum standard we need to reach. As part of meeting that duty we have to publish reports like these every four years. We published the attached documents at the beginning of May pending final approval by the Board at today's meeting.

3.2 NHS Lothian's Equalities and human rights duties extend to staff. This report includes information on employees, including where we stand on equal pay and on our recruitment, promotion and development of staff.

3.3 A recent requirement is for us to produce a statement on our Board Diversity covering the current membership of the Board, and this is included in the report.

3.4 For each key outcome identified in 2013, the report attempts to set out succinctly;
- What has gone well?
- What is still challenging us?
- What we have learned?

3.5 We have worked with local people with learning disabilities to produce an easy read summary of the report; this is also attached.

3.6 The environment that the NHS Board is working in has changed significantly since 2013. The previous approach to rights-based and equalities work had a strong reliance on specific "lead" staff members, and performance-based compliance approaches to meeting our statutory requirements. Neither of these approaches has proved

sustainable or particularly effective. We need to develop a new approach that aligns with our staff's intrinsic motivations for doing their work. It is likely that we will have most impact by aligning our approaches to equalities and rights with our Quality Strategy and the Staff Experience initiatives.

3.7 The report concludes with a proposal that we pause in our pursuit of Equalities and Rights Outcomes, and seek to embed a new approach. We will do this by supporting and facilitating a network of organisations and people across Lothian to devise a new strategy, responding to all of our statutory requirements, but also choosing our own priorities for concerted action. This inclusive work will begin at an open meeting on 28th June to be held at the Equalities Exhibition currently running at the Edinburgh Palette.

3.8 We will work through this Lothian Equalities and Rights Network to devise a new set of outcomes that the network and the NHS Board will commit to improve from June 2018 onwards.

3.9 At the same time we are currently preparing an Improvement Plan setting out immediate actions we know we need to take to address issues arising from the attached reports, to cover the period of development of our new strategic approach.

4 Key Risks

4.1 There is a risk that the Scottish Human Rights Commission and/or the Equalities Human Rights Commission will challenge NHS Lothian for not meeting its statutory requirement to progress all of the outcomes identified in 2013 by the end of April 2017. The probability of this happening is very low.

5 Risk Register

5.1 No material risks known.

6 Impact on Inequality, Including Health Inequalities

6.1 Each of the individual pieces of work referenced in this report are specifically designed to reduce inequalities, and many of them will be linked to individual Impact Assessments. It would not be an appropriate use of resources to carry out an impact assessment on this report itself.

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

7.1 The outcomes which form the basis of this report were developed after 8 months of involvement and consultation, including with staff, community representatives, partner organisations and patients. Whilst not a formal requirement, we **also** built in a short period for public scrutiny of the Outcomes Report on the NHS Lothian website, before final publication of the Report. This g**a**ve us good evidence about both the format and content of the report, which have been incorporated into the final versions.

8 Resource Implications

8.1 The resource implications of preparing and publishing the report can be managed within existing Departmental budgets. It is likely that a business case will need to be developed to ensure that work is progressed where required to ensure that NHS

Lothian's responsibilities to staff and patients, including the new socio-economic duty, assistive communication, and British Sign Language, can be met.

Chris Bruce, Lead on Equalities & Human Rights
14th June 2017
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List of Appendices

Annex 1: Easy read Report
Annex 2: Summary Report
Annex 3: Main Report
Annex 4: Full Reference Report, which includes:

NHS Lothian Equality and Diversity Monitoring Report 2016-17
NHS Lothian Equal Pay Statement 2017
NHS Lothian Board Diversity Statement 2017

Annexes 1 - 4 are all at
http://www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/Pages/OutcomesMainstreamingReport2017.aspx

NHS LOTHIAN

2.7

Board Meeting
21 June 2017

Executive Medical Director and Director of Health and Social Care, East Lothian IJB and Primary Care Policy Lead

PRIMARY CARE UPDATE

1 Purpose of the Report

1.1 This report provides an update to the Board on the risk outlined in the Corporate Risk Register (risk 3829) about the sustainability of general practice services and the action taken since the previous update report in December 2016. This update builds on the previous updates to the Board in October and December 2016, and the regular updates to the Healthcare Governance Committee. The overall picture remains that there continue to be GP practices in difficulty across Lothian, and only limited assurance can be given that the actions underway and proposed will resolve the issues highlighted

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

2 Recommendations

2.1 It is recommended that the Board accepts this report as a source of limited assurance that the actions underway and proposed will resolve the issues regarding sustainability in General Practice.

3 Discussion of Key Issues

3.1 GP practices in Lothian continue to experience rising patient demand from a growing and ageing population and from the drive to provide care in community settings as an alternative to hospital admission. This experience is replicated in most parts of Scotland and affects both in and out of hours.

3.2 Recognition of the need to support primary care services and in particular general practice in the development of new models of care and to supplement the Primary Care Transformation monies with recurrent investment led to the provision of recurrent investment of £2m in 2017/18, with a further £3m in 18/19 and 19/20.

3.3 In terms of current actions all four HSCPs are working on their Primary Care Transformation plans and have held local sessions as a follow up to the pan-Lothian Primary Care Summit on 29 September 2016. Highlights from this work were presented to the NHS Board development session on 1 March 2017 and the second Primary Care Summit on 4 May 2017. The summit on 4th May also focused on examples of sustainability at practice level. It was agreed the next summit should focus on whether the implementation of the plans has made a difference. The plans from the four HSCPs are attached at Appendices 1 to 4.

3.4 The Strategic Planning Committee approved the establishment of a Primary Care Investment and Redesign Board which has met three times. The Health and Social Care Partnerships presented their plans to utilise the NHS funding available. In addition there was discussion on the development of measures that would demonstrate improvement and this will be discussed further at future meetings.

3.5 In addition the directions to NHS Lothian from the four IJBs will reflect action to address local primary care pressures and to remodel services to develop alternative models of care and a broader workforce in primary care.

3.6 In Lothian the number of GP practices with restricted lists continues at around the same level, with a small increase between November 2016 and May 2017. The impact of lists being restricted is that patients are not freely able to register with the practice of their choice. Additional family members can be registered and allocations must be accepted

3.7 The number of assignments (patients being allocated to a GP Practice) has been increasing, although they appear to have plateaued in the last two quarters:

- Financial year 2015/16 – total assignments 825
- April to June 2016 – 817 assignments
- June to September 2016 - 1,500 assignments
- October to December 2016 - 1,653 assignments
- January to March 2017 – 1,515 assignments

3.8 While there is no agreed definition of “in difficulty” there are currently 23 of 123 practices in Lothian receiving support of one kind or another. Practices may be seeking support for a number of reasons such as unsustainable workload, inability to recruit, increasing expenses and reducing income and premises issues. Ongoing pressure and deteriorating access to general practice brings with it instability, implications for patient safety, increased unscheduled care demand, reputational risk to the practices, NHS Lothian and HSCPs and significant financial implications in order to find solutions.

3.9 Three practices moved onto Section 2c (directly managed) contracts on 1 November 2016, 1 March and 1 April 2017. There are now 11 2c practices in Lothian (including the Edinburgh Access Practice (9 in Edinburgh, 1 in East Lothian and 1 in West Lothian). Some practices will spend a period of time as a 2c practice but move back to a 17j model (independent contractor model). HSCPs are considering whether strategically they wish to continue to see the 2c practice model grow.

3.10 A joint update was provided by the Scottish Government and BMA in May 2017 in relation to the GP contract. http://www.gov.scot/Publications/2017/05/2382/0 The document provides more details on the agreed plans following the completion of the Budget Bill in 2017. It also provides a summary of the announcements made by the Cabinet Secretary at the LMC conference in March and, where available, provides further detail on the start dates and operational detail of the commitments. The detailed negotiations are ongoing with the intention that these are completed this year with full details being available in advance of the next LMC conference in December 2017 and a vote thereafter. Despite this considerable uncertainty

remains among the GP community on what aspects of current difficulties the new contract will address.

3.11 Out of Hours and in hours general practice are interdependent. Both need the other to function effectively to ensure patients are able to access the care they need. The major problem out of hours is the availability of GPs to staff rotas. There have been a number of weekends recently when not all bases were able to be kept open and this results in patients travelling to other bases. July and August shifts have always been very challenging to fill, LUCS offers shift swapping for GPs and has previously increased rates over weekends during these months in common with other Boards in Scotland. The Urgent Care Transformation project, led by the Clinical Director for the Out of Hours service, is working to increase the availability of other health care professionals within the service.

3.12 Each HSCP is pursuing premises developments in primary care which can be key to unlocking extra capacity. However capital resources are limited and the NHS Board has the responsibility to prioritise. In addition there are often greater constraints than access to capital that are the cause of capacity problems particularly medical recruitment.

3.13 The HSCPs are pursuing the development of innovation in creating additional capacity in the primary care team. There are ongoing programmes to introduce pharmacists, nurse practitioners, physiotherapists, paramedics and link workers. These are being co-ordinated through the HSCPs working together with Lothian wide supports.

4 Key Risks

4.1 The previously noted risks listed in the October and December update reports remain extant. The definition of the risk in the corporate risk register is under review and will be included in the next corporate risk register report

5 Risk Register

5.1 The issue of General Practice sustainability is included on the Corporate Risk register as very high (Risk ID 3829) and is also included on the HSCPs and the PCCO risk registers. The risk definition is under review.

6 Impact on Inequality, Including Health Inequalities

6.1 No impact assessment has been carried out on this paper. Specific proposals in HSCPs will be subject to integrated impact assessment where required.

6.2 The enhancement of Primary Care Services should assist in addressing the causes and impact of inequality more effectively and efficiently but there is the potential risk that unless the capacity issues are addressed a number of scenarios could be forecast, one of which is the potential for a widening of health inequalities due to the lack of GP capacity to see, support and treat patients.

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

7.1 The primary care priorities outlined in this paper were included in NHS Lothian's Strategic Plan 2014-2024 which was subject to a period of public consultation in 2014

8 Resource Implications

8.1 The resource implications will flow from prioritised investment areas in the IJB Strategic Plans, potential changes to the value of the GMS contract at national level, the local and national investment in primary care and capital investments.

8.2 The Board has committed to invest £5m in primary care over the next 3 years.

8.3 There have been recent announcements from the Scottish Government on funding for pharmacists, link workers and national nurse training and these are being assessed for their impact on NHS Lothian.

8.4 The Primary Care Investment and Redesign Board takes an overview of the new resources being applied to this area.

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29 May 2017
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Appendix 1 – Primary Care Priorities in East Lothian (30 March 2017)
Appendix 2 – Edinburgh Primary Care Strategic Programme - planned action in 2017 (4 April 2017)
Appendix 3 - General Practice Strategic Programme in Midlothian – planned action in 2017 (20 April 2017)
Appendix 4 – West Lothian Primary Care Report (3 April 2017)

East Lothian
Integration Joint Board

Appendix 1

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 30 March 2017

BY: Chief Officer

SUBJECT: Primary Care Priorities in East Lothian

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1 PURPOSE

1.1 To inform the Integration Joint Board of the intended focus of work in 2017-18 to support, stabilise and develop General Practitioner (GP) primary care services across East Lothian. This follows on from a range of actions taken during 2016-17 to support GPs and their teams.

2 RECOMMENDATIONS

2.1 The IJB is asked to note that general practitioner managed services across East Lothian remain under pressure as the result of a number of local and national factors.

2.3 The IJB is asked to approve plans to focus primary care development input and available funding on the following priority areas, all of which are described in more detail in section 3.0:

- Musselburgh Primary Care Access Service
- East Lothian Care Home Team
- Primary care nurse training
- Practice-based pharmacists
- LEGup support for list size growth
- Provision of IT hardware
- Future planning for a new practice in Blindwells
- Diabetes LES.

3 BACKGROUND

Issues Affecting Primary Care Services

3.1 Responsibility for primary care is shared between the NHS Board and the IJBs. The NHS Board has a duty to ensure that its population receives general medical services and can register with a General Practice. The NHS Board through the Primary Care Contracts Organisation (PCCO) also holds contracts with practices and is responsible for delivery of services through the HSCPs and the PCCO, with IJBs responsible for the strategic planning and direction of primary care in their areas.

3.2 In recent years, general practice has been faced with capacity and sustainability problems because of the increasing volume and complexity of workload, GP recruitment and retention issues, reducing profitability of general practice and premises and IT issues.

3.3 The rising patient demand is in part the result of a growing and ageing population and in part the drive to provide care in community settings as an alternative to hospital admission.

3.4 The increasing frailty of the ageing population and the growth in long term conditions places increasing demands on GPs and the practice team. These changes are happening at the same time as GPs are moving to part-time working, there is growing interest in salaried rather than GP Partner posts and senior, experienced GPs are considering early retirement to avoid taxation penalties and NHS pension impacts.

3.5 Across Lothian many practices have restricted their lists to limit the impact of population growth on their practice. This however transfers demand to neighbouring practices, with the potential of resulting knock on list limitations across to further practices. East Lothian is alone among the four HSCPS in Lothian in having no current list restrictions. Discussions are however underway on LEGup (see 3.16) and other supports to maintain open lists across the County.

3.6 The vast majority of practices in Lothian still operate on an independent contractor basis, managing their business without direct NHS Lothian or HSCP input. However, for some practices the recruitment, patient demand, financial, premises and other challenges are such that they have required practical and financial support from the IJBs and the PCCO to maintain services.

3.7 In some cases, HSCPs have had to take over direct management of practices under Section 2c of the GMS contract and the direct employment of the practice staff under TUPE (Transfer of Undertakings (Protection of Employment) Regulations 1981) arrangements. In East Lothian, it was necessary to take Eskbridge Medical Practice into direct HSCP management on 1st December 2015 following retirement and resignation of partners. In common with other HSCPs, East Lothian HSCP has taken the position that the practice may be returned to a 17j

(GP managed) arrangement once the practice is sufficiently stable to allow this change.

3.8 Practice premises development has provided purpose built accommodation across the Health and Social Care Partnerships. However, some practices are subject to inflexible and expensive lease arrangements or are within buildings that are too small or otherwise unsuitable for modern GP Practice. In East Lothian there have been premises developments in Musselburgh, Tranent, Ormiston, Gullane and Prestonpans in recent years with a development at Cockenzie under planning. Further development is required in Haddington, North Berwick, Blindwells and East Linton. Across all practices, IT systems are badly in need of upgrades to equipment, infrastructure and software inter-connectivity with clinical systems.

3.9 In recognition of these issues, on 29 September 2016 East Lothian HSCP organised and hosted on behalf of all IJBs, the first Lothian Primary Care Summit. This sought to develop a shared set of primary care priorities for the IJBs and NHS Lothian. A report on the summit was produced and distributed to the IJBs and to primary care teams across Lothian. At this summit NHS Lothian committed to investing £5m in primary care over 2017-18 to 2019-20. The themes emerging from the summit highlighted the need for:

- Workforce and skill development
- Public information and public education
- Transfer of work from GPs to an expanded Multi-disciplinary Team
- Better electronic information exchange
- Continuing interface work
- Improved professional to professional communication; and
- Resolution to key premises issues.

3.10 Work on these issues is being undertaken at local IJB and at Lothian level.

3.11 An East Lothian Health and Social Care primary care workshop in November 2016 provided local perspectives on the issues facing primary care and gave the opportunity to consider possible actions.

3.12 In addition the HSCP has met with the GP forum to consider in detail the proposals emerging from these events.

3.13 There is national work underway to negotiate a new contract for general practice, but this is not expected to impact on 2017/18.

3.14 In addition there is likely to be national funding for additional pharmacists in practices, additional link workers in practices, nurse training and possible other areas. Details have not yet been announced by the Scottish Government.

Primary Care Developments in East Lothian

3.15 **Musselburgh Primary Care Access Service**

3.15.1 Having taken over management of Eskbridge Medical Practice, East Lothian HSCP has been considering options for joint working with the two other practices in the Musselburgh Primary Care Centre (MPCC) and the re-modelling of service provision to help all the practices to cope with increasing demand.

3.15.2 The issue of 'same day demand' has been identified as a key area to focus on. It is recognised that long term conditions management and ongoing care are both important from clinical, cost and patient experience aspects. The view from General Practice is that if by adequately accommodating same day demand, then chronic illness can be more effectively managed under existing contractual and resource arrangements.

3.15.3 Various strategies to address same day demand have been tried across Scotland and further afield. In Scotland, these have tended to be small in scale and often temporary crisis-related approaches.

3.15.4 The Musselburgh Primary Care Access Service is part funded by the Primary Care Transformation Fund and is being developed in partnership between East Lothian HSCP, the MPCC practices, NHS 24 and the Scottish Ambulance Service and will fully utilise primary care, community and voluntary sector resources, working together to respond to same day demand in order to direct patients to the right point of contact to met their care needs.

3.15.5 The development will provide a telephone-based Primary Care Access Service, whereby all patients seeking unscheduled care will receive initial assessment via a central service delivered by ELHSCP. Following this there will be referral into a relevant pathway, which may be the patient's own GP-led service or one of a number of other options.

3.15.6 Assessment of requests for clinical input will be carried out in partnership with NHS 24 who already work with robust protocols and have extensive experience in self-management advice and signposting. This partnership will allow patients in East Lothian to benefit from this expertise. Experience shows that patients often simply require telephone advice and the historical model, based on the face to face consultation, primarily with a GP is not designed with this need in mind.

3.15.7 Patients needing further face to face medical assessment will see the most relevant clinician. Work will be carried out with NHS 24 to develop their protocols to suit the different arrangements for in-hours clinical teams compared to out-of-hours, while improving access to non-urgent services, such as phlebotomy and treatment room nursing.

3.15.8 It is recognised that many service users contacting GP practices would be better managed elsewhere, e.g. optometry, pharmacy, dentistry, and these would be signposted at an earlier stage.

3.15.9 NHS 24 is working in partnership with ELHSCP to help deliver these objectives. As expected, the process of integrating NHS 24 into an in-hours model is complex and not without challenges. However the NHS 24 has received Scottish Government funding to test the Musselburgh Hub model and has allocated considerable staff and technical resources to the project. If successful the model may be rolled-out across the country.

3.16 East Lothian Care Home Team

3.16.1 Most medical care within care homes is provided by GP surgeries under the GMS contract. However, not all practices offer this service. The contract arrangement has provided funding to participating GP surgeries using essentially the same framework as members of the community living at home. Increasingly, the care home contract funding on offer does not cover the demands placed on practices in delivering complex care in this setting. Latterly, a contract for GP surgeries to offer anticipatory care has provided further funding, but despite this, there is increasing reluctance to provide what are termed 'optional' services to this important patient group. As activity in GP surgeries increases, it becomes more challenging to deliver a quality service to care homes.

3.16.2 The nurse-led East Lothian Care Home Team was primarily established to provide support and advice and training to the staff of care homes to ensure the wellbeing and good nursing care of residents. Further to this, they were available to liaise with and advise GPs managing the same patients on various aspects of care. This service helped forge positive links between ELHSCP and GP providers.

3.16.3 Following the withdrawal of the Eskbridge Medical Practice from their GMS contract in December 2015, the Care Home Team took over most day to day medical management of patients in the majority of Musselburgh Care Homes, greatly reducing the need for GP input and so reducing demand on the practice. The service provides assessment, diagnosis and prescribing, as well as admissions, referrals and care planning. The Eskbridge Medical Centre GPs provide medical support and advice where necessary.

3.16.4 This arrangement has ensured a regular Care Home Team presence within the Musselburgh Care Homes and a greater emphasis on anticipatory care and prevention, rather than reactive medical care. The scope of knowledge of the nurse-led team also means that nursing aspects of patient management can be given greater

consideration in individual patient management planning and in admissions avoidance.

3.16.5 In the coming year, the opportunity will be taken to expand the team to other care homes across the county. As the elderly population expands and as other care homes come on stream (for example the sixty bedded nursing home in Haddington, due in late 2017) this will ensure that primary care receives support in providing care to this important patient group. Initial priorities will be Haddington, Gullane and North Berwick.

3.17 Primary Care Nurse Training

3.17.1 As illustrated by the role of the nurse-led Care Home Team, nurses have an important role to play in the modernisation of primary care services and in the development of the multidisciplinary team to provide a full range of primary care services.

3.17.2 Opportunities must be taken to further develop the role of nurses in primary care if primary care is to continue to cope with increasing demand.

3.17.3 The strategic development of primary care services is heavily dependent on having a sufficient supply of nurses trained at an advanced level. At present, there is Lothian-wide training available (some funded through the Primary Care Transformation Fund). However this funding is limited, so will not provide enough staff for the aspirations of ELHSCP. The potential career opportunities available in an East Lothian primary care service which offers nurses development opportunities would be attractive to any nurses wishing to increase their role in autonomous decision making as part of a nurse-led team.

3.17.4 To further develop such a nurse role, ELHSCP needs to encourage GP Practices to actively engage in Primary Care Nurse training. They themselves need to be adequately incentivised to this and to be confident that their efforts will ultimately result in an improved primary care nursing model.

3.17.5 In the coming year ELHSCP will look at the development and training opportunities in locally managed services, such as the care home team, or deployed in GP practices to be trained in Chronic Disease Management and/or acute illness. The development of the Primary Care Nurse team will put the Partnership in a stronger position to both develop services and to support population growth within GP practices.

3.18 **Practice-based Pharmacists**

3.18.1 To date the Scottish Government funded Practice Pharmacists have been allocated to East Lothian health centres according to need. Their success in transferring medicines-related work from GPs and in medicines management demonstrates the merit of extending such posts to other practices.

3.18.2 The role of the pharmacist in practices is an evolving one which needs to make full use of their specialist knowledge. This particularly applies in relation to developing an alternative patient pathway for patients to consult direct with a pharmacist on a full range of medicines matters instead of having a GP appointment. This will be beneficial for patients and will improve the quality and cost-effectiveness of primary care prescribing.

3.18.3 As the Practice Pharmacist roles become more established, there needs to be a period of evaluation with a view to consolidating the role and to developing it in partnership with the Practice Quality Leads, the GP Quality Clusters and pharmacy leads.

3.19 **LEGup Support for List Size Growth**

3.19.1 List Extension Growth Uplift (LEGup) is a funding stream managed by the Primary Care Contracts Organisation (PCCO) and overseen by the Primary Care Joint Management Group (PCJMG). This aims to *"...encourage structured and supported growth of GP Practices."* The scheme provides a number of one off, non-recurring payments of £25,000 to support lists size growth of 500 patients in one year.

3.19.2 East Lothian's pro-rata share of the Lothian-wide LEGup is one per year. It has been most recently used in two parts, termed half LEGup. This has provided two practices (Prestonpans and North Berwick) with half the usual sum to support growth of 250 patients each.

3.19.3 With the current and projected housing growth across East Lothian there is a need to provide more practices with LEGup support. It is proposed that ELHSCP directly funds a further LEGup in 2017-18, allowing extension of support to practices to accommodate 1,000 patients and to maintain unrestricted lists. This funding would be flexibly allocated according to where the growth pressures are being most acutely experienced.

3.20 **Provision of IT Hardware**

3.20.1 Following on from feedback received from the primary care workshop in November 2016, ELHSCP has been exploring the option of providing practices with dual screen computer

workstations. Dual screens give the clinical user the ability to see different clinical software programmes at the same time, without the need to constantly minimise and maximise different views. Typically, this means, for example, being able to view patient records and hospital letters at the same time. Such an arrangement will provided a significantly enhanced patient consultation and improved efficiency with clinical administration and patient records management.

3.20.2 It is expected that reception and administrative staff will also benefit from a dual monitor arrangement, giving them the ability to view appointment screens at the same time as, for example workflow documentation, so improving productivity.

3.20.3 In addition, the HSCP primary care team is considering approaches to enable reception desk staff to easily capture activity data to monitor patient demand and access. This information will allow individual practices to match their resources to demand. Such information, if available at East Lothian level, will inform HSCP decision making on resource allocation at a county level.

3.21 Future planning for a new practice in Blindwells

3.21.1 There will be a need (depending on planning applications and pace of development) to meet the additional need of between 5,000 and 10,000 new patients at Blindwells.

3.21.2 At some point this will require new premises in the Blindwells development and this will be the subject of a separate business case.

3.21.3 In the early stages it is proposed to work with another local practice to provide facilities and support to 'incubate' a new practice that will then move to Blindwells.

3.21.4 This will require specific funding to meet step costs that will occur before the list size reaches a financially viable level.

3.22 Diabetes LES

3.22.1 Support to the Diabetes Local Enhanced Service (LES) needs to continue in order to sustain and develop GP and Practice Team clinical and lifestyle management support to the growing population of people living with Type 2 diabetes. Work will also be carried out in 2017-18 to 'repatriate' to primary care those East Lothian residents with Type 2 diabetes who are receiving this care in secondary care diabetes clinic settings. Funds released by such activity transfer will be used to offset the increased cost of community based activity.

4 POLICY IMPLICATIONS

4.1 Primary care has been subject to gradual policy change in recent months including the ending of elements of the GP contract (such as the Quality Outcomes Framework) and the introduction of GP Quality Clusters. With the introduction of the new General Medical Services contract in late 2017 into 2018-19 there will be further change. East Lothian's developing Primary Care Strategy will need to respond to these changes and will need to set out how the Partnership will utilise current and future funding streams that will accompany the contract changes.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy

6 RESOURCE IMPLICATIONS

6.1 Financial - It is not possible at this stage to set out the detailed financial implications since how much new national funding will be available is not yet known. However, it is assumed that East Lothian will be funded at 12% of the NHS Lothian investment (£0.24m in 2017/18, additional £0.24m in 2018/19 and additional £0.12m in 2019/20). The priorities set out above will be progressively funded from these sources as funding becomes available.

6.2 Personnel - Developments will be progressed by the East Lothian HSCP Primary Care Team

6.3 Other - There may be a need for communications support, particularly in relation to the introduction of the Musselburgh Primary Care Access Service.

7 BACKGROUND PAPERS

7.1 None

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Primary Care Developments in East Lothian

1 Introduction

1.1 East Lothian Health and Social Care Partnership is planning a range of work to explore models of delivery of primary care services and to address specific issues.

2 Musselburgh Primary Care Access Service (MPCC)

2.1 The Musselburgh Primary Care Access Service is part funded by the Primary Care Transformation Fund and NHS24 and is developing as a partnership between East Lothian HSCP, the MPCC practices and NHS 24.

2.2 The development will provide a telephone-based Primary Care Access Service. All patients of MPCC seeking unscheduled care will receive initial assessment via a central service delivered by ELHSCP, which will refer into a relevant pathway. The service will ensure primary care, community and voluntary sector resources work together to respond to same day demand to direct patients to the right point of contact to meet their care needs. Patients needing further face to face medical assessment will see the most relevant clinician.

3 East Lothian Care Home Team

3.1 Following the withdrawal of the Eskbridge Medical Practice from their GMS contract in December 2015, the East Lothian Care Home Team took over most day to day medical management of patients in the majority of Musselburgh Care Homes, greatly reducing the need for GP input and so reducing demand on the practice. The service provides assessment, diagnosis and prescribing, as well as admissions, referrals and care planning. Eskbridge Medical Centre GPs provide medical support and advice to the team where necessary.

3.2 This arrangement has ensured a regular Care Home Team presence within most of the Musselburgh Care Homes and a greater emphasis on anticipatory care and prevention, rather than reactive medical care. The scope of knowledge of the nurse-led team also means that nursing aspects of patient management can be given greater consideration in individual patient management planning and in admissions avoidance.

3.3 In the coming year, the opportunity will be taken to expand the team to other care homes across the county covering Haddington, Gullane and North Berwick. This expansion will ensure that primary care practices receive support in providing care to this important patient group.

4 Primary Care Nurse Training

4.1 Nurses have an important role to play in the modernisation of primary care and in their contribution to the multidisciplinary team in its provision of a full range of primary care services.

4.2 To extend this work, a sufficient supply of nurses with advanced level training is needed. The limited local funding available (some from the Primary Care Transformation Fund) will not provide enough staff to meet the needs of ELHSCP or the other Partnerships in Lothian. Local funding will therefore be required.

4.3 ELHSCP will develop training opportunities in locally managed services, such as the care home team, or deploy trainees in GP practices to be trained in chronic disease management and/or acute illness. The availability of expertise within the Primary Care Nursing team will support the partnership in responding to population growth and other pressures affecting GP practices.

5 Practice-based Pharmacists

5.1 Scottish Government funded Practice Pharmacists have been allocated to East Lothian health centres according to assessed need. Their success in transferring medicines-related work from GPs and in medicines management demonstrates the merit of offering this support to other practices.

5.2 The HSCP has ambitions to develop an alternative patient pathway for patients to consult direct with a pharmacist on a full range of medicines matters instead of seeing a GP. This will be beneficial for patients and should improve the quality and cost-effectiveness of primary care prescribing.

6 LEGup Support for List Size Growth

6.1 ELHSCP's proportionate share of the LEGup budget (one per year - £25,000) is insufficient to respond to current population growth. ELHSCP intends to directly fund a further LEGup in 2017-18, allowing extension of support to practices to accommodate 1,000 patients and to maintain unrestricted lists. This funding would be flexibly allocated according to where the growth pressures are being most acutely experienced.

7 Provision of IT Hardware

7.1 ELHSCP continues to exploring the option of providing practices with dual screen computer workstations. This facility will give clinical users the ability to see different clinical software programmes at the same time, without the need to constantly minimise and maximise different views. Such an arrangement will provided a significantly enhanced patient consultation and improved efficiency with clinical administration and patient records management.

7.2 It is expected that reception and administrative staff will also benefit from a dual monitor arrangement, giving them the ability to view appointment screens at the same time as, for example workflow documentation, so improving productivity.

7.3 In addition, the HSCP primary care team is considering approaches to enable reception desk staff to easily capture activity data to monitor patient demand and access. This information will allow individual practices to match their resources to demand. Such information, if available at East Lothian level, will inform HSCP decision making on resource allocation at a county level.

8 Future planning for a new practice in Blindwells

8.1 There will be a need (depending on planning applications and pace of development) to meet the additional need of between 5,000 and 10,000 new patients at Blindwells.

8.2 In the early stages it is proposed to work with another local practice to provide facilities and support to ‘incubate’ a new practice that will then move to Blindwells.

8.3 At some point, new primary care premises will be needed in the Blindwells development. This will be the subject of a specific business case.

9 Diabetes LES

9.1 Support to the Diabetes Local Enhanced Service (LES) continues in order to sustain and develop GP and practice team clinical and lifestyle management support to the growing population of people living with Type 2 diabetes.

9.2 Work will also be carried out in 2017-18 to ‘repatriate’ to primary care those East Lothian residents with Type 2 diabetes who are receiving this care in secondary care diabetes clinic settings. Funds released by such activity transfer will be used to offset the increased cost of community based activity.

Appendix 2

Edinburgh Primary Care Strategic Programme – planned action in 2017 (Draft in Development)

Background

1.1 The purpose of this paper is to inform stakeholders of the work that is planned in 2017/18 to support, stabilise and develop primary care services in Edinburgh.

1.2 General Practice is currently facing considerable capacity and sustainability challenges. This is well rehearsed elsewhere, but the additional burden of population growth since 2009 and prospectively, should be emphasised. In Edinburgh, 43 of 73 practices are operating with restricted lists as a result of increasing demand

1.3 The Edinburgh Health and Social Care Partnership have developed a primary care strategic programme to support, stabilise and develop primary care services in Edinburgh. This programme needs to be supported with a confirmed structure which remains outstanding for the proposed Edinburgh Primary Care Support Team.

1.4 The programme will adapt over time to respond to new pressures and opportunities and continue to be shaped. The programme was initially developed in response to a series of crisis interventions for individual practices, but is now evolving into a proactive programme through the application of Transformation Funds and LHB Primary Care investments available from 1.04.17.

2 Edinburgh Primary Care Strategic Programme

The Primary Care Strategic Programme provides a structure to coordinate and prioritise the work to support General Practice. The programme will be updated and refined to respond to new challenges or opportunities. Edinburgh is developing its longer term Primary Care Strategy for the next 15 years.

2.1 The Edinburgh Strategic Plan aims to support the transformation of Primary Care through 6 work streams as stated below:

- Recruitment and retention of GPs
- Developing Primary Care premises
- Wider Workforce capacity and redesign
- Practice teams working differently
- New models to meet the frail older people
- Streamlined Interface with Acute services

In addition, the following improvement priorities should be highlighted:

- Balance the workload on existing practice teams
- Culture Change and People Development
- Creating multidisciplinary capacity within General Practice
- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of the population
- Creating the physical capacity required for current and future population growth linked to the CEC LDP 2016-26

3.0 General Practice Premises & Population

3.1.1 The Edinburgh H&SCP has assessed the impact from house building in Edinburgh and taken action to increase capacity of general practice and reduce the financial impact.

3.1.2 An extensive assessment of population pressure has been made following the CEC LDP finalisation in November 2016. Meetings were held with GP practices across the city and set out in a paper to be presented to the IJB in May 2017 (TBC) The paper describes the required capital (or commensurate revenue) investment of £57M in addition to the capital scheme agreed for delivery in 2017/18;

- Pennywell (NW Partnership Centre)
- Leith Walk
- Allermuir (Firrhill/ Craiglockhart)
- Ratho

3.1.3 List Extension Growth Uplift (LEGup) is a funding stream managed by the Primary Care Contracts Organisation and overseen by the Primary Care Joint Management Group. This aims to "....encourage structured and supported growth of GP Practices." The scheme provides a number of one off, non-recurring payments of £25,000 to support planned list size growth.

3.1.4 Edinburgh's pro-rata share of the Lothian LEGup is three per year. It has been asserted that a minimum of 8-10 per year are required to meet population/practice growth. It may be possible to augment this funding stream with the Transformation Funds and ensure at least one LegUp practice per cluster (8) across the city.

3.1.5 Practice Boundaries are approved by the Primary Care Joint Management Group. A strategic review of practice boundaries in Edinburgh was undertaken during 2016 with practice representatives recognising the benefits of common cluster boundaries which will help to reduce pressure on practices whilst continuing to offer patients a choice of practices to register with. Boundary changes are beginning to occur where a practice has a boundary covering a large area which creates an inefficiency for clinicians undertaking home visits, or where a new housing development will negatively impact a practice that is operating a restricted list or close to its maximum list size. In addition, practices may be 'matched' to swap patient groups and create a better focused catchment area.

3.1.6 Where a house-building development proposal is otherwise acceptable, but cannot proceed due to deficiencies in infrastructure and services, planning

applicants can be required by the Council to make provision for full or part contribution towards the costs of addressing such deficiencies.NHS Lothian or Edinburgh Council can enter into a S75 agreement on behalf of the IJB with a developer to address deficiencies. NHS Lothian has previously entered into one S75 legal agreement in Midlothian. This required the developer to provide a practice building within Shawfair town centre. This sets a useful potential precedent for Edinburgh.

(The extent of the possible developer contribution is set out in the Edinburgh Population and Premises document)

4.0 Out of Hours Services Review

4.1 The Edinburgh H&SCP will work with other Lothian H&SCP to review the arrangements for out-of-hours services in Edinburgh. This work will contribute to changes in the new model of care for out of hours provision recommended in the 2015 report of the independent review – Pulling together: transforming urgent care for people of Scotland.

5.0 Organisational Change and People Development in Practice teams

5.1 The health and care system is changing and individuals and teams working within this system need support to understand the implications of change and how they can contribute and benefit from the change. The Headroom Project had made a huge contribution in Edinburgh over the last three years and this work will be carried forward by a combination of the new Clusters and the Primary Care Linkworker Network.

5.2 The H&SCP want to support practice teams to understand the changes happening in the wider health and care system, how the practice team can benefit from these changes and how they can lead change both within their team and across the wider system. To do this the H&SCP has started to provide support for practices and will create a programme of support for practices.

5.3 An explicit objective for this work is to create time and space for practice teams to consider how they want to develop their service and how they want to the health and care system to develop to help improve the outcomes and experience of their patients. This will complement and support the dialogue developed in Headroom and now being carried forward in cluster groupings.

6.0 Create multidisciplinary capacity within practice teams

6.1 The H&SCP will apply funding to support practices to take on new clinical roles and services that were not within a traditional practice team. This is the centre piece of our Transformation approach and builds on a number of early successes in supporting practices with alternatives to medical capacity.

- 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 building on the innovation of the Boroughloch Practice.
- Extending the provision of practice-based pharmacist and pharmacy technician support.
- Embed the Linkworking Service across the City and evaluate the impact of the service.
- Continue to develop the CPN role within Primary Care teams building on the successful introduction of thus role in two Edinburgh Practices during 2016
- Continue to develop the pharmacist role in Primary Care, both within and out with the Practice Team

6.2 It is important that all new roles and services are evaluated to find out if the development has made the required impact and can justify ongoing funding.

7.0 Patient Experience

7.1 The H&SCP will work with practices and the public to understand the experience of people accessing general practice services and work with both to improve the experience. The H&SCP will provide more support for Reception teams though the provision of additional training provided through the Linkworker Network: There is a growing issue shared by some members of the public about the experience of contacting practice reception staff. The Partnership understands the difficult position that reception staff are placed acting as gatekeepers to overwhelmed practice teams, dealing with difficult conversations and working to consistently provide a professional service. Training has been developed and piloted through Headroom to support reception staff to provide this crucial role.

7.2 An early example in Edinburgh estimates that 6% of consultation requests can be deflected outside the Practice Team by skilled receptionists. A further work programme will be implemented to support the further roll out this practice.

8.0 Implementing the Prescribing Action Plan

8.1 The Edinburgh Prescribing Action Plan will manage the expenditure on medicines in Edinburgh of circa £75m per annum. The Plan has numerous projects delivered at practice level, cluster level, City level and across Lothian as appropriate. The cost and quality of Edinburgh prescribing continues to set the benchmark for Scotland.

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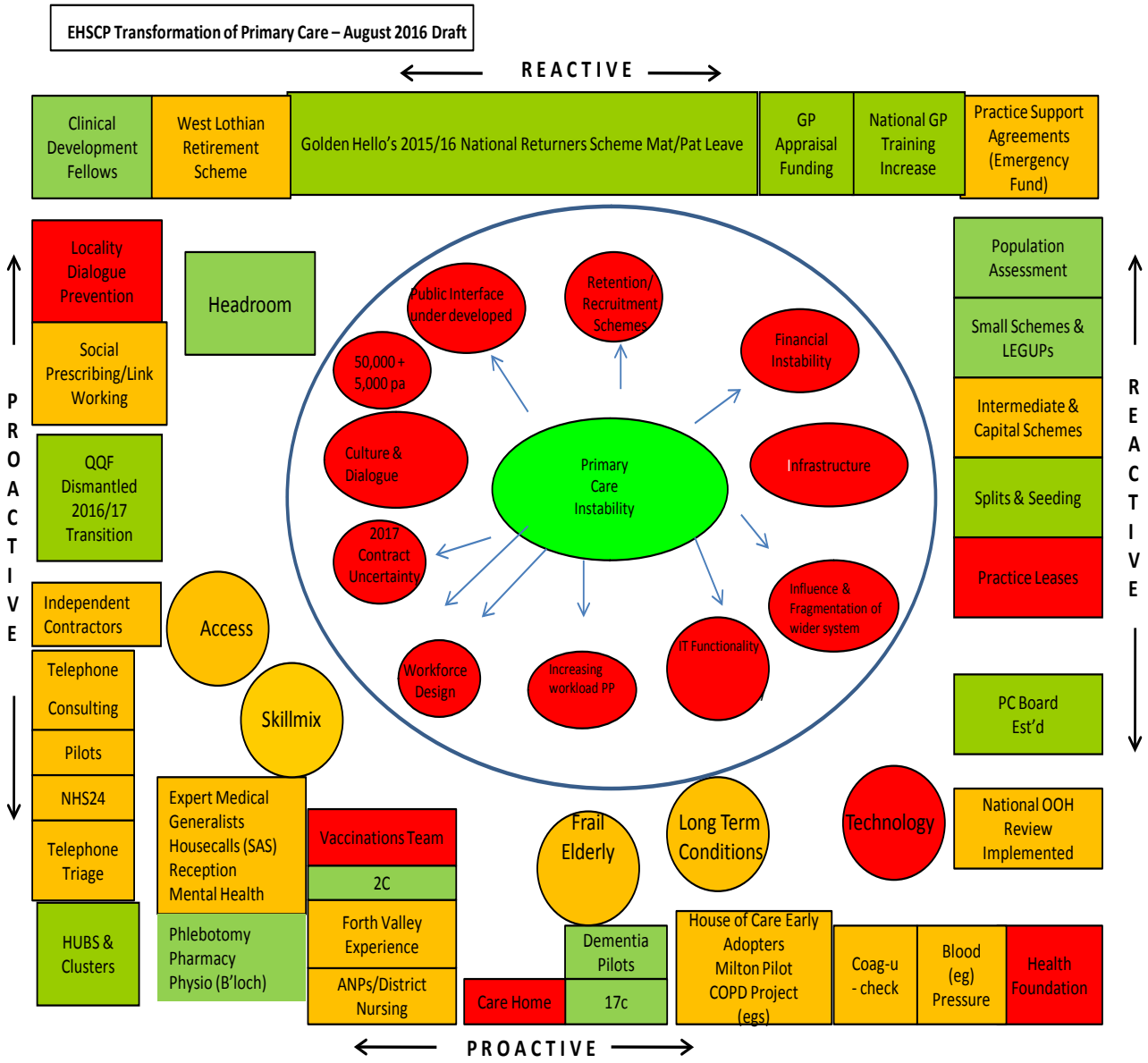
EHSCP Transformation of Primary Care – August 2016 Draft
REACTIVE
Clinical Development Fellows
West Lothian Retirement Scheme
Golden Hello's 2015/16 National Returners Scheme Mat/Pat Leave
GP Appraisal Funding
National GP Training Increase
Practice Support Agreements (Emergency Fund)
PROACTIVE
Locality Dialogue Prevention
Social Prescribing/Link Working
QQF Dismantled 2016/17 Transition
Independent Contractors
Telephone Consulting
Pilots
NHS24
Telephone Triage
HUBS & Clusters
Headroom
Access
Skillmix
Expert Medical Generalists Housecalls (SAS) Reception Mental Health
Phlebotomy Pharmacy Physio (B'loch)
Vaccinations Team
2C
Forth Valley Experience
ANPs/District Nursing
Public Interface under developed
Retention/ Recruitment Schemes
50,000 + 5,000 pa
Financial Instability
Culture & Dialogue
Primary Care Instability
Infrastructure
2017 Contract Uncertainty
Influence & Fragmentation of wider system
Workforce Design
Increasing workload PP
IT Functionality
Frail Elderly
Long Term Conditions
Technology
Care Home
Dementia Pilots
17c
House of Care Early Adopters Milton Pilot COPD Project (egs)
Coag-u - check
Blood (eg) Pressure
Health Foundation
Population Assessment
Small Schemes & LEGUPs
Intermediate & Capital Schemes
Splits & Seeding
Practice Leases
PC Board Est'd
National OOH Review Implemented
REACTIVE
PROACTIVE

Appendix 3

April 20th 2017

General Practice Strategic Programme – planned action in 2017

Please note that this paper will be tabled at the Midlothian Integration Joint Board on April 20th. Therefore is still a draft paper.

Background

This paper describes the framework of the General Practice Strategic Programme and the actions planned in it in 2017.

1.1 The Midlothian Health and Social Care Partnership have developed a primary care strategic programme to support, stabilise and develop primary care services in Midlothian. A draft programme was presented to the IJB in November 2016.

1.2 The programme will adapt over time to respond to new pressures or opportunities and continue to be shaped by clinical and public views. There is an ongoing programme of engagement with community groups of interest and with general practices.

1.3 The purpose of this paper is to inform the Integration Joint Board of the work that is planned in 2017/18 within this programme to support, stabilise and develop primary care services in Midlothian.

1.4 General Practice is currently facing considerable capacity and sustainability challenges caused by a combination of patient factors, system factors and supply factors. In Midlothian over half the practices are operating with restricted lists as a result of increasing demand.

2 Midlothian General Practice Strategic Programme

2.1 The GP Strategic Programme provides a structure to coordinate and prioritise the work to support General Practice to meet the needs of patients. The programme will be updated and refined to respond to new challenges or opportunities. It is not helpful to have a fixed long term strategic plan for primary care because pressures on the system and the landscape will evolve over time and Midlothian needs a programme that can remain agile to respond.

2.2 The programme has two aims and seven identified improvement areas:

2.3 Strategic Programme Aims:

Aim 1: Make General Practice in Midlothian sustainable and resilient to current and future demand.

Aim 2: Better Care for Individuals, better health for populations, lower per capita cost.

2.4 Strategic Programme improvement priorities:

- Reduce the workload on existing practice teams
- Culture Change and People Development
- Redefining the relationships required for collaborative working between practice teams and other health, care and voluntary services
- Create multidisciplinary capacity within General Practice
- Reduce per capita cost of healthcare
- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of the population

3 Planned Primary Care Developments in Midlothian in 2017/18 and 2018/19

The following are the actions planned in Midlothian to support and stabilise general practice in Midlothian.

4 Reduce the workload on existing practice teams

4.1 General Practice expansion

4.1.1 The Midlothian H&SCP has assessed the impact from house building in Midlothian and taken action to increase capacity of general practice and reduce the financial impact. The following developments are planned which will increase the capacity of general practice in Midlothian by between 7,300 and 8,300 patients or between 9% and 11% of the existing total practice list number in Midlothian.

- Newtongrange Clinic established in 2017.
- Newbyres practice building will be upgraded in 2017/18.
- Loanhead Health Centre will move in 2017 onto the new community school campus.

4.1.2 In addition an expansion to Danderhall Medical Centre is planned for 2019 which will allow this practice to double capacity to 6000 patients.

4.1.3 This new capacity will accommodate the predicted population growth in Midlothian over the next four or more years. Further work is required working closely with the Midlothian Council Planning to identify future requirements for additional capacity. For example, a new practice will be developed in Shawfair town centre around 2024 to accommodate a further 10,000 patients.

4.1.4 Impact of Loanhead expansion and Newtongrange Clinic

4.1.5 These developments will jointly benefit the patients and existing practices in the Bonnyrigg area. Newtongrange will also benefit Pathhead, Newbyres, Newbattle and Dalkeith Practices. It is hoped that this development will reduce pressure on the practices operating with a restricted list allowing the practices to reopen later this year.

4.1.6 The H&SCP will work with all practices listed to coordinate the public communication and transfer of patients between practices. Patients do not have to change practice unless the patient has moved to a new dwelling that is outside the boundary. The practices with restricted lists will write to all patients who are living outside their boundary but within the Newtongrange or Loanhead practices offering the patients the opportunity to move practice.

4.2 LEGup Support for List Size Growth

4.2.1 List Extension Growth Uplift (LEGup) is a funding stream managed by the Primary Care Contracts Organisation and overseen by the Primary Care Joint Management Group. This aims to "....encourage structured and supported growth of GP Practices." The scheme provides a number of one off, non-recurring payments of £25,000 to support planned list size growth.

4.2.2 Midlothian's pro-rata share of the Lothian LEGup is one per year. It is intended in 2017/18 that this will contribute to the development of the Newtongrange Clinic. The expansion of Loanhead Medical Practice requires a further LEGup and it is proposed that the Midlothian H&SCP directly funds a further LEGup in 2017/18. The IJB should anticipate demand for future LEGup allocations that will need to be funded from the IJB's budget.

4.3 Practice Catchment review

4.3.1 Practice Boundaries are approved by the Primary Care Joint Management Group. There is currently a restriction on any boundary change within Midlothian. A strategic review of practice boundaries will be undertaken during 2017 with practice representatives to agree a single proposal for Midlothian practices that will help to reduce pressure on practices whilst continuing to offer patients a choice of practices to register with. Boundary changes are likely to occur where a practice has a boundary covering a large area which creates an inefficiency for clinicians undertaking home visits, or where a new housing development will negatively impact a practice that is operating a restricted list or close to its maximum list size.

4.4 S75 Policy

4.4.1 Where a house-building development proposal is otherwise acceptable, but cannot proceed due to deficiencies in infrastructure and services, any or all of which will be created or made worse as a result of the development, planning applicants can be required by the Council to make provision for full or part contribution towards the costs of addressing such deficiencies.NHS Lothian or Midlothian Council can enter into a S75 agreement on behalf of the IJB with a developer to address deficiencies. NHS Lothian has previously entered into one

S75 legal agreement in Midlothian. This requires the developer to provide a practice building within Shawfair town centre.

4.4.2 The H&SCP is currently developing policy language and a S75 policy will be presented to the IJB for agreement which will contribute to potential S75 agreements for developers to cover non-recurring costs incurred as a direct result from new house building.

4.5 Making the Right Choices

4.5.1 Redirecting patients to other services with the 'Making the Right Choices' communication initiative.

5 Redefining the relationships required for collaborative working between practice teams and other health, care and voluntary services

5.1 Collaborative Leadership

5.1.1 NHS National Education Scotland has been commissioned to help strengthen locality working in Midlothian. They will work in Penicuik supporting staff from the local practice the H&SCP and local voluntary organisations to seek improvements for the coordination of care for patients who are housebound. This work will start in Summer 2017.

5.2 Out of Hours Services Review

5.2.1 The Midlothian H&SCP has started reviewing the arrangements for out-of-hours services in Midlothian. This work will contribute to changes in the new model of care for out of hours provision recommended in the 2015 report of the independent review – Pulling together: transforming urgent care for people of Scotland.

5.3 Organisational Change and People Development in Practice teams

5.3.1 The health and care system is changing and individuals and teams working within this system need support to understand the implications of change and how they can contribute and benefit from the change. The H&SCP want to support practice teams to understand the changes happening in the wider health and care system, how the practice team can benefit from these changes and how they can lead change both within their team and across the wider system. To do this the H&SCP has started to provide support for practices and will create a programme of support for all practices to access that will include Reception team development; leadership and organisational development in practices; enhancing practices' contribution to the development of the health and care system, and creating more capability for improvement using quality improvement methodology.

5.3.2 An explicit objective for this work is to create time and space for practice teams to consider how they want to develop their service and how they want to the health and care system to develop to help improve the outcomes and experience of their patients.

5.4 Create multidisciplinary capacity within practice teams

5.5 The H&SCP is supporting practices to take on new clinical roles or services that were not within a traditional practice team.

- 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. During 2017 a new physiotherapy role will be developed in Midlothian initially working within Pathhead, Strathesk and Newbattle Practices
- Extending the provision of practice-based pharmacist and pharmacy technician support.
- Embed the Wellbeing Service in 8 health centres and evaluate the impact of the service

5.6 It is important that all new roles and services are evaluated to find out if the development has made the required impact and can justify ongoing funding.

6 Better care for individuals, better health for populations, lower per capita cost

6.1 eFrailty programme

6.2 The Midlothian H&SCP is working with the Midlothian Quality cluster, Healthcare Improvement Scotland and NHS Lothian eHealth to establish the eFrailty index in all practices in Midlothian. This uses clinical codes to identify and grade the frailty of all patients in the practice. Currently it is not possible for practices or for the H&SCP to identify all the people living within frailty in Midlothian. Once the Efrailty index is established it will improve coordination and anticipatory care for people with frailty.

6.3 Patient Experience

6.3.1 The H&SCP will work with practices and the public to understand the experience of people accessing general practice services and work with both to improve the experience. The H&SCP will provide more support for Reception teams though the provision of additional training: There is a growing issue shared by some members of the public about the experience of contacting practice reception staff. The Partnership understands the difficult position that reception staff are placed acting as gatekeepers to overwhelmed practice teams, dealing with difficult conversations and working to consistently provide a professional service. Therefore training will be provided to support reception staff to provide this crucial role.

6.4 Implementing the Prescribing Action Plan

6.4.1 The Midlothian Prescribing Action Plan will manage the expenditure on medicines in Midlothian of circa £17m per annum. The IJB has received a

presentation on the action plan in November 2016. The Plan has numerous projects. One of these projects, the Penicuik Deprescribing Project aimed to review and reduce the number of medications that patients were prescribed. The project focused on patients over the age of 80 who were on four or more medications. All were invited to attend the practice for a review by a GP or pharmacist. In almost 80% of reviews there were one or medications identified which could either be reduced or stopped. The results from this pilot will be disseminated across Midlothian so that other practices can take up the initiative.

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Appendix 4

PRIMARY CARE REPORT

REPORT BY DIRECTOR

A PURPOSE OF REPORT

This paper outlines the current issues and challenges being faced by General Practice which are affecting the sustainability of Primary Care provision and provides an overview of the measures being taken to support General Practice and the key priorities emerging from the West Lothian Primary Care Summit held on 22nd February 2017

B RECOMMENDATION

1) To note the contents of the report
2) To note the current issues and challenges in sustaining Primary Care Services in West Lothian
3) To support the priorities identified through the partnership and the Primary Care Summit for further development
   a) LEGUP support for list size growth
   b) Development of emergency fund to support practices in difficulty to maintain service provision
   c) Enhance the capacity of primary care teams with extended role practitioners to increase capacity and sustainability in primary care.
   d) Develop marketing and recruitment strategy to support practices with recruitment
   e) Continue to support training of advanced nurse practitioners
   f) Expand REACT and develop Frailty Hub and Rapid Access Clinic
   g) Elderly Care Facilities Quality Care Programme
   h) Signposting and Support Hubs to promote self management and direct access to alternative services
   i) Invest in IT hardware and software to support direct patient care and information sharing
   j) Advance health and social care integration through better joint working between primary and social care

C TERMS OF REPORT

Background

It is well recognised that primary and community care services are facing major challenges; with an increasing workload, an aging population, and increasingly complex medical problems being diagnosed and managed in the community. Investment in primary care has fallen behind investment in hospitals, despite increasing expectations of the work that should be done in primary care. The relationship between the public and health professionals is also changing with an increasing focus on giving people information and involving them in decisions about their care.

Population growth in the core development areas of Armadale, East Calder, Whitburn, Bathgate and Winchburgh is having significant impact on General Practices and their capacity to manage the demand associated with increases in list size. This has led to practices putting restrictions on their list which impacts both on the population not being able to register with a GP and the workload of neighbouring practices.

LEGUP (List Expansion Grant Uplift Scheme) provides a short term financial incentive for practices to take on more patients and is managed by the Primary Care Contracts Organisation and overseen by the Primary Care Joint Management Group. The expectation is that once practices have been supported to expand, the increased list size will generate the increased income needed to maintain service provision. The HSCP have distributed this funding (1 grant of £25K) to support practices with high population growth over the last two years.

The IJB agreed the **premises** priorities for Primary Care at its meeting on 14th March2017 which include:

a. Development of new Health Centre premises in East Calder
b. Development of an additional GP practice in new building in Armadale
c. Refurbishment of Whitburn Health Centre
d. The established development of Blackburn Partnership Centre to be progressed to implementation in September 2017.

Sustainability of GP services is crucial to our Primary Care provision. Whilst the majority of practices operate on an independent contractor basis, for some practices the recruitment, patient demand, financial, premises and other issues are such that they have required practical and financial support from the HSCP and PCCO to maintain service provision. The establishment of an **emergency fund** to support sustainability would be advantageous in order to maintain service provision and capacity.

Over the past three years the HSCP has had to take over direct management of two practices under Section 2c of the GMS contract due to retirements or resignations. Following a period of stabilisation the HSCP have sought to return the practice to a GP managed contract and have been successful with this approach. From the 1st April the HSCP have taken Deans & Eliburn into a 2c managed service arrangement and will be taking the opportunity to develop the primary care team with advanced skilled practitioners to test a model for change.

Premises, GMS income and associated funding streams are only part of the community service capacity which needs to be developed. This work needs to come together with the workforce planning for all associated disciplines and the development of new roles and partnership working to manage capacity issues and support provision of primary care.

West Lothian Primary Care Summit

The West Lothian Primary Care Summit took place on 22nd February 2017. The discussion focused on collaborative working across primary, secondary and social care and how we could work together to improve sustainability in primary care. The summit was attended by representatives from West Lothian GP practices, acute services, social care, voluntary and independent sectors, Scottish Ambulance service, senior managers and IJB and NHS Lothian board members. The key themes emerging from the summit are summarised below.

Expansion of the Primary Care Team

With major problems with GP recruitment and retention and an aging nursing workforce there is a need to develop short and long term strategies to recruitment and retention

and to maximise opportunities to expand the primary care workforce through the use of other healthcare professionals. This needs to be underpinned with workforce planning including identification of necessary skills and competencies. For example:

- More use of AHPs with new practitioners as part of primary care team under GP direction e.g. Physiotherapy extended scope practitioner model in development for pilot with two practices from May 2017
- Psychologist to support mental health caseload
- Psychiatric nurses to provide acute assessment and care planning for mild to moderate mental health patients- testing model in one practice from April 2017
- Integrated Care Pharmacists to undertake wide range of clinical work at practice level including prescribing.
- SAS Primary Care Paramedic to be based in practices for home visits/minor illness/injuries. Model in development with SAS in West Lothian.
- Patient transport/ volunteer drivers to bring patients to the health centre and reduce demand for house calls/ domiciliary phlebotomy/DN visits.

It will not be possible to provide every practice with this wider range of practitioners and therefore we will look to cluster provision with groups of practices to optimise resource use.

West Lothian has 22 practices and current level of GP vacancies is equivalent to10 WTE. These vacancies are spread over several GP Practices.

In additional to national actions on GP training and retention there is a need to develop a professional standard **marketing and recruitment** strategy to include contractor practice vacancies.

There was also concern regarding locum rates and when these are inflated that this impacts on market availability and costs of locums for other practices and that a national agreement on locum rates would be advantageous.

Over recent years, primary care **Advanced Nurse Practitioner (ANP)** posts have been established, with these practitioners managing a similar acute caseload to GPs and having a key role in our modern primary care workforce. Therefore we will seek to continue to support ANP training and development.

As the increasing number of frail older people living with multiple complex health conditions are supported to live in community settings a very significant and expanding proportion of GP time is required to manage the additional clinical care demand.

The Frailty Programme was established to established to transform the way we work, taking a whole system approach to redesign services to manage current and future demand. The programme covers primary and secondary care, the acute sector and social care within West Lothian. The Primary Care Summit provided positive feedback on **REACT** with the GPs being supportive of an expanded and more accessible service.

The development of a **Frailty Hub and Rapid Access Clinic** will provide patients, their families and GPs with one point of contact to refer frail elderly patients for appropriate assessment and care. This will build on the successful REACT service and will help to ensure patients are assessed and provided with the appropriate care in the right place.

Elderly Care Facilities Quality Care Programme has been developed to support improvements in the quality of care for those in residential facilities. The programme will be led by a dedicated care home lead GP and will aim to streamline care, reduce

inappropriate emergency admissions and unscheduled care demand on GPs, LUCS, and ambulance services.

Research suggests that 27% of GP appointments were potentially avoidable and it was recognised that we should continue to do what works well and learn from successes in other areas.

There is a clear appetite to avoid medicalisation and to use resources better to empower patients to self manage and direct refer to a range of agencies and services. We have developed **Signposting** communication which is being widely distributed through a variety of media to ensure information is available and accessible to the West Lothian population.

To support the signposting of patients we have developed triage/signposting training for practice staff to increase competencies and skills in support of their roles and responsibilities. This training has been made available to all staff in the West Lothian practices and through time will optimise use of resources and promote self management as the norm.

In addition there was a clear desire to manage mental health distress in a more proactive way with less emphasis on medical care and more on social supports. This could be supported through the development of **Support Hubs** and this will be explored further. In addition to mental health it was also thought that this type of support model could be used effectively for MSK – 1st point of contact for MSK problems; Alcohol problems and social work/ social care distress.

Invest In Information Technology

GP practice clinical IT systems are provided and maintained by NHS Lothian eHealth. Most practices in Lothian use VISION, a smaller number of practices use EMIS. There is widespread agreement that IT provision to GP practices is outdated. Most GP practices have ageing PCs with outdated and poorly compatible software. GP systems are very slow and are prone to crashing.

These limitations are extremely frustrating and operationally inefficient as they impact on GP consulting time. The opportunity cost of time spent waiting for systems to load and rebooting PCs in the consultation is immense, not to mention the cumulative effect of these frustrations on morale.

GP systems also have no connectivity with those used in the acute sector, the out of hours service, community nursing, social care and the Scottish Ambulance Service.

The following IT priorities emerged:

- To establish with e-health what can be done to sort capacity and improved hardware and software in General Practices and support provision of mobile technology such as tablets for home visiting and remote working
- Set up and fund text reminder/cancellation service for patients.
- Teleconference/videoconference facilities.
- Promote IT self help resources such as Babylon.
- Improve pathway into social services to support real-time records update with systems that link.
- Support sharing of information e.g.
    - The SAS see patients (some multiple times) but are unable to feedback information to GP practices. SAS have capacity to send patient report

forms direct to practices but NHSL IT not willing to support implementation.
- Patients also have social care needs and need to be able to support sharing information with social work.

There was positive discussion on how to **advance Health and Social Care Integration** which could be improved through:

- Development of social care "Anticipatory Care Plans" to support appropriate interventions and prevent admissions due to crisis
- Review of social work referral systems to improve access and resources.
- Develop joint working teams – health/social care/ voluntary sector – a "community MDT" for each locality with shared ownership which would avoid duplication and streamline process for clients.
- Case managers directly linking with social care to optimise patient care.
- Agreement on schedules and timeframes to support joint working e.g. agreement on response times for crisis prevention.
- Work with voluntary organisations to offer more early intervention.
- More structured post-discharge process to signpost to appropriate services and better integration with discharge hub to facilitate this.
- Review benefits system to reduce impact on GP workload
- Managing public perception on changes especially implementation of *Realistic Medicine* which will require political and organisational support

It was clear that the GPs considered they are best placed to determine how resources should be spent in primary care and that there is a balance to be struck between developing HSCPand NHS Lothian services and devolving funds directly to GPs. We will continue to engage with GP Clusters and the Primary Care and Community Forum to learn from evidence and test changes in order to maximise opportunities and support best use of available resources.

The above priorities will be incorporated into the development of West Lothian's Primary Care Plan which will also take account of the changes in the new GMS contract as these are published.

D CONSULTATION

West Lothian Primary Care Summit February 2017

Primary Care & Community Forum

E REFERENCES/BACKGROUND

F APPENDICES

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted.
National Health and Wellbeing Outcomes	All National Health and Well Being Outcomes
Strategic Plan Outcomes	Primary Care is critical to all Strategic Plan Outcomes
Single Outcome Agreement	We live longer healthier lives and have reduced health inequalities Older people are able to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Mutual Aid, Management of Risk
Resource/finance	Within available resources
Policy/Legal	None
Risk	High Risk on HSCP Risk Register

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3rd April 2017