

BOARD MEETING

DATE: WEDNESDAY 22 JUNE 2016

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

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



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

AGENDA

Agenda Item

Lead Member

Welcome to Members of the Public and the Press

Apologies for Absence

1. **Items for Approval**

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|-------|---|------|---|
| 1.1. | Minutes of the Previous Board Meetings held on 6 April and 11 May 2016 | BH | * |
| 1.2. | Running Action Note | BH | * |
| 1.3. | Audit & Risk Committee - Minutes of 18 April 2016 | JMcD | * |
| 1.4. | Finance & Resources Committee - Minutes of 4 May 2016 | GW | * |
| 1.5. | Healthcare Governance Committee - Minutes of 15 March 2016 | RW | * |
| 1.6. | Strategic Planning Committee - Minutes of 24 March & 14 April 2016 | BH | * |
| 1.7. | East Lothian Integration Joint Board - Minutes of 25 February, 31 March & 21 April 2016 | DG | * |
| 1.8. | Edinburgh Integration Joint Board - Minutes of 11 March & 13 May 2016 | GW | * |
| 1.9. | Midlothian Integration Joint Board - Minutes of 11 February, 17 March & 14 April 2016 | CJ | * |
| 1.10. | West Lothian Integration Joint Board - Minutes of 23 March, 31 March & 5 April 2016 | MH | * |
| 1.11. | Schedule of Board & Committee Meetings for 2017 | BH | * |
| 1.12. | Committee Memberships and Terms of Reference | BH | * |
| 1.13. | NHS Lothian Patients' Private Funds - Annual Accounts 2015/16 | SG | * |

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

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

2. **Items for Discussion** (subject to review of the items for approval)
(9:35am - 12:00pm)
- 2.1. Annual Report & Accounts for the Year Ended 31 March 2016 *(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.)* **SG** ®
 - 2.2. NHS Lothian Corporate Risk Register **DF** *
 - 2.3. Financial Position to 31 May 2016 **SG** *
 - 2.4. Quality & Performance Improvement **AMcM** *
 - 2.5. Review of Medical Paediatric Inpatient Services in Lothian **JC** *
3. **Next Development Session:** 20 July 2016 at 9:30 a.m. in the Boardroom, Waverley Gate.
4. **Next Board Meeting:** Wednesday 3 August 2016 at 9:30 a.m. in the Boardroom, Waverley Gate.
5. Resolution to take items in closed session
6. Minutes of the Previous Private Meeting held on 6 April 2016 **BH** ®
7. Matters Arising
8. Edinburgh BioQuarter and the City Deal **SG** ®
9. Any Other Competent Business

Board Meetings in 2016

3 August 2016
5 October 2016
7 December 2016

Development Sessions in 2016

20 July 2016
7 September 2016
2 November 2016

DRAFT

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 6 April 2016 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mrs Kay Blair; Councillor D Grant; Councillor R Henderson; Mr M Hill; Ms C Hirst; Mr P Johnston; Councillor C Johnstone; Mr A Joyce; Mrs A Meiklejohn; Mrs A Mitchell; Mr P Murray; Mr J Oates; Councillor F Toner; Mr G Walker; Professor M Whyte and Mrs L Williams.

Executive and Corporate Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources & Organisational Development); Mr J Crombie (Chief Officer); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Interim Nurse Director / Director of Strategic Planning, REAS & Prison Healthcare) and Dr S Watson (Chief Quality Officer).

In Attendance: Mr J Forrest (Chief Officer, West Lothian Integration Joint Board); Ms J Morrison (Head of Patient Experience) and Mr P Reith (Secretariat Manager).

Apologies for absence were received from Mrs J McDowell and Dr R Williams.

Welcome and Introduction

The Chairman welcomed Professor Moira Whyte of the University of Edinburgh and Dr Simon Watson the new Chief Quality Officer to their first formal Board meeting.

The Chair commented that members would notice a slight change in the style of some Board papers and advised that Alan Payne had been reviewing the Committee structures and papers. Some of the papers submitted had been withdrawn and others edited to bring them into line with guidance. Mr Payne would continue with his review and, together with the Chief Executive and the Chairman, would carry out a quality review of papers submitted for Board meetings.

Declaration of Financial and Non-Financial Interest

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

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. No such requests had been made.
- 1.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations in respect of the previously circulated "For Approval" papers without further discussion.
- 1.3 Minutes of the Board Meetings held on 3 February and 2 March 2016 - Approved.
- 1.4 Running Action Note - Approved.
- 1.5 Acute Hospitals Committee - Minutes of 1 March 2016 - Endorsed.
- 1.6 Audit & Risk Committee - Minutes of 7 September 2015 and 29 February 2016 - Endorsed.
- 1.7 Finance & Resources Committee - Minutes of 20 January and 9 March 2016 - Endorsed.
- 1.8 Healthcare Governance Committee - Minutes of 26 January 2016 - Endorsed.
- 1.9 Staff Governance Committee - Minutes of 29 July, 28 October 2015 and 27 January 2016 - Endorsed.
- 1.10 Strategic Planning Committee - Minutes of 21 January and 11 February 2016 - Endorsed.
- 1.11 East Lothian Integration Joint Board - Minutes of 28 January 2016 - Endorsed.
- 1.12 Edinburgh Integration Joint Board - Minutes of 15 January 2016 - Endorsed.
- 1.13 Mid Lothian Integration Joint Board - Minutes of 10 December 2015 - Endorsed.
- 1.14 West Lothian Integration Joint Board - Minutes of 16 February 2016 - Endorsed.

2. Items for Discussion

3. Financial Position to February 2016 and Update to Year End Forecast

- 3.1 Mrs Goldsmith introduced a circulated report providing an overview of the financial position for the 11 months to February 2016 and providing assurance on the delivery of a breakeven position.
- 3.2 Mrs Goldsmith commented that this was the first time in the 2015/16 financial year that she had been able to report an underspend. For the first time she could say with confidence that NHS Lothian would breakeven at the end of the financial year. A large number of efficiency savings still had to be delivered of which around

£2.5m would be coming from discounts and rebates on drugs which would be booked in the last month of the year.

3.3 Mrs Blair welcomed the Director of Finance's report and asked if there was confidence that other areas of the Local Reinvestment Plan would be delivered.

3.4 Mrs Goldsmith reminded colleagues that the financial year had got off to a good start with efficiency savings and she was more confident that the policy of leaving it up to business units to deliver services to a set budget would be a more effective way of achieving targets. The emphasis would be on focusing on month to month delivery of services within budget.

3.5 Mrs Allan asked if there were still opportunities in terms of the configuration and number of beds and Mrs Goldsmith emphasised that as a result of the Deloitte Report the need to close older sites was recognised and progress on this would be addressed in future reports on efficiency savings.

3.6 The Board:

- noted the that the cumulative financial position at period 11 showed an NHS Lothian overspend of £2.3m with an in month underspend for February of £2m;
- noted that the year to date position had been supported by the release of £17.6m of reserves and internally generated flexibility;
- noted the risk of delivering £6.2m of efficiencies and a £200,000 underspend in month 12 to support the achievement of a breakeven position;
- noted the revised confidence in the delivery of a breakeven position.

4. Update on the 2016/17 Financial Planning Process

4.1 The Chairman drew members attention to the tabled amended Appendix 1 of the circulated report.

4.2 Mrs Goldsmith introduced a circulated report on updating the 2016/17 Financial Planning Process advising that, together with the management team, she had been developing the NHS Lothian Financial Plan for 2016/17 towards the aim of the Board approving the final Financial Plan at its meeting on 11 May 2016. This was consistent with the Board's Standing Orders which stated the requirement; "The Board shall approve its financial plan for the forthcoming financial years, and the opening revenue and capital budgets".

4.3 It was noted that the development of the Financial Plan had been more complex this year both with the extent of the financial challenge and the creation of the four Integration Joint Boards. As a consequence, the process to date had already identified a range of issues for the Board to consider.

4.4 Mrs Goldsmith reminded colleagues that the Board also had a requirement to set budgets for the delegated functions for the four Integration Joint Boards for 2016/17. As the Financial Plan would not be finalised until May there was a requirement for the Board to set the budgets for the Integration Joint Boards in

advance of this. The outlined plan would form the basis of formal indicative budgets to the Integration Joint Boards.

- 4.5 Mrs Goldsmith emphasised the need for a plan to address the current balance. The long term Financial Plan currently estimated non-recurring expenditure of £33m in respect of prescribing, nursing and local reinvestment plan delivery. In this context, it was important to acknowledge that Lothian's distance from NRAC parity during 15/16 was around £25m against which the dependence on £33m of non-recurring expenditure should be balanced.
- 4.6 Mrs Goldsmith reminded the Board that there was a statutory responsibility for the Board to achieve a financial breakeven and that the detailed plans had been discussed at the March Development Session as well as the Finance & Resources Committee.
- 4.7 It was noted that the carry forward shortfall had been partially offset by an increase in NRAC funding of £14m which the Scottish Government had confirmed for 2016/17 but which related to 2015/16. With a further movement in the formula this left a remaining NRAC shortfall for 2016/17 of £19m and a summary of the financial challenge for 2016/17 prior to the utilisation of additional resources was detailed in the report.
- 4.8 Mrs Goldsmith emphasised that it was important to recognise that this figure reflected the growth where the Board had no or limited discretion over the expenditure. Any further expenditure would simply add to the scale of the financial challenge unless that expenditure immediately led to greater savings in other areas. With this in mind, it was planned to continue to hold a 1% reserve as a contingency to help the Board manage unforeseen events.
- 4.9 It was noted that a major challenge would be identifying around £12m to fund the continued use of the independent sector to enable the delivery of the treatment time guarantees, as achieving a financial balance and delivering treatment time guarantees were both statutory requirements.
- 4.10 Mrs Goldsmith advised that a number of areas for potential savings had been identified but the Financial Plan currently remained unbalanced with a gap of £31m. NHS Lothian's position was worse than many other NHS Boards because of the demographics and the significant gap in NRAC funding.
- 4.11 It was noted that work was still underway on a number of workstreams looking at both recurring and non-recurring benefits and Mrs Goldsmith advised that it might be necessary to accelerate the investment in quality improvement.
- 4.12 Professor McCallum commented that there would need to be a sophisticated approach to managing the delivery of services in a different way without creating costs elsewhere in the system.
- 4.13 Mr Davison commented that in addition to the £22m savings identified, the Board would have to work for a further £31m on top of this and savings of this magnitude had never been achieved in the past.

- 4.14 Mrs Mitchell queried how realistic the estimates of low and medium risks were and how had they been evaluated and Mrs Goldsmith advised that whilst more work still had to be done on this, the figures had been reviewed by senior members of the finance team.
- 4.15 Mr Murray referred to the risk to the achievement of the treatment time guarantees and suggested that there should be an increased monitoring of performance. Mrs Goldsmith agreed that monitoring was important but expressed doubt that quality savings of this scale could be delivered as soon as the financial year 2016/17.
- 4.16 Mr Crombie emphasised the need to be aware of the Board's present reliance on the private sector. Work had been undertaken on this over the past year and investment made in increasing NHS Lothian's own capacity meant that the use of the private sector for patients in Ophthalmology, ENT and Gynaecology could be stopped. Orthopaedics, however, was a key area of concern in which NHS Lothian continued to have a dependence on the private sector in spite of being in the upper quartile performance figures for Orthopaedics. Work was underway to increase the capacity in Orthopaedic trauma to reduce the number of Orthopaedic admissions. Mr Crombie hoped to bring a report to the June Board meeting and commented that increasing demand on these services was already being seen. **JC**
- 4.17 Mrs Blair asked if there were any barriers to getting out of contracts with the private sector and Mr Crombie confirmed that notice had already been given that a number of private sector services would no longer be required.
- 4.18 Councillor Toner welcomed the return of resources spent previously on the private sector to the NHS and sought more details on the proposed savings. In particular he sought further information on when reductions would happen and when further information would be available to Board members.
- 4.19 Mrs Goldsmith emphasised there was no intention to reduce services, the emphasis was rather on delivering the same level of service with fewer resources. Any reduction in services would require a dialogue with the Scottish Government. It was noted that any discussions about the way in which services were delivered could be held at a future Development Session.
- 4.20 Councillor Toner questioned the achievability of delivering exactly the same service for less money and Mrs Goldsmith explained that it was all about delivering the service in different ways such as by reducing sickness levels and using a different skill mix. She advised that further details were available but these did not tend to be put into a financial position report to the Board.
- 4.21 Mr Hill questioned whether the proposals would increase the risk to patients and asked what confidence the Director of Finance had in the proposals. Mrs Goldsmith advised that many of the proposed savings would not start until April and managers would be looking at other options to deliver services within the defined budget. She emphasised that the move away from setting a target for savings by fixing budgets was much more popular with managers as it allowed for greater flexibility.
- 4.22 Mr Walker commented that the proposals could be gone into in more detail at the Finance & Resources Committee meeting. He felt that achieving savings in the

Primary Care prescribing budget when it was currently overspent by £12m in 2015/16 would be challenging.

- 4.23 Mrs Goldsmith commented that there were a number of strands of work going on in controlling the prescribing budget which gave her more confidence. All the Integration Joint Boards were seeking to put money into additional pharmacy support to help General Practitioners reduce prescribing. In addition, there was a new focus on compliance with formularies and there had been discussions with Scottish Government about additional funding to help in this area.
- 4.24 Dr Watson commented that planning would require a considerable amount of consultation and work was already underway to determine what would be in the proposals.
- 4.25 Mr Davison advised that he had been in discussion with Dr Watson and the Chairman on a Quality Management System to drive this and a bespoke Board Development event would be arranged on this.
- 4.26 Mr Crombie emphasised that NHS Lothian was working closely with Scottish Government on time to treatment guarantees and reiterated that the delivery of these would be dependent on implementing the Deloitte Report recommendations.
- 4.27 In response to a question from Mr Ash, Mrs Goldsmith confirmed that the indicative budget figures for Integration Joint Boards included set aside. There had been a reduction in funds for day centre provision and she reminded the Board that within the Integration Scheme each Integration Joint Board required to obtain regular reports and make adjustments in-year.
- 4.28 With the dissent of Councillor Toner being recorded, the Board:
- agreed to commit to the delivery of a programme of low and medium risk efficiency schemes summarised in Appendix 2 of the report;
 - agreed the utilisation of £20.8m of non-recurring benefits and support of financial balance set out in paragraphs 3.17 & 3.18 of the report;
 - recognised at this stage there remained a gap of £31m and that work would continue to identify how this might be addressed, including any benefits from nationally coordinated efficiency schemes and contingency arrangements with Scottish Government in the context of NHS Lothian being £19m below its NRAC parity share;
 - agreed to accept an increased risk around the delivery of time to treatment guarantees in order to avoid the currently levels of expenditure in the independent sector, recognising the work ongoing to mitigate this risk internally;
 - acknowledged the increasing reliance on non-recurring resources to support financial balance and the need to work with the Scottish Government and Integration Joint Boards to develop a financial framework which recognised the significant demographic pressure in Lothian and internally to accelerate a programme of quality improvement which addressed unwarranted variation and waste;

- agreed the indicative budgets for Integration Joint Boards set out in Appendix 3 to the report.

5. Quality and Performance

- 5.1 Professor McMahon introduced a circulated report giving an update of the most recently available information on NHS Lothian's position against a range of quality and performance measures.
- 5.2 It was noted that this report was still work in progress and that there had been some further improvement in performance.
- 5.3 Following the discussion at the February Board meeting, the role of Board Committees in the assurance of quality and performance had been explored with the Chairs of the Healthcare Governance and Acute Hospitals Committees. Arising from this, a number of topics historically considered at the Healthcare Governance Committee would be the focus in future of the Acute Hospitals Committee, recognising that the measure concerned related fundamentally to hospital activity. System-wide measures would continue to reside with the Healthcare Governance Committee.
- 5.4 Professor McMahon advised that there was ongoing discussion of a shared assurance requirement of both the Board and the Integration Joint Boards and this had been discussed at a Healthcare Governance workshop held on 18 March 2016. As assurance arrangements developed with Integration Joint Boards, steps would need to be taken to ensure that these dovetailed into the approach the Committees were adopting.
- 5.5 Details of the assignment of measures between the Acute Hospitals Committee, Healthcare Governance Committee, Finance & Resources Committee and Staff Governance Committee were noted.
- 5.6 Professor McMahon commented that overall performance was generally showing signs of some improvement, cancer standards were being maintained and the performance in receiving test results had improved.
- 5.7 Mrs Mitchell commented that she was encouraged by the additional reporting and supported the Governance Committees taking on responsibility for detailed monitoring although she felt that performance should still be reported directly to the Board.
- 5.8 Professor McMahon detailed the assurance process and advised that the Board would be receiving details of actions being taken to address performance and quality concerns from the Minutes of the respective Governance Committees.
- 5.9 Mrs Blair commented that she had held discussions with her team and the Chair of the Healthcare Governance Committee and had agreed that these proposals should be brought forward.
- 5.10 Professor McMahon confirmed that he would be discussing the involvement of the Staff Governance Committee with Mr Joyce.

- 5.11 Mr Murray suggested that as this process evolved during the first quarter it would be relevant to triangulate it with efficiency savings, QI and PI. He was concerned that the reporting was not sufficiently conclusive and that NHS Lothian's specific concerns were not adequately addressed.
- 5.12 Professor McMahon advised that the reports addressed the specific performance targets for which Scottish Government held NHS Lothian accountable. However, this was a work in progress and would develop and be influenced by the QI work being undertaken.
- 5.13 Mr Davison commented that whilst he understood Mr Murray's point, the Board was in a different situation now with only 1% growth compared to 7% growth in 1990. As a Board, NHS Lothian spent too much on the acute services and not enough on mental health services. He accepted that there was a need to triangulate quality, performance and cost and that ultimately these should be used to monitor and review the strategic vision.
- 5.14 Professor McCallum suggested that the position was that the Acute Hospitals Committee would be monitoring the immediate process, the Healthcare Governance Committee the medium term and the Board longer term. She suggested that the proposed scheme gave a better set of evidence to Scottish Government.
- 5.15 Mr Walker commented that the proposals were a start and that he would like to see Dr Watson's influence appearing through this as it developed.
- 5.16 The Board:
- noted that the proposed performance measures were a work in progress and subject to this qualification agreed to approve the changes proposed in the selection of performance measures reported to ensure appropriate consistency with the Scottish Government's Local Delivery Plan guidance for 2016/17;
 - approved the suggested allocation of matrix to Board committees and the process proposed on identifying risk tolerance for these measures;
 - approved the proposed assurance process with Board committees undertaking an enhanced role
 - accepted the report as assurance that of the 40 measures considered, 15 were met and that lead Directors had action plans in place to address performance in those 24 where performance was not of the standard sought.

Professor Whyte left the meeting.

6. Improving Access to Psychological Therapies and Child and Adolescent Mental Health Services

- 6.1 The Chairman welcomed Mr Forrest to the meeting.
- 6.2 Professor McMahon introduced a circulated report giving an update on the progress and actions that partnerships and NHS Lothian were taking to improve

access to Psychological Therapies and Child and Adolescent Mental Health services to meet the HEAT standard. He advised that the level of performance in psychological therapies on 18 weeks for first treatment had improved from 30% in August 2014 to 70% in February 2016.

- 6.3 It was noted that due to TRAK configuration it had not been possible to report on all services delivering psychological therapies but that this had not been rectified for a number of services (Clinical Health Psychology, Neuropsychology and third sector Guidance Self Help services) and data for the last quarter of 2015 had now been resubmitted to the Information Services Division.
- 6.4 Professor McMahon advised that retaining staff had been challenging with a number of staff in fixed term positions leaving and it was intended to maximise the role of nursing to assist in improving access.
- 6.5 It was noted that there continued to be an increased demand for Child & Adolescent Mental Health services with a 17% increase in referrals over the last year. NHS Lothian had one of the highest rates of accepted referrals across all Health Board areas and the service had recognised the need to better manage demand for services whilst ensuring that children and young people received the appropriate help and support that they required.
- 6.6 Professor McMahon advised that NHS Lothian's Child & Adolescent Mental Health services had one of the lowest rates of 'did not attend' appointments for Scottish Boards. Cancellation rates, however, remained high and many of these were at very short notice. This combined rate of non-attendance resulted in significant wasted capacity across the service. To address this, information about the impact of 'did not attend' and 'could not attend' on waiting and treatment times was included in all appointment letters. Implementing text reminder systems and patient focus booking should improve the 'did not attend' and 'cancelled' rates.
- 6.7 Professor McMahon advised that the Scottish Government had recently announced a new package of support to improve access to psychological therapies and Child & Adolescent Mental Health services with the first component now allocated to territorial Health Boards. NHS Lothian's share was £630,325 in 2016/17 increasing to £996,793 in 2017/2018 through 2019/20.
- 6.8 Mr Davison emphasised the importance of linking with the QI work to improve the design of the delivery of the service.
- 6.10 It was noted that no signal had been received from Scottish Government that the 18 week target would be reduced. Mr Forrest advised that it was entirely possible that patients might have been seen by a consultant but could still be waiting to receive psychological therapies.
- 6.11 Mr Walker thanked Professor McMahon and welcomed the report. He was concerned at the 'did not attend' rate which was a huge waste of resources. It was noted that Lothian had the highest referral rate for Child and Adult Mental Health services in Scotland and Professor McMahon advised that reasons for this were being examined.

- 6.12 Dr Watson commented that if there was to be any progress in this area more information would be required, particularly if there was to be speculative investment.
- 6.13 Mr Davison commented that although there was a tendency to overbook appointments in areas where there was a known level of patients not attending, Child and Adolescent Mental Health services appointments tended to be longer and could not be overbooked in this way.
- 6.14 The Board:
- agreed to accept the report as assurance that the system of performance reporting now captured previously unreported psychological therapies, and the level of performance in psychological therapies on 18 weeks for first treatment had improved from 30% in August 2014 to 70% in February 2016;
 - agreed to accept the report as assurance that further work was underway to configure the remaining psychological services on TRAK;
 - agreed to accept the report as assurance that there were robust service improvement plans in place to address the performance challenges in Child & Adolescent Mental Health services where there was increasing demand for services, and the increase in the number of people waiting over 18 weeks;
 - agreed that the priority focus for psychological therapies in adults and child adolescent mental health services for the coming year needed to be on those patients who had waiting in excess of 18 weeks;
 - agreed to support the proposed allocation of new Scottish Government funding aimed to build capacity which reflected this prioritisation.

7. NHS Lothian Local Delivery Plan 2015/16 Report

- 7.1 Professor McMahon introduced a circulated report providing a progress update on the delivery of the 2015/16 Local Delivery Plan actions and 2016/17 Corporate Objectives. He advised that the Edinburgh Integration Joint Board was looking at a capacity of Health Visitors, particularly in anticipation of the reduction of the named person. Other issues such as smoking on NHS grounds were also being addressed.
- 7.2 It was noted that the Local Delivery Plan for 2016/17 was being developed and there was a need to monitor decisions against the achievement of the Local Delivery Plan. The 2016/17 Local Delivery Plan would be signed off at a short special Board meeting on 11 May and Councillor Toner queried why it had not been possible for the Board to discuss paediatric services at that meeting.
- 7.3 Mr Davison explained that the deadline for Local Delivery Plans had been changed by Scottish Government and that only the first part of the May Development Session would be to consider the Local Delivery Plan. After that, the Development Session would discuss the report of the Royal College of Paediatricians and Child Health before formal proposals were put to the 22 June Board meeting.

7.4 The Board:

- agreed to note the risks against delivery of the Local Delivery Plan, particularly in relation to very high and high risk areas relating to delivery of LRP and performance as set out in section 4.1 of the report.
- noted that the draft 2016/17 Local Delivery Plan had been submitted to the Scottish Government on 21 March for review and the final 2016/17 Local Delivery Plan would be presented to the special meeting of the Board on 11 May 2016 for approval.

8. Patient Feedback

- 8.1 Professor McMahon introduced a circulated report providing an update on the range of ways people could give feedback, with a focus on complaints and feedback activity within NHS Lothian and that this report had been in response to requests from Board members at the previous Board meeting for a progress update.
- 8.2 It was noted that the response rate on the 'Tell us 10 Things' local patient survey programme had been quite low and work was underway to see if this could be improved. The Lothian Professional Nursing Advisory Committee would be discussing senior nursing support, how the return rate could be improved across all areas and what actions could be taken by the clinical team to improve the response rates for all the questions.
- 8.3 Professor McMahon explained that NHS Lothian was working with Patient Opinion, a not for profit organisation allowing people to share their experience of healthcare via their website. A number of stories about NHS Lothian had been posted and work was underway with Patient Opinion to improve the reporting and sharing of these stories.
- 8.4 There were a number of common themes and in particular, people were concerned about the way in which they were spoken to by staff. There were two specific targets to be met by the Board; an initial response should be sent within 3 days and a full response should be sent within 20 days. Ms Morrison had been working hard to recruit new staff to fill the vacancies in the Department but these staff had to be trained and it was taking longer to get the service up to speed than had been anticipated. A benefit, however, was that new staff were in a position to challenge how things had been done in the past and newer more efficient processes were being developed.
- 8.5 Dr Watson commented that in the current safety conscious environment there was a move to look at how things had gone well rather than why they had gone badly. As the process moved forward it would be important to reference positive comments.
- 8.6 Mrs Mitchell expressed her satisfaction with the position as a starting point but was concerned that any reduction in the number of calls being taken could lead to missed opportunities.

- 8.7 Mrs Mitchell asked how lessons were learned from the complaints and Professor McMahon advised that this was dealt with within teams and he would be taking up with the Chief Nurses how new lessons learned from such complaints could be taken forward.
- 8.8 Mr Crombie advised that where particular themes were identified these would be discussed at the Directors forum to ensure that issues were addressed and Departments were now starting to see reduced numbers of complaints.
- 8.9 Mr Davison commented that a confounding issue was where conflicting reports were received about the quality of service in the same ward, demonstrating the complexity of the interaction between staff and patients.
- 8.10 Mrs Meiklejohn commented that if the new system at the Royal Edinburgh Hospital was working as the statistics appeared to show, it should be rolled out across Lothian.
- 8.11 Ms Hirst thanked Professor McMahon for the report and asked why, if the statistics were improving, the Ombudsman was challenging decisions. She felt that walkrounds on wards were extremely useful and the experience gained on these should be captured. It was important to gather feedback from staff, patients and visitors to see the whole picture.
- 8.12 Mr Hill commented that the responses to the question about how much information about care and treatment was given suggested that more work was required to develop the engagement of patients and families.
- 8.13 The Board:
- noted the most recent complaints and feedback activity and performance and the draft terms of reference for the proposed Quality Assurance Committee that had been supported at the March meeting of the Healthcare Governance Committee.
 - noted the Scottish Public Services Ombudsman activity during 2016 and the most recent quarterly report from the patient advice and support services.

9. Corporate Risk Register

- 9.1 Dr Farquharson introduced a circulated report setting out NHS Lothian's Corporate Risk Register for assurance.
- 9.2 Dr Farquharson advised that the Risk Register had been discussed at various Board committees each dealing with their assigned risks. Issues such as delayed discharges were already covered in the Quality and Performance report.
- 9.3 Mrs Mitchell queried how cases where controls were not adequate would be addressed and Dr Farquharson advised that this was one of the issues that would be dealt with in the new Quality and Performance report.
- 9.4 Professor McMahon advised that he would be bringing forward proposals for a reporting format which would address that issue.

AMcM

- 9.5 Mr Hill sought clarification on whether there would be any overlap between the Board's Risk Register and those of the Integration Joint Boards.
- 9.6 Councillor Toner advised that West Lothian Community Health and Care Partnership had previously held a Risk Register and this was being brought back by the Integration Joint Board.
- 9.7 Mr Ash advised that it was his understanding that the Integration Joint Board's Risk Registers reflected their risks as a corporate body and as the new system bedded in the reporting format would evolve.
- 9.8 The Board:
- agreed to accept the circulated report as assurance that the Corporate Risk Register contained all the appropriate risks, contained in section 3.2 and set out in detail in Appendix 1, to inform assurance requirements.
 - Noted that NHS Lothian remained outwith its Risk Appetite on corporate objectives where low and medium risk appetite had been set, with the exception of Scheduled care
 - noted actions set out in accompanying Board papers which sought to rectify areas outwith appetite
 - noted that the risk appetite on corporate objectives would be integrated into the Quality and Performance report and actions to address current achievement against the plans and lead targets and reduce duplication.

10. Healthcare Associated Infection Update

- 10.1 Dr Farquharson introduced a circulated report giving an update on progress and actions to manage and reduce healthcare associated infection across NHS Lothian.
- 10.2 Dr Farquharson advised that the change in format of Appendix 1 of the report reflected the way in which NHS Boards must now report to Scottish Government.
- 10.3 It was noted that NHS Lothian had not achieved the efficiency target for staphylococcus aureus bacteraemia but it was anticipated that NHS Lothian should demonstrate a reduction on the previous year's rate. The most up-to-date publicly available data from Health Protection Scotland showed NHS Lothian's rate was lower than the overall NHS Scotland rate.
- 10.4 In respect of Clostridium Difficile infection, whilst NHS Lothian had not achieved the efficiency target, it was anticipated it would demonstrate a reduction on the previous year's rate. The most up-to-date publicly available data from Health Protection Scotland indicated that NHS Lothian's rate was higher than that of NHS Scotland but that it had improved significantly since the third quarter of 2015.
- 10.5 Dr Farquharson commented that Health Protection Scotland had confirmed that NHS Lothian's key area for reduction in Clostridium Difficile infection continued to be prudent prescribing as there was no evidence to indicate cost transmission. It

was noted however that whilst prudent prescribing would assist reduction it could not eliminate Clostridium Difficile infection as there would be unavoidable instances as a consequence of appropriate and essential antimicrobial treatment. In this respect members of the medicines management committee and pharmacists were providing information to general practices on appropriate antibiotic prescribing.

10.6 The Board noted that following the publication of the unannounced inspection report on the Royal Hospital for Sick Children the Health Protection review had been undertaken. The assessment report following this visit noted that many of the recommendations were as a result of individual incidents or areas and not systematic failure and NHS Lothian had been encouraged to ensure the areas that demonstrated good compliance with the standards assessed were provided with positive feedback, empowering staff to challenge any non-compliance and that NHS Lothian should continue to foster a culture that allowed pure monitoring across all staff groups.

10.7 Mrs Mitchell commented that the action points in Appendix 2 to the report required updating as “ongoing” was not an appropriate status.

10.8 The Board:

- agreed to acknowledge receipt of the mandatory Scottish Health Department Healthcare Associated Infection Reporting template for March 2015
- agreed to encourage clinical teams to reduce the number of preventable infections by taking a zero tolerance approach to invasive device related staphylococcus aureus bacteraemia and encourage clinical teams to be aware of high risk antibiotics which could predispose individuals to Clostridium Difficile infection by promoting prudent antimicrobial prescribing in both community and acute sectors.

11. Update on Royal College of Paediatrics and Child Health Review of Medical Paediatric Inpatient Services in Lothian

11.1 Mr Crombie introduced a circulated report giving an update on the Royal College of Paediatrics and Child Health Review of Medical Paediatric Inpatient Services in Lothian and the recent public meetings held by NHS Lothian in each local authority area.

11.2 Mr Crombie confirmed that the draft report from the Royal College would be brought to the May Development Session and the formal and final report would be submitted to the June meeting.

11.3 Councillor Toner asked that the draft report be made available sufficiently in advance of the Board Development day.

11.4 Mr Crombie advised that the St John’s Hospital Stakeholder Group had been briefed about the discussions with the Royal College and he hoped to be able to let members have the draft report on 6 May.

11.5 Councillor Toner commented that he would have welcomed a longer lead in time and asked about recruitment as he understood that vacancies had not been advertised for the last few months.

11.6 Mr Crombie advised that the Stakeholder Group had already been notified of the recruitment of 2 paediatric fellows and that there was no issue in respect of the ward nursing rota for April which was now covered. One consultant previously on maternity leave had now returned and although there was an issue with middle grade staff the rota was currently stable. Recruiting 2 vacant posts was currently being undertaken through the internet and Mr Crombie undertook to provide Councillor Toner with the appropriate link to the advertisements. JC

11.7 Mr Johnston congratulated Mr Crombie and Mrs Mitchell in the way in which the public meetings had been handled and the confirmation provided to members of the public. He also noted that the comments made at these meetings had been published and been fed into the Royal College of Paediatric and Child Health process.

11.8 The Board:

- noted that public meetings had now taken place in each local authority area in Lothian and that the questions and issues raised at each of these meetings had been submitted to the Royal College of Paediatrics and Child Health to further inform their review.

12. Date and Time of Next Meeting

12.1 A Special meeting of the Board would be held at 9:00am on Wednesday 11 May 2016 and the next regular meeting of the Board would be held between 9:30am and 12:30pm on Wednesday 22 June 2016 both in the Board Room, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

13. Invoking Standing Order 4.8

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

DRAFT

LOTHIAN NHS BOARD

Minutes of a Special Meeting of Lothian NHS Board held at 9.30am on Wednesday 11 May 2016 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG.

Present:

Non Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mrs K Blair; Cllr D Grant; Cllr R Henderson; Mr M Hill; Mrs C Hirst; Cllr C Johnstone; Mr A Joyce; Mrs J McDowell; Mrs A Meiklejohn; Mrs A Mitchell; Mr P Murray; Mr J Oates; Mr G Walker; Professor M Whyte and Dr R Williams.

Executive and Corporate Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mr J Crombie (Chief Officer, University Hospitals and Support Services Division); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health and Health Policy); Professor A McMahon (Interim Nurse Director/Director of Strategic Planning/REAS and Prison Healthcare) and Dr S Watson (Chief Quality Officer).

In Attendance: Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mr P Johnston, Cllr F Toner and Mrs L Williams.

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 for consideration, identifying the relevant agenda item and the nature of their interest. There were no declarations of interest.

1. Welcome and Introductions

1.1 The Chairman welcomed members of the public and Board members to the Special Board meeting and outlined the programme for the day.

2. NHS Lothian Local Delivery Plan for 2016/17

2.1 Professor McMahon commented that the Local Delivery Plan (LDP) 2016/17 represented NHS Lothian's formal contract with the Scottish Government. He advised that the final submission was due to the Scottish Government by 31 May 2016 and that he was therefore seeking the approval of the draft LDP which could be augmented with changes suggested by Board members at the current meeting. In the event that any changes were proposed it was being suggested

that they should be agreed and signed off by the Chief Executive and Chairman in order not to delay the submission process to the Scottish Government.

- 2.2 The Board noted that an earlier draft of the LDP had been submitted to the Scottish Government for comment in March 2016. Feedback had been incorporated in the final draft of the LDP. Professor McMahon provided the Board with details of the key risks associated with delivery of the 2016/17 LDP the detail of which were identified in the paper.
- 2.3 The Board noted that the current LDP was the first one which took account of the new Integration Joint Board (IJB) arrangements and that the current year would be regarded as a developmental year with the process developing in a more robust manner in future. It was agreed that there would be merit in mentioning the impact of IJB directions and associated issues like complaints in the body of the final submission to the Scottish Government.
- 2.4 The Board noted that the LDP would reflect the fact that plans were in place to mitigate key risk areas such as the impact of stopping using private sector capacity as well as issues around the Named Person Legislation and Health Visitors and District Nurses. Reference would also be made to HBCCC (Hospital Based Complex Clinical Care) beds which were being considered in their entirety with the initial report from a Health Improvement Scotland (HIS) investigation being published at the end of May with the recommendations being reflected in a future action plan.
- 2.5 The Board noted that primary care was well trailed in the LDP not just in terms of premises but also access, GP capacity and District Nursing and Health Visiting. General workforce and bed redesign issues were also trailed in the LDP.
- 2.6 The point was made in respect of primary care pressures that part of the financial plan referred to the need to stop and reduce spend in some areas whilst the financial plan made reference to essential developments and it was difficult to rationalise this difference. It was suggested there would be benefit in being specific in the LDP about the specificity of funds and targeting of these.
- 2.7 It was also suggested there was a need to caveat the LDP in respect of the GP contract given the possibility for significant revenue resource and cost implications. The Chief Executive reminded the Board that the GP contract technically would not be implemented until 2017 although it would be appropriate to trail concerns raised given that there was as yet insufficient detail available about the consequences of the new GP contract.
- 2.8 Mrs Blair commented there was a need to be clear about responsibility and accountability lines in respect of the Board and the IJB as there was a lot in the document around primary care which impacted on the IJBs. Professor McMahon reminded the Board the LDP was the formal NHS Lothian contract with the Scottish Government and in that regard NHS Lothian would be held to account. It was noted that the Scottish Government were still working through the performance management arrangements for IJBs and that although

currently the LDP was the only source of accountability it was anticipated that this might change moving forward.

- 2.9 The Board noted that IJB directions would influence what the Board was required to provide in terms of services. The Chief Executive commented that he welcomed the creative tension that would arrive through the introduction of IJBs and advised that he had a personal objective set in this regard. He commented that the only area of contention when developing the LDP had been around the initial statement that no further investment would occur in Acute Hospital Services in respect of the set a side budget re shifting the balance of care. This had been moderated to state that there will be no further increase in the set a side budget without agreement of the IJBs. He commented that the narrative around the directions was around collaborative working.
- 2.10 The point was made that the document did not highlight the changes in service provision and the potential unintended consequences of the decision not to continue to use the private sector. It was anticipated that there might be an increased cost in not treating patients in the private sector in that they would show up through the Accident and Emergency Department. It was agreed that this eventuality should be highlighted further in the LDP. Professor McMahon advised that he was working with Mr Crombie and his team around how best to manage the consequences of the decision not to use the private sector as this might impact on increased waiting times and numbers of patients waiting longer for elective surgery. It was agreed that the increased level of uncertainty should be referenced in the final version of the LDP.
- 2.11 The Chairman commented that there was a need to apply upward pressure in order to ensure that performance management and accountability responsibilities were clarified as quickly as possible.
- 2.12 The Board were advised that the main significance of the LDP was that NHS Lothian was submitting to the Scottish Government a financial plan that was out of balance for the first time ever. The Board were advised that the document was iterative and only provided an estimate of expenditure albeit with a greater level of uncertainty than in the previous year which needed to be reflected more in the LDP document. Mrs Goldsmith commented that now the year end had concluded there was more clarity around carry forward pressures. There were still issues around acute drugs and prescribing costs which were problematic.
- 2.13 The Board noted that not all financial allocations had yet been issued from the Scottish Government. It was further noted that the NHS Lothian savings target of £82.1m represented 6.1% against an average level of 4.95% across Scotland. It was suggested that the NHS NRAC position covered most of the differential gaps.
- 2.14 It was noted that an additional round of financial planning was being undertaken with a view to progressing to a position where the system would commit to deliver 2% of savings which would reduce the finance expenditure gap forecast. The Board were advised of a number of non recurring options to reduce the financial gap including a review of the balance sheet which would provide a one off £10m benefit. In addition £3m would be taken out of recurrent reserves.

- 2.15 The Board noted that the potential impact of stopping spending £12m in the private sector had been included in the LDP in terms of activity. The importance of stressing the link between the private sector decision and potential consequences was made. It was reported the Lothian position was not out of line with the rest of Scotland.
- 2.16 Mrs Goldsmith advised that it had been agreed with the Scottish Government that NHS Lothian would submit an LDP which included a shortfall of £21m on the basis that the system would attempt to move to a balanced position for the end of the financial year. It was reported in order to attempt to move to this position that benchmarking work had been undertaken around workforce, bed numbers and drugs although the potential impact for savings through this exercise had been limited. It was felt given the drivers on how to deliver the service were limited that the quality management system agenda as reflected in the LDP would be key in moving towards a sustainable position through the integration of management and clinical processes. It was hoped that the strategic plan and IJB directions would have an impact on the configuration of services that would support sustainability in the future.
- 2.17 The Board noted that service configurations continued to be looked at and if progress could be made around social work delays and discharge to assess protocols then this could accelerate the disposal of the Astley Ainslie Hospital and Liberton Hospital sites which would give financial and service redesign benefits. It was noted that Professor McMahan was also progressing work around nursing bank and agency spend which included feeding into a national work programme around locum costs. In addition it was noted that there were a number of national workstreams underway which might result in some financial benefit accruing further in the year.
- 2.18 The Board noted that discussions continued with the Scottish Government in respect of the NHS Lothian funding base. It was noted that recently released population statistics had suggested that Lothian was the fastest growing region in Scotland and that it would be important to discuss this issue with the Scottish Government. It was noted however that these discussions would have to be supplemented by an evidence base that could be clearly supported.
- 2.19 The question was raised in respect of efficiency savings slippage whether it was thought that these savings would be made eventually albeit not in the current calendar year or whether they would not materialise because of service pressures. Mrs Goldsmith advised that in the previous year savings targets were not fully achieved and that these would carry forward into the current year's financial position. Mrs Goldsmith commented that within the current year she felt that 25% of the schemes identified as medium risk still required to be supported by robust evidence. It was noted that there would remain significant challenge around efficiency savings and that this would become a particular focus of the Finance and Resources Committee in the current year.
- 2.20 Mr Ash commented that when NHS Lothian had provided their written budget offer to IJBs that this had been based on planning at the time and had not been updated. Mrs Goldsmith reminded colleagues she had identified non recurrent

resources which were being fed into the IJB budgets. It was noted however there was a need to develop a plan to alleviate the reliance on non recurrent resources with additional funding having been made in respect of acute drugs, mental health and UNPACS.

- 2.21 Mr Ash reminded colleagues that the IJBs had not agreed the funding allocation process and had only at this point received the first offer with further letters needed to reflect the current position. He felt there was still a number of issues that had to be resolved and that IJBs could only deliver funded services.
- 2.22 Mr Murray commented from experience elsewhere that the LDP seemed to provide a lot of understanding of operational issues and suggested that a lot of the detail of what had been done to pull together the document was not needed from a governance perspective. He suggested that the LDP needed to be prefaced with a number of caveats including how the LDP reduced the risk viz the NHS Lothian corporate risk register and the criteria to achieve this. He did not understand how NHS Lothian could operate on a year on year financial basis as this was an almost impossible position to manage particularly when not in full possession of details around the finance available to deliver services. He commented that the point made earlier about the need for clarity around performance and accountability was also important particularly in respect of governance performance. Mr Murray felt that the LDP could have been used as a vehicle to put forward sustainability issues.
- 2.23 In addition Mr Murray commented that there were also issues about how the person centred approach was being delivered with there being a need for the Board to assure itself around the appropriateness of proposed directions of travel. He felt this could have been addressed in the covering paper.
- 2.24 Mr Murray felt that the gap in available resources must be capable of being bridged even if the solutions were unpalatable and related back to high risk contingency albeit in an uncertain environment. He felt it would be appropriate for the Scottish Government to see the level of risk required to cover the financial gap. Mrs Goldsmith reminded the Board that the Scottish Government were not accepting the level of the financial gap and expected NHS Lothian to mitigate this through the financial year. Mr Murray commented that the LDP needed to provide more of an understanding of how this would be achieved.
- 2.25 Mr Murray questioned the contribution of specialist Boards and made reference in particular to staff awareness and training. He did not feel that bespoke solutions were necessarily the answer and felt there was a need for there to be read across the range of development activities including those that had spend profiles that cut across Scotland. An example was given about the lack of coordination around the provision of defibrillators and the apparent conflicts between national and local considerations.
- 2.26 The Chairman commented that he concurred with the views put forward by Mr Murray and that he was aware that some of these issues were being taken forward through the Corporate Management Team. It was noted that there was a number of hosted national workstreams that had been established under the leadership of Chief Executives.

- 2.27 Councillor Henderson commented in that he would have extreme difficulty in supporting the proposals around the reduction in drug and alcohol expenditure particularly as he did not have a clear understanding of the service impact. He commented that he would not be able to sign up to a position where there was a reduction in alcohol and drug expenditure of £800k per annum.
- 2.28 Professor McCallum commented that she shared Councillor Henderson's concerns and commented that this represented a risk at both population and service level and there was a need to investigate sources of creative funding. It would be important to fully utilise the service that was available. It was noted that work was underway with IJBs and local foras to look at the impact of any reduced funding and to mitigate the impact of this. The Board felt there was a need to highlight such funding gap issues in the LDP.
- 2.29 Mrs Mitchell commented with reference to the £21m funding gap in the LDP that before approving the plan she would need reassurance that this position was realistic. She felt that the current position only served to compound the problem in future years. She was concerned that there did not appear to be a probability index and felt that the £21m was in reality a movable feast. The Vice Chair commented that she was also uneasy about the financial plan being out of balance particularly given the fact that the LDP represented NHS Lothian's formal contract with the Scottish Government.
- 2.30 Mrs McDowell commented that she did not think that the risks of delivering on the 2016/17 financial plan had been fully fleshed out in the LDP. Mrs Goldsmith commented the NHS Lothian was in uncharted territory and that this was the first time that an unbalanced financial plan had been submitted to the Scottish Government. She commented that there were a number of known risks although these could not be fully quantified at this stage although work continued with the endorsement of the Scottish Government with a view to balancing the books through the identification of other savings which might come from a number of sources including national workstreams. It was agreed that further clarification around this position would be included in the LDP final paper.
- 2.31 The Chairman commented that ongoing financial management processes needed to address the uncertainty of the position and to also recognise the upside and downside of risk with there being a need for a revised articulation of the continuous improvement process.
- 2.32 Mr Walker commented that he agreed with the need for ongoing articulation of risk. He commented in terms of the savings target that he would like to see the targets set out in terms of savings set and actually achieved over the previous few years. He felt consideration of such issues on a percentage basis could mask the true extent of the issue. He felt that if the £82m was set out in terms of the previous years achievement against target that this would help in setting an appropriate context. He commented that he also welcomed the inclusion of the Quality Management agenda although he was concerned that this did not make mention of any investment. He felt it would be important to identify the

investment funding available as well as the sources of investment as not all of these were recurrent.

2.33 Mr Walker commented that he agreed with the comments made by Councillor Henderson about the alcohol and drug budget. He commented that the Board could make a decision to fund the shortfall thereby increasing the gap in the financial plan. He commented that it did not come out in the plan that not funding services like alcohol and drug provision could be a false economy as alternative methods of treatment were more expensive. Mrs Goldsmith commented that there was a need to look at all of the bundled allocations as there were a number of areas where allocations had been reduced by 7½%. This issue had been discussed at the Corporate Management Team where it had been agreed that all allocations would be looked at as consideration had not yet been given on how to address the reduction in bundled funding. Mr Walker commented that the current version of the LDP implied that NHS Lothian was accepting the cuts and commented that it would be important to question why the gap in the LDP could not be increased to accommodate these issues.

2.34 The Chief Executive commented that all of the points raised were legitimate. He commented however as Accountable Officer he could not fund services that he did not have a source of funding for. He commented that currently the Board was operating ultra vires in respect of having a £21m financial gap and that the key issue was to reduce this gap rather than to increase it. He commented that the focus of discussions with the Scottish Government were all around reducing the £21m gap. He advised that the current version of the LDP increased risk in respect of treatment time guarantees and achieving financial balance. He commented that he was keen that NHS Lothian was clear about its values and commented that he felt it was unacceptable that NHS Lothian was starting the financial year with a £21m financial gap. He commented that in part the LDP was forecasting assumptions over numerous amounts of variables as well as being clear about specific service consequences in terms of access following the withdrawal of private sector funding as well as a raft of issues like the drug and alcohol services budget. He commented at this point that he could not provide the Board with assurance that all plans and objectives would be delivered. The Chief Executive commented however that NHS Lothian was not alone in having unidentified savings challenges and at least another 4 or 5 Boards were in a similar position.

2.35 Dr Williams commented that he was surprised that the LDP did not mirror the corporate risk register. He also felt that there was a lack of emphasis in the LDP around the workforce. The Chairman commented that he also had a concern that the LDP was not articulating risk and relative levels of risk as best as it could whilst at the same time recognising the continuing improvement process. He felt that it would be important to make issues like the alcohol and drugs agenda more explicit in the LDP. He commented that this was not about increasing the gap in the LDP but about raising the Boards very serious concerns about the risk to services and patients as a consequence of such reduced funding. It was noted that the issues around alcohol and drugs could be included as a highlighting example under an overarching prevention heading.

- 2.36 Councillor Henderson commented that he understood the need for NHS Lothian to operate within its means although he had a very specific concern about the reference to alcohol and drugs in the plan as he felt that the pressure would pass directly to IJBs which would have a consequential impact on the level of service provided. He commented that he could not agree to any interim proposals that represented a risk or reduction to the current service provision.
- 2.37 Mrs Goldsmith commented that the financial plan essentially compiled what had happened to allocations received and was therefore a factually correct statement. She commented that any reduction in allocation reflected the position passed on by the Scottish Government to NHS Lothian and then to IJBs. Professor McMahon commented that he and Mrs Goldsmith would liaise in terms of developing a narrative that addressed the issues raised which would be shared with Board members.
- 2.38 The Chief Executive advised that it was highly unlikely that the Scottish Government would agree the LDP because of the level of risks reflected in it and the fact that the NHS Lothian system was currently out of financial balance. He commented however that it would be possible in the LDP to make reference to the unease of the Board about the reductions in bundled allocations and the impact these would have on services. It would also be appropriate to reference the fact that the projected overspend very closely related to the NRAC position. He stressed however that he could not as Accountable Officer countenance increasing the deficit currently articulated in the LDP although it would be possible to make explicit Board member concerns in the LDP submission.
- 2.39 The Board agreed the recommendations contained in the circulated paper subject to these being quantified by the comments and recommendations made during the discussion at the Board. In particular the Board agreed that any further amendments to the LDP including qualifications and outcomes arising from discussions at the Board meeting should be agreed through the Chairman and Chief Executive in order not to compromise the submission date of 31 May 2016 to the Scottish Government.

3. National Cleft and Lip Palate Review

- 3.1 Professor McMahon advised the Board of a national review and consultation process being undertaken in relation to surgical aspects of cleft and lip palate services. A consultation process was currently underway and was about to conclude. The process had included several stakeholder meetings. NHS Lothian had on the back of these stakeholder meetings and based on the views of the Royal College reviewed its position around single handed practitioners in terms of service sustainability and best clinical practice.
- 3.2 The Board noted that NHS Lothian's contribution to the consultation would be to support a single surgical service to be provided on a single site in Glasgow. The proposal was that NHS Lothian response to the consultation in governance terms could be agreed through the Acute Hospitals Committee at its meeting on 6 June 2016.

3.3 The Board agreed to approve delegation of authority in this issue to the Acute Hospitals Committee with the outcome being notified to the rest of the Board.

4. Date and Time of Next Meeting

4.1 The next meeting of Lothian NHS Board would be held on the 22 June 2016 at 9.30am in meeting room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

RUNNING ACTION NOTE

Action Required	Lead	Due Date	Action Taken	Outcome
Integration Update (25/06/14)				
<ul style="list-style-type: none"> Update report to future Board meetings. 	AMcM	Ongoing	<i>Papers on Directions being taken to the Acute Committee (7 June) and the SPC (9 June) for discussion. Back to the Board if actions require to be elevated.</i>	
Revised Corporate Communications Strategy (25/06/14)				
<ul style="list-style-type: none"> Arrange further discussion either at a development session or at a future Board meeting. 	AB	Ongoing	<i>Paper to future Board meeting.</i>	
Delayed Discharges (05/08/2015)				
<ul style="list-style-type: none"> Provide more detail on the lack of availability of care packages, particularly identifying if the problem was a recruitment or a budget issue 	AMcM	Ongoing	<i>This should be for the four IJB Chief Officers to answer.</i>	
Consent Agenda (05/08/2015)				
<ul style="list-style-type: none"> Bring forward proposals for a review of the Consent Agenda process. 	BH	September 2015	<i>Process of evaluation underway</i>	
Review of Medical Paediatric Inpatient Services (02/12/2015)				
<ul style="list-style-type: none"> Present Report to the Board 	JC	June 2016	<i>Paper on Board Agenda</i>	
<ul style="list-style-type: none"> Provide Councillor Toner with the appropriate link to the advertisements for the vacant consultant posts at St John's 	JC		<i>Complete</i>	
Workforce Risk Assessment (02/12/2015)				
<ul style="list-style-type: none"> The Slater Report to be considered in more detail at a future Board meeting. 	AMcM/JC		<i>This relates to delayed discharges as above and should sit there.</i>	

Action Required	Lead	Due Date	Action Taken	Outcome
Orthopaedic Services (06/04/2016)				
<ul style="list-style-type: none"> Bring a report to the June Board meeting 	JC	June 2016	<i>Orthopaedic review completed and signed off by Strategic Planning Committee</i>	
Corporate Risk Register (06/04/2016)				
<ul style="list-style-type: none"> Bring forward proposals for a reporting format which would address the issue of cases where controls were not adequate 	AMcM	August 2016	<i>Ongoing</i>	

AUDIT & RISK COMMITTEE

The draft minutes of the meeting held on 18 April 2016 are attached.

Key issues discussed included:

- The Committee was advised that NHS Lothian had been provisionally informed that Scott Moncrieff would replace Audit Scotland as external auditors for NHS Lothian. When this appointment is made there will be a conflict for Scott Moncrieff to continue to provide Internal Audit Services. Procurement of a new internal audit provider will proceed in due course.
- The Committee has highlighted the need to coordinate the monitoring of high risks where performance is outwith risk appetite. The Committee has received reports of actions being taken to bring performance back within risk appetite on these issues but recognises a need to coordinate with other Board Committees that monitor performance on these in greater detail.
- Committee members noted a need to ensure that there is a common understanding of the nature of 'assurance'. Further work will be undertaken to address this issue.

Key issues on the horizon are:

- Coordination of audit and risk management functions between NHS Lothian and the new IJBs is required. The Chair has been asked to convene a meeting of IJB Audit Officers and NHS Lothian representatives.

Julie McDowell, Chair

DRAFT

NHS Lothian

Audit & Risk Committee

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 18 April 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms J McDowell (in the Chair); Mr M Ash; Councillor D Grant; Ms C Hirst; and Mr P Murray.

In Attendance: Ms J Bennett (Associate Director for Quality Improvement & Safety); Mrs H Berry (Chief Internal Auditor); Jim Crombie (Chief Officer – University Hospitals & Support Services); Mr T Davison (Chief Executive); Dr D Farquharson (Medical Director); Mr J Forrest (Director, West Lothian Integration Joint Board); Mrs S Goldsmith (Director of Finance); Mr B Houston (Chairman); Ms F Ireland (Deputy Director –Corporate Nursing); Mrs R Kelly (Associate Director - Pay, Policy, and Performance Management); Mr C Marriott (Deputy Director of Finance); Mr D McConnell (Audit Scotland); Professor A McMahon (Interim Nurse Director); Ms J Morrison (Head of Patient Experience); Mr J Old (Financial Controller); Mr A Payne (Corporate Governance & VFM Manager); Ms K Steele (Internal Audit Manager); and Miss L Baird (Committee Administrator).

No apologies for absence were received.

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.

1. Minutes of the Previous Meeting

1.1 Minutes of the previous meeting held on 29 February 2016– The Committee approved the circulated minutes as a correct record.

2. Matters Arising

2.1 Matters Arising from the Meeting of 29 February 2016 – The Committee accepted the update on the actions detailed within the Running Action Note.

2.1.1 Dr Farquharson provided a further update on healthcare associated infection. He highlighted that comparing 2015/16 to 2014/15, Staphylococcus aureus Bacteraemia (SAB) rates had reduced from 0.35 to 0.29 per 1000 bed days and Clostridium difficile (c. Diff.) had reduced 0.47 to 0.38 per 1000 bed days. He referred to a recent Health Protection Scotland quarterly report which indicates that NHS Lothian is no longer an outlier for C. diff., SABs and the prescription of C4 antibiotics.

2.1.2 The Committee noted the positive progress in relation to Healthcare Associated Infection.

2.1.3 The Committee agreed to accept the report.

3. Internal Audit Medical Rostering (February 2016)

- 3.1 Dr Farquharson gave a brief overview of the report highlighting the important and significant control objectives and the actions identified to mitigate them.
- 3.2 It was noted that actions to implement a robust and consistent eRostering system would be taken forward by Scottish Government and NHS Lothian. The Medical Director - Acute Services has written to clinical management teams to stop them developing local and or interim solutions to eRostering.
- 3.3 Dr Farquharson advised members of challenges related to unauthorised shift swaps and the legal implications for NHS Lothian: work to mitigate this risk would remain on going due to the high turnover of FY1 doctors.
- 3.4 Ms Berry assured the Committee that Internal Audit were content with the management response and actions agreed.
- 3.5 The Committee agreed to accept the report.

Dr Farquharson and Mrs Kelly left the meeting.

4. Briefing on Decisions the ARC can make

- 4.1 The Committee discussed the report, the nature of the recommendations received and how these could be reviewed in advance of being presented to the Audit and Risk Committee. Ms Hirst commented that it was important that papers remained focussed on matters pertinent to the Audit & Risk Committee, and provided assurance that other committees were addressing the matters relevant to their remit.
- 4.2 Mr Ash requested that the document be revised to include an expectation of what was required within each report and actions required to provide assurance if the reports received were deemed inadequate. Mr Payne agreed to reflect on this matter out with the meeting and feedback.
- 4.3 The Committee agreed to accept the report.

AP

5. Risk Management

NHS Lothian Corporate Risk Register Update

- 5.1.1 Ms Bennett gave a detailed overview of the report. She highlighted that the Risk Management Steering Group would be examining the risks on the corporate risk register to determine if they were as equally significant as the scoring currently suggests later that day.
- 5.1.2 Following some consideration the Committee were satisfied with the explanation of the General Practice Workforce Sustainability timeline and processes provided within the report.
- 5.1.3 Ms Bennett explained that the actions to address risks are routinely set out in separate Board papers, and this paper on the Corporate Risk Register

purposely tries to avoid duplication. Members debated this matter in detail, concluding that the further mapping and design work was required to bring together risk management and risk appetite in line with planning and performance of the organisation; feeding assurance to the Audit and Risk Committee and ultimately the Board whilst validating the risk register. Mr Houston agreed to take this matter forward with Mr Payne out with the meeting.

BH/AP

Mr Forrest joined the meeting.

5.1.4 The Committee accepted the paper as assurance that the Corporate Risk Register contains all appropriate risks and accepted the information on the review of the Board's Performance management system and the incorporation of risk appetite within the new quality and Performance Report.

5.2 Risk Appetite– Delayed Discharges

5.2.1 Mr Crombie gave a detailed overview of the report. The committee was advised that it is now the role of integration joint boards to put in place packages of care to eliminate delayed discharges, and Lothian NHS Board needs to work with them to achieve this. Delayed discharges do create systemic problems within the acute hospitals, and it was agreed that the NHS Lothian Corporate Risk Register should reflect that the Acute Hospitals Committee should exercise oversight of this risk.

JB

5.2.2 Mr Davison advised the Committee that improvements in delayed discharges had been made in East Lothian and the City of Edinburgh; whilst Mid and West Lothian continued to perform well; though progress had been made assurance that targets could be achieved and sustained cannot be given at this time.

5.2.3 Ms Bennett advised that the risk register had not been amended to take into account the new target of 72 hours as yet and proposed a staged process to bring risk back within appetite. Members agreed the risk should be updated to incorporate the new target.

JB

5.2.4 The Committee agreed that the report provided it with limited assurance that an action plan was being developed to tackle delayed discharges. However it agreed that it had no assurance that performance would be brought sustainably within the risk appetite. The committee agreed that further work was required to identify the point at which the Board accepts residual risk and comes to a firm conclusion on its position.

JB

5.3 Risk Appetite – Patient Experience

5.3.1 Professor McMahon and Ms Morrison gave a detailed overview of the report. They highlighted that risk tolerance had been based on 1 of the 10 questions and could not be considered a reliable measure until further work to improve the return rate had been completed and improvements were made to support systems available to wards.

- 5.3.2 Members proposed that Professor McMahon and Ms Morrison consider seeking expert advice to assist with the identification of the appropriate sample size in order to receive reliable patient feedback.
- 5.3.3 The Committee commended the direction of travel and looked forward to a further report at its September meeting. **JM/AMCM**
- 5.4 Risk Appetite – Stroke
- 5.4.1 Mr Crombie gave a detailed overview of the report. He highlighted the request to change the target from stroke unit access to total bundle compliance and the plan to improve access to stroke services and bring performance within risk appetite.
- 5.4.2 The Committee noted and commended the work to date however it could not take assurance until it had sight of the figures produced under the new target. It was agreed that a report on the new target would be brought back to the September meeting for consideration. **JC**
- 5.4.3 The Committee agreed to recommend to the Board a revised stroke appetite/ tolerance measure from just stroke unit to total bundle compliance, with a bundle appetite of 80% and tolerance of 75% from April 2016 to March 2017. **JB**
- 5.4.4 The Committee noted the report as assurance that an improvement plan was in place.
- 5.5 Risk Appetite – Finance
- 5.5.1 Mrs Goldsmith gave a detailed introduction, highlighting the significant challenges that the Board faces in addressing the root causes of the Board’s financial challenge.
- 5.5.2 The Committee discussed the financial position and the likelihood of achieving financial balance, the risk associated with not achieving financial balance and the implications for services if action was taken to achieve financial balance. Members agreed that they could not discuss this matter further until the Board had had necessary dialogue with Scottish Government colleagues.
- 5.5.3 It was suggested that the Board should take further measures to feed into the early stages of the development of law or national strategy/ policy, so that the financial implications are recognised and managed at that point. Mrs Goldsmith advised that NHS Lothian would attempt to influence legislation where there may be financial impact, however this was not always possible.
- 5.5.4 The Committee agreed that this paper should be referred to the Finance & Resources Committee for advice as to how to proceed. **JMcD**
- 5.5.5 The Committee noted that the root causes of the financial challenge were being explored and that the organisation has a programme of work underway to address the challenge.

6 Internal Audit & Counter Fraud Reports

6.1 Internal Audit – Progress Report April 2016

6.1.1 Mrs Berry gave a detailed overview of the report. She highlighted that following queries at the February meeting she had met with Mrs Goldsmith to discuss altering the Key Performance Indicators (KPIs). It was agreed that KPIs 4 and 5 would be amended to 15 days making target dates for draft reports and management response more achievable.

6.1.2 The Committee accepted the report.

6.2 Public Dental Service Accounts Receivable (November 2015)

6.2.1 Ms Steele and Mr Forrest gave a brief overview of the report. Mr Forrest anticipated that management actions would be concluded by the end of September.

6.2.2 The Committee accepted the report.

6.3 Bank and Agency Staffing (January 2016)

6.3.1 Ms Steele gave a brief overview of the report. She noted a number of weaknesses in the key controls, highlighting the critical issue relating to use of the register of approved bank staff and the need to ensure that new bank and agency staff are appropriately authorised by following the bank staff process.

6.3.2 Ms Ireland advised the Committee that opportunities to confirm the suitability of staff had occurred prior to the member of staff being considered by the bank. She advised the Committee that there were robust processes in place within the bank and work with the Director of Pharmacy and Ms Howard's Team to capture relevant new starts through the bank and agency staffing procedures and mitigate these errors was on-going.

9.3.2 The Committee accepted the report.

6.4 Financial Planning (March 2016)

6.4.1 Ms Berry gave a brief overview of the report. She noted that though the financial position was extremely challenging the controls in place were for the most part adequately designed and, to the extent that the timing of the audit allowed, they were confirmed as operating effectively.

6.4.2 The Committee discussed the importance of ownership of budgets. Mrs Goldsmith expected that that changes to the budget sign off process would encourage ownership and adherence to budgets.

6.4.3 The Committee agreed to accept the report.

6.5 Follow-Up of Management Actions Report (April 2016)

6.5.1 Ms Berry gave a detailed overview of the report. She highlighted that following the Corporate Management Team Meeting 34 actions had been

closed, plus a further 4 since the report being issued to the Committee. Management continue to provide information to the Internal Audit team with renewed momentum.

6.5.2 The Committee recognised the positive improvement following the last meeting and anticipated continued progress at future meetings.

6.5.3 The Committee accepted the report.

7. Counter Fraud Activity

7.1 Mr Old gave a brief overview of the report. He highlighted that at present there were 4 open referrals and 4 open referrals.

7.2 The Committee agreed to accept the report.

8. External Auditors

8.1 NHS Lothian Reviews of Key Controls 2015/16

8.1.1 Mr McConnell introduced the report, advising that there were no significant weaknesses within the key controls therefore Audit Scotland could rely on internal audit and the key controls in their annual certification process.

8.1.2 The Committee agreed to accept the report.

9. General Corporate Governance

9.1 Action Plan relating to Compliance with Policies

9.1.1 Mr Payne introduced the report. He informed the Committee of the extensive engagement with management to identify the root cause of the issues and develop a meaningful action plan.

9.1.2 The Committee agreed to accept the report as assurance that an action plan was in place to address the issues raised in the Compliance with Policies and Procedures (April 2015) audit report. Members requested a further update in September before moving to an annual reporting schedule.

AP

10. Any Other Competent Business

10.1 External Audit Appointment

10.1 Mrs Goldsmith advised the Committee that NHS Lothian had been provisionally informed Scott Moncrieff would replace Audit Scotland as external auditors for NHS Lothian. She highlighted the conflict for the current provision of the Internal Audit Services and though she was content with Scott Moncrieff's appointment as external auditors she noted the loss of Ms Berry's expertise within the Internal Audit Team; Mr Marriott would lead procuring a new internal audit provider and feedback on progress in due course.

CM

11. Date of Next Meeting

- 11.1 It was noted that the next scheduled meeting of the Audit & Risk Committee would be held on Monday, 20 June 2016 at 9:00 in Waverley Gate, Edinburgh. Committee members only are asked to attend by 8.45 for the scheduled 45-minute pre-meeting.

DRAFT

NHS Lothian

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9.30am on Wednesday 4 May 2016 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr P Johnston (Chairing); Mrs K Blair; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Mr M Hill; Mr B Houston; Professor A McMahon; Mrs L Williams and Mr T Davison.

In Attendance: Mr J Crombie (Chief Officer); Mr I Graham (Director of Capital Planning); Mr C Marriott (Deputy Director of Finance); Mr D Ridd (Communications); Mr P McLoughlin (Strategic Programme Manager)(Item 96.4); Mr C Stirling (Hospital Director, WGH)(Item 96.4); Mr D Small (Chief Officer East Lothian IJB)(Item 96.5); Mr A Milne (Project Director Hub Major Initiatives)(Items 96.5 and 96.6); Mr C Graham (Secretariat) and Ms Sorrel Cosens (Observing).

Apologies for absence were received from Mr G Walker.

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.

92. Minutes of the Previous Meeting

92.1 The minutes of the previous meeting held on 9 March 2016 were approved as a correct record.

93. Running Action Note

93.1 The Committee received the circulated running action note detailing outstanding matters arising, together with the actions taken and the outcome.

94. Matters Arising

94.1 Theatres Improvement Programme Update – Mr Crombie advised that the programme was now established and moving forward with the six work stream approach. Finance colleagues were recruiting project management support, interim support was being provided from the efficiency and productivity team resource. A formal paper for the Committee on progress and outcomes would come to the next meeting.

JC

94.1.1 Ms Blair asked whether Deloitte were still involved with this work. Mr Crombie stated that Deloitte had been involved in signing off the work and commented on the agreed structure. Mrs Goldsmith added that Deloitte had been commissioned jointly with the Scottish Government. The proposal for the next phase was still to be agreed. Mr Marriott

pointed out that he would shortly be meeting with Deloitte to firm up the next phase and would bring back appropriate updates in due course.

94.1.2 Mr Hill asked about the programme from the national point of view. Mr Crombie gave reassurance that the Lothian programme would move forward independently despite the structure being shared nationally this would now slow Lothian progress. The Committee accepted the update.

94.2 Integration Joint Boards (IJBs) letter with formal budget proposals – Mrs Goldsmith reported that discussions with the IJBs remained ongoing. Once the Board financial plan was agreed Mrs Goldsmith would write formally to the IJBs.

94.3 Meeting of the Director of Finance and the IJBs Chief Finance Officers to discuss the budget proposals – Mrs Goldsmith stated that the situation was similar to the formal budget proposals, with discussions still ongoing. There had been several meetings with the section 95 officers and chief financial officers. The IJB budgets model was being worked through and there would be an independent view of this work to ensure allocations are correct.

94.3.1 Ms Blair asked for assurance that there was sufficient liaison between the Board's Audit and Risk Committee and the IJBs. Mrs Goldsmith shared this concern that this needed to be improved so was unable to provide assurance. The priority would be to establish IJBs working budget and then the focus would be on how the audit process would work.

94.3.2 It was noted that Midlothian and East Lothian had appointed council internal auditors without having discussions with the health board; this of course was perfectly acceptable but leads to differing processes across the IJBs. There was a need to consider how the audit programme would work within the IJBs and how assurance would be provided. Mrs Goldsmith stated that there would be a need for all the Board committees to consider their relationships with the IJBs and how this would impact on committees' terms of reference.

94.3.2 Mr Hill suggested that there may be merit in inviting all audit committee chairs and finance officers from the IJBs to meet to go through roles and remit so that proper assurance could be given; to ensure consistency and to avoid unnecessary duplication. Mr Houston agreed that this would be a good approach but noted that this would apply more to the Board's Audit and Risk Committee. Mrs Goldsmith agreed to make the necessary arrangements for such a meeting. **SG**

94.4 Briefing for new Non Executive members on Edinburgh Bio Quarter – Mr I Graham reminded the Committee of the opportunity to visit the Bio Quarter site along with the chair of the economic committee council. Alternatively Mr Graham could circulate a presentation giving background information.

94.4.1 Mr Houston stated that visiting the site was a good idea but he was unclear of the purpose. Mr Graham clarified that the visit would be to provide briefing to new Non Executive Directors who knew little of the history or background of the site. Mrs Goldsmith added that it would also be helpful in understanding the role and constitution of the Bio Quarter. Mrs Goldsmith agreed to take the action of organising a visit forward. **SG**

95. Financial Position

95.1 Draft 2015/16 Year end position – Mr Marriott gave the highlights from the report, the

numbers in the report remained draft as they were subject to external audit. The Committee noted the achievement of the underspend position.

95.1.1 There was discussion on improvements in Edinburgh with £1.3M released from the Integrated Care Fund; pay expenditure pressures nursing; critical highlight 11% higher bank; area recovery plans critical areas; out of area treatments pressures; medical supplies and equipment pressures; LRP position and 16/17 monitoring. It was noted that a lot of out of area spend patients came through REAS. Mrs Goldsmith stated that the main reason for the overspend in this area was that it had not previously been properly funded. Professor McMahon added that the area had been significantly underfunded and the paper outlines how the resource can best be reprovisioned with flexibility. Mr Hill stated that given the significance of the spend in this area was there sufficient monitoring of pressure around it?

95.1.2 Professor McMahon replied that in the last few months the raised profile around better mental health and specialities had helped. This area had always overspent and the focus was now on turning this around with better governance and a different model.

95.1.3 Ms Blair asked about the agency and nursing bank budget and the under delivery of schemes. Professor McMahon reported that the agreed savings target for agency spend was £5.2M. There would also be a ban on agency use as of 15 May 2016. It was hoped that this target would be achieved. There had also been an agreed around generic recruitment which will be managed by the nurse bank.

95.1.4 There was discussion on project management support and the need to have this for the delivery of major schemes. There would also be a need for project management with a lot of the incoming quality work and there was no point putting in major schemes without the appropriate resource. It was noted that more substantive project management posts were now being recruited for, externally to the NHS. In the past project management had been brought in on temporary contracts, which led to uncertainty over posts. The organisation needed to value its project management resource as it had a key role to play in supporting the organisation.

95.1.5 Mrs Goldsmith stated that whilst the financial position appeared positive there was some work to do to understand what changed since the December position. Understanding the position was further complicated with the integration joint boards now established.

95.1.6 Ms Williams asked about the GP prescribing overspend and whether the cost per unit was something which could be looked at from a procurement perspective. Mrs Goldsmith stated that this was something that would need to be done nationally to influence price and this has been raised several times.

95.1.7 The Committee noted the achieved financial targets subject external audit review and recorded thanks to the Finance Team for its excellent work to get to this position.

95.2 Draft 2016/17 Financial Plan update – The tabled presentation was received. Mrs Goldsmith summarised the current position with the financial gap now reduced to £20M and it was noted that this was an improvement on the figures taken to the April Board meeting.

95.2.1 Mrs Goldsmith reported that the key factor to the change in position had been following a meeting with the Scottish Government at which there had been discussion around the use of a 1% reserve to be played in as part of the Local Delivery Plan (LDP) submission. The Scottish Government will accept the LDP with the £20M gap which will be reviewed

through the course of the year. The LDP would be considered by the Board members on 11 May.

95.2.2 At the meeting with the Scottish Government there had been discussion around the usefulness in the pursuit of NRAC and it was recognised that there was currently no source of funds available to cover Lothian's NRAC shortfall. Mrs Goldsmith reported that she intended to continue the push for NRAC parity.

95.2.3 There was also potential additional funding of £10M which could be released from the national balance sheet. The national position on this was awaited, if this was the case then the suggestion would be to hold back the 1% reserve and use the £10M. This would be the basis on which the plan would go to the Board for sign off as part of the LDP.

95.2.4 There was discussion on movement around the year end position; this included acute medicines; waiting times and land costs. This then gave the best estimate cost profile for 2016/17. There was also movement with the baseline pressure for junior doctors and this issue would be taken to the Board's Corporate Management Team on 9th May 2016.

95.2.5 Ms Blair asked about patient experience feedback (positive or negative) given changes with the treatment time guarantee and GP prescribing. Mr Crombie stated that waiting time for outpatients had been pushed back but there was deterioration with the treatment time guaranteed position across Scotland. The concept of patient expectation had been raised at a number of different fora. It was acknowledged that NHS Scotland needed to do better around patient expectation national and that boards doing this individual was dangerous as it could lead to a postcode prescribing type situation.

95.2.6 There was discussion on service impacts of any reductions. Cllr Henderson flagged his concerns about this. Mrs Goldsmith stated that each of the IJBs were exploring service impacts, as most were within primary and community care.

95.2.7 Mr Houston added that Ms Blair's question around patient experience was becoming more and more fundamental. The Board was in a situation decision whereby spending money in ways that would inevitably have patient impact. There needed to be enough understanding of what any impact would be; assessment of this in advance and much more reliable monitoring of impact. This needed to a core board requirement moving forward. Mr Houston added that all of this does come back to the NRAC situation, as the Board suffers and continues to do so, leads to the pressure of making decisions that have the consequence of patient impact.

95.2.8 The Committee noted the draft 2016/17 financial plan.

96. Property and Asset Management Investment Programme

96.1 Property and Asset Management Investment Programme: Five year plan 2016/17 – 2020/21 – Mr I Graham introduced the paper providing the outturn of the 2015/16 property and asset investment programme, and five year plan from 2016/17.

96.1.1 Mr Graham reported that in terms of programmes going forward, there remained an over commitment to key risk areas e.g. Western General; diagnostic and treatment centres at the Bio Quarter and St John's Hospital. There were also a number of key risk projects identified for GP premises.

96.1.2 In terms of the Scottish Government's report on the Annual State of NHS Scotland Assets and Facilities, this may be published in September 2016 but confirmation is awaited. The Scottish Government have confirmed that the Property Asset Management Strategy for 2016 will just be an update outlining significant changes from last year rather than requiring a full strategy this year.

96.1.3 There was discussion on ESA2010 refinancing; the Royal Hospital for Sick Children and DCN project; the REAS programme; Bangour Hospital site; PPP contract (RIE) and the implementation of the Scottish Government Policy for all public sector land to be registered by 2024.

Mr Davison joined the meeting at 10.40am.

96.1.4 Mrs Goldsmith reported that the Lauriston master plan was still to do and there needed to be serious consideration of priorities going forward.

96.1.5 The Committee agreed the recommendations as listed in the paper and agreed the proposed investment programme for five years from 2016/17.

96.2 Full Business Case Addendum: Lothian Partnership Centre Bundle – The Committee noted the addendum and also that the financial close sign off had happened on 1 April 2016.

96.3 Standard Business Case: Cardiotocograph (CTG) Decision Support and Archiving System – Mr Crombie informed the Committee that the paper represented a significant step forward in the provision of safe and effective care in the obstetrics environment, aiding decision making. It was noted that all relevant governance processes had now received sign off. The Committee noted the recommendations within the paper.

96.3.1 Ms Blair asked about the consideration of eHealth implications. Mr Crombie stated that eHealth had been heavily involved with the proposals and would continue to be so. There was discussion on generically applying an eHealth involvement section to all Board committee papers.

96.3.2 Mr Hill stated this was a laudable project to take forward and asked about greater monitoring to ensure revenue neutrality. Mr Crombie assured the Committee that the detail sat behind the project. Mr Hill asked whether the Committee should expect this level of detail.

96.3.3 It was agreed that for such cases in future greater detail and information should be provided as part of the post project audit of outcome.

96.4 Standard Business Case: Robot Assisted Laparoscopic Prostatectomy

Mr McLoughlin and Mr Stirling joined the meeting.

96.4.1 Mr Stirling introduced the Business Case and reported that this significant development had support from charitable (partnership with Prostate Scotland); regional and national levels. This proposal was for the third of three robots which made up part of the Scottish Government National Cancer Strategy.

96.4.2 This was also a significant development for the Western General Hospital campus and a key commitment for taking surgical services forward on the site.

96.4.3 The Committee noted that the current service sustainability relied on one surgeon. The key thing with this Business Case was to create a more sustainable regional prostatectomy service. Moving from a position where demand cannot be met to a regional south-east Scotland service and team by the end of the year.

96.4.4 Ms Blair asked about the timeframe for setting the service up. Mr McLoughlin stated that if approved today work on national procurement will increase and the training programme would start in the summer with a view to the three surgeons trained and operating independently by September/October 2016. The service would be running on its own feet by the turn of the year.

96.4.5 Mr Hill welcomed the Business Case as an impressive example of good regional planning. Mr Hill asked if the revenue consequences listed net of inferred savings added pressure to the financial plan or had these been taken into account. Mr Crombie confirmed that these had been taken into account and that regional boards would contribute their share.

96.4.6 Mr Davison stated that as the chair of the regional SEAT and Cancer Group, there had been a lot of questions at the outset of this work as to whether this was actually needed and this had been given a good airing at two or three group sessions. It had been concluded that this development was needed given the threat of service collapse otherwise. NHS Lothian would be hosting this service for SEAT with governance from the regional level.

96.4.7 The Committee welcomed the service development and approved the Standard Business Case for robotic prostatectomy surgery in the South East of Scotland.

Professor McMahon left the meeting at 11am

Mr McLoughlin and Mr Stirling left the meeting.

96.5 East Lothian Community Hospital - [East Lothian Community Hospital Fly-through Video](#)

Mr Small and Mr Milne joined the meeting.

96.5.1 Capacity for Surgical Treatment and Diagnostics – Mr Crombie reported that the paper was a summary of the information which was recently received by the Board's Strategic Planning Committee (SPC). The Committee noted that the SPC had reached a consensus view that the business case for the East Lothian Community Hospital should not include a general anaesthetic theatre; therefore the paper was being submitted as a Day Surgery model without General Anaesthetic. The Committee supported the business case going forward on this basis.

96.5.2 Business Case and Decant – Mr Small stated that agreement was being sought to support the revised Business Case programme, and advance decant costs, for East Lothian Community Hospital (ELCH). The Committee noted the revised timetable set out in the paper:

- Outline Business Case to F&R – July 2016
- Full Business Case to F&R – September 2016
- Financial Close – November 2016
- Construction commencement – January 2017

- 96.5.2.1 Ms Blair asked about the £1.5M outstanding shortfall within the business case. Mr Milne confirmed that work to mitigate this was ongoing with the Scottish Government. Mr Milne also confirmed that the hard modular wards were not like portacabins, having being used in the past as a compliant clinical solution.
- 96.5.2.2 The Committee noted the revised Business Case programme (Day Surgery model without General Anaesthetic) and timetable. The procurement of the preferred option around modular wards was approved.

Mr Small left the meeting.

96.6 New Project Request: Royal Edinburgh Hospital, Phase 2 – Mr I Graham stated that this new project request (NPR) was part of the formal process under the hub engagement and procurement. Mr Milne clarified that approval was being sought for new project requests to be issued to hub southeast. These new project requests are split into two contractual arrangements:

- The capital funded element of the MacKinnon House redevelopment
- Second revenue funded project - integrated rehabilitation from Astley Ainslie Hospital and facilities management building support site

96.6.1 The Committee approved the issue of the NPRs for the proposed REH 2 capital funded scheme to hub SE, and REH 2 revenue funded scheme to hub SE and delegated the conclusion of the Key Stage Review to the Project Director.

Mr Milne left the meeting.

97. For Information

97.1 Property and Asset Management Investment Programme 2016/17 Business Case Monitor - The Committee noted the paper.

98. Date of Next Meeting

98.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 13 July 2016 at 9.30am in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

HEALTHCARE GOVERNANCE COMMITTEE

The draft minutes of the meeting held on Tuesday 15 March 2016 are attached.

Key issues discussed included:

Health Visiting; key risks and action plan

- Members had received the previously circulated paper which was further to the update at the previous meeting and described the actions that were being taken to meet the key risks identified.
- The detailed risk assessment and action plan were noted, and updates would be provided by the IJBs under their future standing agenda item.

Corporate Risk Register

- The committee was informed that the Corporate Risk Register would in future be used to drive the agenda.
- A paper had been previously circulated. Dr Farquharson noted that some services had been asked to present their actions to mitigate risks on the risk register to the Audit and Risk Committee. To minimise duplication of effort, the same reporting format would be used for both reports.
- Ms Bennett noted that the risk registers for the Integrated Joint Boards and the Acute Hospital Committee were being developed and would be presented at future meetings in 2016, with the Integrated Joint Boards having a standing agenda item.

Learning from Adverse Events

- It was noted that there was still a large backlog of incidents which had not been reviewed within the 66 day target. This would be a priority for the coming year with the backlog expected to be cleared in the next 9 months. Resources in the Quality Assurance team had been reallocated to work on the backlog and to improve local processes for reviewing incidents.
- Improvement programmes were already in place to cover common themes of incidents, such as pressure ulcers, falls and suicide. New incidents were being reviewed and closed first. The committee was not assured at this stage, and asked for a detailed action plan at the July 2016 meeting.

Update on Stroke Standards Compliance

- A number of quality measures were showing an improvement, but there were still some challenges, for example: swallowing assessment; admission to a dedicated stroke unit; and thrombectomy treatment.
- Dr Dennis expected improvements to be made on actions outlined in the presentation within two years, and that current targets would be met at that time.
- The committee would receive a progress report in 1 year

Key issues on the horizon are:

Healthcare Governance Assurance Need

- Ms Bennett spoke to the previously circulated paper which set out the assurance needs identified in the 2014-15 annual report and identified current gaps using submissions from the Committee members.
- It was noted that some responsibilities would be devolved to the Integrated Joint Boards. In order to ensure that Healthcare Governance Committee received assurance on its areas of responsibility the process of assurance for IJBs was being worked on, and IJBs would report to the Healthcare Governance Committee as a standing item at each meeting.
- Members wanted to see more detail on actions being taken before the second recommendation 'to confirm actions to reduce assurance risks' could be approved. A further paper would be submitted at the next meeting to explain these more fully.

Dr Richard Williams
Non Executive Director
Chair

NHS Lothian

Healthcare Governance Committee

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 15 March 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr R. Williams, Non-Executive Director (chair); Ms S. Allan, Non-Executive Director; Ms P. Eccles, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Mr B. Houston, Board Chairman; Mr A. Sharp, Patient and Public Representative.

In Attendance: Ms J. Bennett, Clinical Governance Manager; Dr R. Bhopal, Public Health (item 64.1); Ms F. Cameron, Head of Infection Prevention and Control (item 65.1); Dr E. Davidson, Public Health (item 64.1); Dr M. Dennis, Consultant in Stroke Medicine (item 66.1); Dr D. Farquharson, Medical Director; Mr J. Glover, Service Manager, Royal Edinburgh Hospital (item 64.1); Ms K. Grieve, Strategic Programme Manager (item 61.1); Ms F. Ireland, Assistant Director, Nursing Workforce and Business Support (item 66.4); Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms A. Neilson, Public Protection Team Manager (on behalf of Professor McMahon); Ms B. Pillath, Committee Administrator (minutes); Ms C. Rostron, Associate Nurse Director (on behalf of Mr Crombie); Mr J. Sherval, Specialist in Public Health (on behalf of Professor McCallum); Ms M. Wilson, Chief Nurse, Edinburgh Health and Social Care Partnership.

Apologies: Dr B. Cook, Medical Director, Acute Services; Mr J. Crombie, Chief Officer, Acute Services; Mr T. Davison, Chief Executive, NHS Lothian; Ms W. Fairgrieve, Partnership Representative; Mr J. Forrest, Chief Officer, West Lothian Health and Social Care Partnership; Ms C. Hirst, Non-Executive Director; Mr A. Joyce, Employee Director, Non-Executive Director; Professor A. McCallum, Director of Public Health and Health Policy; Professor A. McMahon, Interim Nurse Director; Ms A. Meiklejohn, Chair of the Area Clinical Forum, Non-Executive Director; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership; Professor A. Timoney, Director of Pharmacy; Cllr F. Toner, Non-Executive 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.

58. Quorum

58.1 According to the provisions made in the Terms of Reference of the Committee, Mr Houston co-opted himself as a member of the Committee in his role of non-executive director of NHS Lothian, so that a quorum of three non-executive directors would be present and the meeting could take place. As Mr Houston was

not able to be present for the whole meeting, some items were taken as discussion only, as noted in the minutes following.

59. Patient Story

- 59.1 Ms Neilson read out correspondence from the family of a patient who had had a negative experience as a patient in NHS Lothian in 2009, but a positive experience more recently in 2016.

60. Committee Cumulative Action Note and Minutes from Previous Meeting (26 January 2016)

- 60.1 The updated cumulative action note had been previously circulated.
- 60.2 The minutes from the meeting on 26 January 2016 were approved as a correct record.

61. Matters Arising

61.1 Health Visiting; key risks and action plan

- 61.1.1 The meeting was not quorate for this item; discussion recorded.
- 61.1.2 The Chair welcomed Ms Grieve to the meeting. Members had received the previously circulated paper which was further to the update at the previous meeting and described the actions that were being taken to meet the key risks identified.
- 61.1.3 There had been discussion at the Corporate Management Team at the end of 2015 on whether the system could be maintained based on the four localities, or whether a single system management was required. It was decided at that time that a move to a single system was not necessary as strategic co-ordination already took place between areas. This would be considered again if problems persisted after changes currently being made, including recruitment of staff. Ms Myles noted that staff from all areas were now working well together, and a single system would not necessarily improve this. The detailed risk assessment and action plan were noted.

62. Emerging Issues

62.1 GP Contracts; Integrated Joint Board Assurance

- 62.1.1 The meeting was not quorate for this item; discussion recorded.
- 62.1.2 Dr Farquharson advised that GP contracts would be changed with implementation of the new GMS contract in 2017. The GP would be part of a multi-disciplinary practice team working with other community services, and the GP would not necessarily be the first point of contact for patients.
- 62.1.3 The Quality and Outcomes Framework (QOF) would be discontinued and replaced by a system of quality leads in each GP practice who would meet with other quality leads in their area to determine quality measures relevant to the area. The Scottish Government had released some monies to provide backfill costs to release the

quality leads from practice. The strategy for GPs was relatively clear, there needed to be agreement from the other professions to support this change.

- 62.1.4 This change would have implications for GPs, community healthcare workers, and patients. It would be critical to involve patients and members of the public with qualitative work on assessing the impact of this change, and engagement with the public on explaining the new system would be important. Dr Williams noted that the national group leading on this was including this in its strategy.

63. Corporate Risk Register

- 63.1 The meeting was not quorate for this item; discussion recorded.
- 63.2 A paper had been previously circulated. Dr Farquharson noted that some services had been asked to present their actions to mitigate risks on the risk register to the Audit and Risk Committee which had led to some concerns about duplication of work in areas which were also part of the assurance framework of the Healthcare Governance Committee. To minimise duplication of effort, the same reporting format would be used for both reports.
- 63.3 Ms Bennett noted that the risk registers for the Integrated Joint Boards and the Acute Hospital Committee were being developed and would be presented at a future meeting in 2016.

64. Person Centred Culture

64.1 Additional Needs and Diversity Information Task Force Update

- 64.1 The Chair welcomed Dr Bhopal and Dr Davidson to the meeting, and they spoke to their previously circulated paper. Ms Morrison noted that in addition to the long term plans to routinely include and check additional needs information in patient records and when treating patients described in the report, some areas were using local mechanisms to do some of this in their areas; for example the Emergency Department was using a TRAK alert to identify patients with learning disabilities.

The support of GPs and GP sub committee was noted, as was the intention that data could be entered in either primary or secondary care, and shared across systems. This was not yet in place.

- 64.2 The recommendations made in the paper were approved by the Committee. Mr Houston noted that at the next update a more specific business case for achieving the aims of the task force would be useful.

64.2 Person Centred Culture Report

- 64.2.1 The meeting was not quorate for this item; discussion recorded.
- 64.2.2 Ms Morrison spoke to the previously circulated paper. Ms Morrison noted that it was important that patients had a range of opportunities to give feedback to the organisation, but that these were managed centrally.

64.2.3 It was noted that for a short period of time phone calls to the Patient Experience Team had been limited to two hours per day so that a backlog of complaints could be logged. Patients were still able to contact the team by email and letter.

64.2.4 Dr Williams noted that Lothian had been an outlier amongst Scottish Boards for numbers of complaints not upheld by NHS Lothian but upheld by the Scottish Public Services Ombudsman. Ms Morrison noted that the previously agreed Quality Assurance Committee would be set up to take on the qualitative review of complaints, thus the decisions should become more in line with the Scottish Public Services Ombudsman.

64.3 Staff Survey Report

64.3.1 The meeting was not quorate for this item. The previously circulated NHS Lothian staff survey report was noted for information. This had been discussed in detail by other Committees of the Board, and was included at this meeting as a matter arising from the previous meeting.

65. **Safe Care**

65.1 Healthcare Associated Infection Update

65.1.1 The Chair welcomed Ms Cameron to the meeting and she spoke to the previously circulated paper. Improvements were beginning to be identified in the *Clostridium difficile* Infection and *Staphylococcus aureus* Bacteraemia rates and it was expected that a further reduction would be demonstrated by the end of the HEAT target year.

65.1.2 The key area in reduction of *Clostridium difficile* Infection was antibiotic prescribing in both primary and secondary care; precautions in place meant that transmission between patients rarely occurred. The experience in other Boards showed that the change in prescribing policy introduced in Lothian in February 2015 was likely to take a few years before a resulting change in trend would be detected. This was because of the time taken for robust compliance with the policy and because of the timescale of the development of the infection in the patient. A change in the sampling process could remove asymptomatic carriers of *Clostridium difficile* who did not have the infection and should not be included in the figures.

65.1.3 Antimicrobial pharmacists were key resources for changing prescribing practices. Dr Williams noted that the Committee had supported the proposal for an additional antimicrobial pharmacist, to work in primary care but that this post had not been funded. Some additional resources had been provided from within the Pharmacy budget.

65.1.4 Work was in progress to support clinical teams in taking ownership of action to reduce infections. The Infection Control site based committee structure including key site clinicians as members would be key to this.

65.1.5 The Committee and Board had previously approved the HAI Action Plan, and had stated that they expected an improvement in the rates by July 2016.

65.2 Public Protection Update

- 65.2.1 Ms Neilson spoke to the previously circulated paper and highlighted the Prevent Action Plan, which would be circulated following the meeting, and the extension of the MAPPA arrangements from 31 March 2016 to include category 3 offenders, which were violent offenders with a criminal conviction. **BP**

65.3 Learning from Adverse Events

- 65.3.1 Ms Bennett spoke to the previously circulated paper. It was noted that there was still a large backlog of incidents which had not been reviewed within the 66 day target; a lot of work had been done on this with the services and this would be a priority for the coming year with the backlog expected to be cleared in the next 9 months. Resources in the Quality Assurance team had been reallocated to work on the backlog and to improve local processes for reviewing incidents. It was noted that some open incidents were historical and staff in the area at the time of the incident were no longer in post, so that learning was less meaningful.
- 65.3.2 Improvement programmes were already in place to cover common themes of incidents, such as pressure ulcers, falls and suicide. New incidents were being reviewed and closed first. The committee asked for a detailed paper giving an update on the situation at the July 2016 meeting.

66. **Effective Care**

66.1 Update on Stroke Standards Compliance

- 66.1.1 The Chair welcomed Dr Dennis to the meeting and he delivered a presentation which had been previously circulated.
- 66.1.2 A number of quality measures were showing an improvement, but there were still some challenges, for example: swallowing assessment; admission to a dedicated stroke unit; and thrombectomy treatment.
- 66.1.3 In response to a question, Dr Dennis advised that the reason for limited availability of thrombectomy in NHS Lothian was the small number of clinicians trained to carry out this intervention; there were currently 2 and would be 3 in July. 4 or 5 would be required for a 24 hour service, as well as accompanying team of nurses, radiographers, and available theatres. There was a shortage in the UK of trained staff as evidence for the efficacy of the intervention had only been available from 2015.
- 66.1.4 Actions were being taken to try to reduce the differing standards between weekday and out of hours so that the same standard was achieved at all times. This was a UK wide situation.
- 66.1.5 Dr Dennis expected improvements to be made on actions outline in the presentation in the next two years, but noted that national targets could have been raised again during this time, so that whilst current targets should be met, there might be a shortfall against any new targets. Dr Dennis noted that he would likely

be retiring in the near future, so he was working hard to ensure good practices were embedded in the system, and did not require a single enthusiast to promote.

66.2 Nursing and Midwifery Council Annual Report

66.2.1 The annual report had been previously circulated. Presentation of the report by the Nursing and Midwifery Council was deferred to the next meeting. **BP**

66.3 Quality Report

66.3.1 Ms Bennett spoke to the previously circulated paper.

66.3.2 It was noted that reports of adverse events with harm had increased. The data had been analysed in detail and it was found that the increase was due to better reporting which was more accurate in classification of harm.

66.3.3 The cardiac arrest rate had not reduced, but NHS Lothian already had a low rate compared to other areas in Scotland. Dr Farquharson noted that the HSMR and cardiac targets ended in December 2015; the Scottish Patient Safety Programme was considering the next targets.

66.4 Clinical Policy and Documentation Annual Report

66.4.1 The Chair welcomed Ms Ireland to the meeting and she spoke to the previously circulated paper.

66.4.2 In response to a question from Ms Gormley, Ms Ireland advised that all new policies would be impact assessed as part of the approval process.

66.4.2 The recommendations made in the report were approved.

67. Committee Effectiveness

67.1 Healthcare Governance Assurance Need

67.1.1 Ms Bennett spoke to the previously circulated paper which set out the assurance needs identified in the 2014-15 annual report and identified current gaps using submissions from the Committee members.

67.1.2 Concern had been raised about the corporate support for equality and mutuality as there was no longer anyone in post co-ordinating this. It was suggested that the equality and mutuality point of view was often missed and was difficult to bring up in discussion, and that the part of Committee papers meant to address this was often not used as intended. Mr Houston was keen to consider how Board papers better met these issues and how there could be assurance that this need was being considered and met when developing policies and services. This would be part of the work that Alan Payne was doing on guidance for writing Board papers and on how the content of papers linked to decisions made. Ms Bennett noted that the responsibilities of the previous equality committee had been transferred to all other Committees.

- 67.1.3 Other areas noted in the paper included a concern about the volume of papers for each meeting and the need to strengthen the link between the Healthcare Governance Committee and the Staff Governance Committee, as staffing was key to good clinical care.
- 67.1.4 The first recommendation in the paper was approved, but Members wanted to see more detail on actions being taken before the second recommendation 'to confirm actions to reduce assurance risks' could be approved. A further paper would be submitted at the next meeting to explain these more fully. **JB**

68. Exception Reporting Only

Members noted the following items for information:

- 68.1 Controlled Drugs Team Annual Report;
68.2 Regional Eating Disorder Unit Update from SEAT (South East and Tayside)
68.3 Equality and Diversity; Easy Read Letters and Health Information

69. Other Minutes: Exception Reporting Only

Members noted the minutes from the following meetings for information:

- 69.1 Area Drug and Therapeutics Committee, 5 February 2016;
69.2 Clinical Management Group, 8 December 2015, 12 January 2016;
69.3 Lothian Infection Control Advisory Committee, 8 December 2015;
69.4 Public Protection Action Group, 17 February 2016;
69.5 Information Governance Assurance Board, 26 January 2016;
69.6 Health and Safety Committee, 27 October 2015;
69.7 Organ Donation Sub-Group, 19 January 2016;
69.8 Acute Hospitals Committee, 30 November 2015;
69.9 Clinical Policy and Documentation Group, 10 December 2015.

70. Date of Next Meeting

- 70.1 The next meeting of the Healthcare Governance Committee would take place at **9.00 on Tuesday 24 May 2016 in Meeting Room 7, Second Floor, Waverley Gate.**
- 70.2 Further meetings in 2016 would take place on the following dates:
- 26 July 2016;
- 27 September 2016;
- 29 November 2016.

DRAFT

NHS Lothian

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 1pm on Thursday 24 March 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo place, Edinburgh EH1 3EG.

Present: Mr B Houston (Chair); Mrs J Anderson; Mr T Davison; Mrs S Goldsmith; Mr M Hill; Mr P Johnson; Mr A Joyce; Professor A McCallum; Mr Rob McCulloch-Graham; Professor A McMahon; Mrs A Meiklejohn; Mr P Murray and Mr G Walker.

In Attendance: Mr C Briggs; Ms L Irvine (for item 84) and Mr D Weir.

Apologies for absence were received from Mr A Boyter, Mr J Crombie, Mrs C Harris, Ms E McHugh and Mr D A Small.

82. Declaration of Financial and Non Financial Interest

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

83. Minutes of the Previous Meeting Held on 11 February 2016

83.1 The Minutes of the previous meeting held on 11 February 2016 were approved as a correct record.

84. Mental Health and Callum Pathway

84.1 Ms Irvine provided the committee with a detailed presentation, copies of which had been distributed in advance of the meeting which covered Callum's Pathway; a sense of belonging; mental health configuration; using evidence to change practice and a sense of belonging 2 in our changing landscape.

84.2 It was noted in respect of Hannah, Scott, Callum and Sophie that these virtual patients were based on ISD data and represented an accurate representation of the population and that the stories behind these people were based on real persons.

84.3 The committee noted that a funding bid had been made for interpersonal therapy as a distress brief intervention which it was hoped would be rolled out in both Edinburgh and Addiewell Prisons. It was noted that over the past 4 years it had been possible to secure £7.87m of funding from grants, awards and tests of concept for use in mental health and that this had been utilised in public social partnerships, re: D collective and the transformation station. It was felt that there was scope for this process to be transferred into other areas of the Health and Social Care agenda and this was in the process of being discussed.

- 84.4 Ms Irvine drew to the committee's attention the totality of recent Scottish Government allocations and advised on where these had been deployed. She also commented on the importance of relationships which was explained in detail to the committee.
- 84.5 It was reported in terms of inequalities and social justice that a new social partnership around the creation of a Health and Wellbeing Hub was being taken forward in conjunction with Hibernian Football Club at both their Easter Road Stadium and at Willowbrae.
- 84.6 The committee were advised that Ms Irvine was currently building on good work already in place and that this was timely as the Scottish Government were looking at their own strategy. Ms Irvine advised that she felt that the 'a sense of belonging' should be a 10 year vision in order to establish services which addressed the prevention and early intervention agenda.
- 84.7 The Chairman thanked Ms Irvine for her presentation and commented that the item was before the committee for information and not specific decision.
- 84.8 Mrs Meiklejohn commented that her question also related to item 6 on the agenda in respect of governance and decision making. The importance of the Programme Board remaining a Lothian wide mechanism was stressed in order to ensure there was clarity around governance and how decisions were made as this was an area of potential risk. It was noted this would also be important in order to avoid adverse unintended consequences and to ensure that any bids to the Scottish Government or elsewhere were undertaken and submitted on a consistent basis.
- 84.9 Professor McMahon advised that the Strategic Planning Committee retained overall governance responsibility and updated on work already underway in respect of the Royal Edinburgh Acute Services and Mental Health areas where discussion had been undertaken in respect of community elements transferring to the Edinburgh Integration Joint Board (IJB). He commented that there was a need to look at the Programme Board in terms of infrastructure to ensure that appropriate players were participating fully in ongoing debate. Professor McMahon commented that he felt moving forward there would be a need for fewer forums and to have a clearer focus about where decisions were made.
- 84.10 The committee were advised by Professor McCallum that this was a complex arena and that she felt there was opportunities to shape the response to a new Government strategy and the updated Mental Health Act and to ensure the engagement of primary care and research and development colleagues from the beginning of the process. There was also a need to align resource expertise as well as financial resources to make sure that issues were considered on a ground up and ground down basis and in a clear and transparent manner.
- 84.11 Mr Murray commented that he welcomed the intention to progress on a 10 strategic basis and he felt that this would be beneficial in avoiding waste and in ensuring proper levels of coordination. Mr Hill commented on a meeting he had attended the previous day in a non NHS Lothian capacity in respect of food poverty and food banks. It had been reported at this meeting that there had been an alarming increase in the number of young men reporting with mental health issues. He questioned in this respect whether NHS Lothian's approach to partnership building and working was as robust as it could be. Ms Irvine commented that she felt strongly that progress would be limited moving forward if dialogue was only held with Health and Social Care colleagues and she felt there was a need to engage fully with Community Planning Partnerships. It

was noted that progress would be made in this regard. Mr McCulloch-Graham commented that working in partnership would open up resources for the health sector as it would allow access to Council services. He commented that in his view getting people back to work addressed all health outcomes including mental health and in this respect the City of Edinburgh Council had established a reemployment route. He commented that IJBs should be the conduit for ensuring that all relevant aspects affecting people with mental health issues should be addressed through future investment in building work.

84.12 Mr Walker commented that IJBs should be part of the connectivity debate and that he would welcome further discussion around how the Edinburgh IJB could play a lead role in this area in future. He commented however that what was missing from the debate was a link on how work in this area improved performance against Board targets like Child and Adolescent Mental Health Services and Psychological Therapies. He suggested if Board level performance was not being improved then this would be an issue. Ms Irvine commented that she would be happy to come back and discuss this issue further and commented that part of the issue around the CAMHS and Psychological Therapies issues was that people had not received early intervention treatment and therefore had moved onto a requirement for crisis intervention. She commented it was for this and similar reasons that she favoured a 10 year strategy.

84.13 Mr Murray commented on his view for a need for a Health and Wellbeing Committee or other similar forum which would have as part of its function a requirement to manage the external and internal work around areas like mental health to improve outcomes to a point where people would not require access to acute hospital services because the early intervention model had been so successful in the first instance. He reminded the committee of his previous comments of the change focus in the fire service onto the prevention agenda which had taken a period of around 15 years to come to total fruition.

84.14 The committee noted the update report.

85. Integration Joint Boards Directions to NHS Lothian Progress 2016/17

85.1 Mr Briggs provided the committee with a detailed presentation, copies of which had been distributed in advance of the meeting which covered the background to the preparation of the directions along with the expectation that these would be in place for 1 April 2016. It was noted that all 4 strategic plans had either been signed off or were being signed off and that a number of common themes had emerged as detailed in the presentation. It was noted that NHS Lothian was not in receipt of directions from any IJB at the present time and that budgets had not yet been finalised.

85.2 The committee were advised of a number of outstanding common issues and the fact that the financial implications needed to be resolved. It was noted there was a clear risk to NHS Lothian that 'no change' equalled a £4m per month pressure in acute services.

85.3 The committee noted the formalisation of the Chief Officers Group and that a proposed workshop would be held in mid April to understand directions and resolve outstanding issues. It was noted that the review of the Strategic Planning Directorate had been completed and would be reported upon later in the meeting.

- 85.4 Mr Briggs felt moving forward that IJB strategic plans needed to work in symbiosis with NHS Lothian plans and that the Lothian Hospitals Plan would be the successor to Our Health, Our Care, Our Future. In the future it would be important to acknowledge the benefits of creative and positive tension.
- 85.5 Mrs Goldsmith commented that budgets were finalised albeit within the context that NHS Lothian did not yet have a balanced financial plan and that budgets would be issue based on the information available.
- 85.6 Professor McMahon commented that he would welcome discussion about the timeline for moving the proposition forward and commented there was a need to tie down robust direction and to consider how to manage the financial position.
- 85.7 Mr McCulloch-Graham commented that a significant amount of work had been undertaken in respect of the directions in Edinburgh. He commented that there had been different expectations on what the directions would contain and how detailed they would be. It was noted that guidance from the Scottish Government was light in this area. It was noted that draft directions for the Edinburgh IJB had been passed to NHS Lothian earlier in the day. Mr McCulloch-Graham commented that he would wish to discuss with NHS Lothian and the Council the detail of the directions as some of these would need to be worked through in the current year. He commented that at a recent meeting it had been recognised that all 4 IJBs plus NHS Lothian and the acute sector had a vested interest in reducing the overspend in financial terms in the acute sector. It was noted that a workshop had been established to obtain traction around this area and that there would be actions emerging from this on both sides. The committee noted that the Edinburgh IJB directions from 1 April 2016 remained at high level although it was felt that they were sufficiently detailed to allow continuance of business. It was noted that directions would be developed as the year progressed and that some of these would need to be worked through on a joint basis like mental health. A working group had been set up in partnership about how to move to the new Royal Edinburgh Hospital facility and that directions would be issued on the back of this once further detail was known.
- 85.8 Mr Hill commented that he seen the draft directions for West Lothian and these were at high level and that more detailed directions would require to be worked through. He commented that he welcomed the establishment of the working group as this would provide an opportunity for dialogue between the IJB, the Board and other stakeholders and would hopefully lead to joint commitments to address known challenges.
- 85.9 Mrs Meiklejohn commented that as IJBs became established they would wish to do things differently and for that reason the dialogue opportunities through the working group would be important to ensure a coordinated approach. Mr McCulloch-Graham advised that changes had already happened and that not all workstreams would require a direction and updated the committee on progress being made around delayed discharges as an example.
- 85.10 Mr Davison commented that the NHS Lothian financial plan was not balanced. NHS Lothian had been provided with a 1% uplift to achieve targets and deliver efficiency savings. He suggested there was scope for some IJB direction to be useful in assisting with the financial position particularly in respect of bed or whole facility closures. In terms of Mr Briggs presentation he reminded the committee that the point had previously been made that there would be no investment in the acute sector. It was recognised this would not be a feasible position because of pay awards and drug

costs. However the statement was still true in that it would not be possible in the future to open new beds as had happened in the past.

- 85.11 The committee were advised by Mr Davison by way of example that diabetes was a delegated function and the prevalence of type 1 diabetes was rising with a consequent increase in the prescribing of insulin pumps. This was an issue that needed to be discussed further with it being hoped that IJB directions would issue around this position in future. The position in terms of the GP stakeholder intimation that the provision of local enhanced services for type 2 diabetes would cease to be provided by primary care and that the initial contact would be with the acute sector was discussed.
- 85.12 Mr Walker commented that directions should not be regarded as instructions and that there was a need to change service through dialogue. He commented that he was currently not clear what all of the issues were that needed to be resolved and suggested there would be benefit in these being put on the table for further dialogue. He commented that his current assumption was that the system would progress on a business as usual basis until the direction of travel changed. In the meantime it would be important that all partners were talking the same language whilst accepting the benefit of positive and creative tension.
- 85.13 Mr Davison agreed with the need to discuss the range of outstanding issues. He commented in some areas this would require difficult decisions about whether to positively choose to recurrently fund services using money that was not available in order to incur less of an overspend. He commented that these were areas where directions might help.
- 85.14 Professor McMahon advised that he, Mr Crombie, Mr Briggs and the 4 IJBs had created a panel which met on a monthly basis and would bring back propositions that people could sign up to in a way that reduced conflict.
- 85.15 Mr Murray commented whilst he understood the points being made by Mr Davison he felt that the challenge was to work outside the constraints of a 12 month assessment period in order to invest and develop preventative measures that would provide longer term gains. He also questioned what NHS Lothian's role was in respect of lobbying the Scottish Government to be patient in supporting such a process and suggested that his previous comment about the establishment of a Health and Wellbeing Committee would allow the Board to take the longer term view outwith the constraint of the 12 month funding model.
- 85.16 Mr Hill commented in terms of creative tensions that he felt if a direction came out in the manner of a formal and explicit representation of what needed to be done then he would feel that the process had failed. He felt that the key issue was to progress issues through discussion with the appropriate group in order that any emergent directions did not come as a surprise to the service.
- 85.17 The Chairman questioned whether the Strategic Planning Committee were content from a planning perspective that the arrangements discussed were in place across the whole of NHS Lothian. Update reports were provided in respect of each area. Mr Hill commented that if the Chairman meant by that statement that there was the same degree of discussion around the IJB table as had just occurred at the Strategic Planning Committee then this was not happening in West Lothian and he felt there was some way to go before that level of debate could happen. He advised that further discussions had intended to be prompted at the IJB meeting held the previous day

although this had not occurred. He felt that there was a need for the NHS and Council to work together and to enter into meaningful conversations about how to progress. Professor McMahon commented that he hoped that the IJB forum would facilitate this to happen.

85.18 Mr Walker commented that a number of colleagues had attended the Clinical Governance Committee Workshop and he had come away from this with concerns around the implications of the forthcoming GP contract. He commented that there was a need to be clear about ensuring that the forthcoming contract did not get in the way of progress elsewhere and there would be a need to remain sighted on this. Mr Davison commented that he was not yet sighted on this issue although he stated that IJBs should be the instruments of strategic direction for primary care and that he would have thought that IJB representatives should have been involved nationally through the contract negotiation process. Professor McMahon undertook for the next meeting to bring back an outline of the GP contract and any pertinent issues as well as details of who was taking the lead on these. **AMcM**

85.19 It was agreed to receive regular updates on progress in developing IJB direction.

86. Public Health Review Report

86.1 Professor McCallum provided the committee with a presentation copies of which had been circulated in advance of the meeting. She commented as context that the Public Health Review in Scotland had focused on a number of particular issues and advised that every European country had been required to undertake a review because they were signed up to the achievement of long term health gains.

86.2 The committee noted in respect of the Scottish process that discussions had been held around academic and public health education training and relationships with the wider workforce. It was noted that the national landscape was cluttered and that there was a need to obtain clarity on what was intended to be delivered in the future. It was noted that there had been no shared view across Scotland about the function of public health.

86.3 The Public Health Review had identified a lack of a national strategy and the fact that investment was not being made at a sufficient level in the right place. It had also been noted that there was a requirement for academic effort to be better focussed in future and the need to build on partnership working. It was noted that the Public Health Review had stopped short of providing solutions but had identified areas where there was a need to work in a more effective way.

86.4 Mr Johnston commented that he had been involved in the review process and had been cautiously disappointed about the outcome of the review as he had been hoping for something more radical in terms of a pathway for change. Mr Hill commented that he had also been disappointed and commented that if you accepted the relationship between poverty and ill health and continued to do nothing different then this position would only worsen. He felt that there was a need to focus efforts explicitly on areas where improvement benefit was known rather than addressing issues that suited scientific interest. He felt that the Government should be encouraged to influence the tax regime in order to address areas and issues like poverty. He felt there was a need to stop funding initiatives that were recognised as beneficial but which provided no evidence of effectiveness. Mr Hill commented that he was unsure of NHS Lothian's

role in terms of lobbying the Scottish Government around investment and tax planning policy.

- 86.5 Mr Murray commented that whilst acknowledging the report was not as helpful as had been anticipated that it was still important to consider NHS Lothian's response to it. He felt that there was a need to pursue vigorously the issues discussed at the committee and to be on the front foot in moving this agenda forward.
- 86.6 Mr Davison commented that maintaining healthy populations was expensive in healthcare terms. The point was made in response that most people living in poverty were engaged in some form of employment and that inequality existed in to old age. Professor McCallum agreed that tax and other issues could be structured differently to help progress the agenda. She commented that the key issue was to look at middle-aged people in terms of prevention and health improvement and that this was the key difference between Scotland and peer countries.
- 86.7 The Chairman suggested that that the previous comments tied back to whether or not NHS Lothian had a lobbying role.
- 86.8 Mr Walker commented that the review report felt like a gap analysis and questioned who was arguing a different case. He questioned how best to engage and respond robustly to the review report which was not felt to be the answer moving forward.
- 86.9 Mr Murray made reference to the comments in the review report about the workforce and reminded the committee of previous comments about how fire fighter roles had changed into a more preventative role although this had taken 15 years to come to fruition. He felt that all NHS staff had a preventative role and this should be displayed in routine contact with patients. The committee were advised that NHS Lothian's healthy working environment related to the facilities that NHS Lothian provided. It was not felt at the moment that NHS Lothian had an agreed position with IJBs about what public health should do with it being felt that there would be a common set of requirements across all IJBs.
- 86.10 It was noted that in England public health was part of Council services and encouraged good access to other services i.e housing which was good in developing a coordinated public health agenda. An example was provided of anti smoking clinics being led by housing officers which had resulted in significant numbers of people having successfully stopped smoking.
- 86.11 Professor's McMahon and McCallum would bring back a further report on how to feed in and apply upward pressure in respect of the comments made on the review report at the current meeting.

AMcM/AKM

87. Strategic Planning Directorate Review

- 87.1 The committee received and noted a paper detailing the Strategic Planning Directorate organisational change commitments to support development and the implementation of Health and Social Care Partnerships strategic plans and the NHS Lothian hospital plan. It was noted that the proposals had been supported by the Workforce Organisational Change Group and Corporate Services Partnership Forum.

- 87.2 Professor McMahon commented that he hoped that these arrangements would provide equity and parity. He suggested that the cross matrix and relationships with mental health would further develop to reflect pan Lothian resources.
- 87.3 It was noted that the arrangements were interim and would change as IJBs further developed.

88. Draft Local Delivery Plan 2016/17

- 88.1 The committee noted that the local delivery plan (LDP) was work in progress with the final submission being due to the Scottish Government by the end of May 2016. The submission would be discussed on 11 May 2016 at a special Board meeting. It was noted that the circulated paper included issues around the need to address financial pressures.
- 88.2 Mr Murray with reference back to the public health review reflected the ethos of what might be done differently in future years. He commented that he would welcome the opportunity to consider the paper in more detail as he had only received it in the past few days. It was noted that the LDP would be discussed at the special Board meeting on 11 May 2016.
- 88.3 Mr Davison commented that before the special Board meeting there would be a need to consider that NHS Lothian would be submitting an LDP that proposed stopping spending a significant amount of money in the private sector and this might have a consequence and impact in achieving legally binding treatment time guarantees. The LDP would also report a £30m financial shortfall of which £20m related to under funding of NRAC which it was hoped would be off-set against the £30m figure. Mr Davison commented that this would be the first occasion where NHS Lothian would be submitting an LDP that was in deficit. The committee noted that NHS Lothian also anticipated £11m contribution from the nationally coordinated schemes process established by the Scottish Government. This and the previous reference to the NRAC shortfall equated to the £30m deficit reported at the meeting.
- 88.4 Mr Davison commented that he Mrs Goldsmith had taken on board comments made at the recent private Board meeting about the need for discussions around the financial position to be held in public.
- 88.5 The committee noted the updated LDP.

89. Date and Time of Next Meeting

- 89.1 The next meeting of the Strategic Planning Committee would be held on Thursday 14 April 2016 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

DRAFT

NHS Lothian

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 9.30am on Thursday 14 April 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo place, Edinburgh EH1 3EG.

Present: Mr B Houston (Chair); Mr M Ash; Mr J Crombie; Mr T Davison; Dr D Farquharson; Councillor D Grant; Mr M Hill; Mr P Johnston; Mr A Joyce; Professor A McCallum; Mr R McCulloch-Graham; Professor A McMahon; Mrs A Meiklejohn; Mr P Murray and Mr D A Small.

In Attendance: Mr C Briggs; Mrs S Egan (for item 12); Dr M Douglas (for item 8); Mr C Marriott (deputising for Mrs S Goldsmith); Mr A Milne (for item 9); Ms D Milne (for item 6); Dr G Scott (for item 6) and Mr D Weir.

Apologies for absence were received from Mrs J Anderson, Mrs K Blair, Mr A Boyter and Councillor F Toner.

1. Declaration of Financial and Non Financial Interest

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

2. Agenda Re-ordering

2.1 Proposal made by the Chairman around agenda re-ordering were approved and are reflected in the following minute.

3. Minutes of the Previous Meeting Held on 24 March 2016

3.1 The Minutes of the previous meeting held on 24 March 2016 were approved as a correct record subject to the following minor amendments: -

84.5 Delete 'and at Willowbrae'

85.18 Clinical Governance Committee should read Healthcare Governance Committee.

4. Matters Arising from the Previous Meeting

4.1 Integration Joint Board Directions – Professor McMahon in response to a question from Mr Ash advised that an update would be brought to the June 2016 meeting. **AMcM**

5. East Lothian Community Hospital Capacity for Surgical Treatment and Diagnostics

- 5.1 Mr Davison apologised for the lateness in issuing the paper. He commented there was a risk of delaying the East Lothian Business Case and he had asked the team to get to a definitive position in the next few weeks. The first phase of the process was to report to the Finance & Resources Committee specific issues about theatre capacity and utilisation. Mr Davison commented that as would be demonstrated in the forthcoming presentation that the solution was not 'an either or' one and that two of the three options were suboptimal. He hoped that the Strategic Planning Committee would be able to make a firm recommendation on a preferred option or a combination of options to the Finance & Resources Committee.
- 5.2 Mr Briggs spoke in detail to the circulated paper advised that he was looking for a consensus view to take to the main meeting of the Finance and Resources Committee. He commented that the East Lothian Community Hospital was a key strategic issue for both NHS Lothian and the East Lothian Integration Joint Board (IJB) and had been subject to significant public consultation. The East Lothian Community Hospital provided new opportunities on how to deliver health services. It was noted that the Scottish Government had approved the initial agreement and that the business case had initially been intended to be discussed by the Finance and Resources Committee in February. Mr Briggs updated on the position in respect of inpatient bed space and usage. It was noted that 20 beds would be constructed as part of the development but would be moth-balled as part of the future proofing exercise to recognise future demographic issues in East Lothian. It was reported that expanded endoscopy and other treatment and diagnostic space would be off-set by not providing general anaesthetic theatre capacity.
- 5.3 Mr Briggs advised that the latter point had been informed by consolidation of current performance and utilisation in theatres, including consideration of the types of procedures currently being undertaken in the current theatre space. This position had been reached in autumn 2015 and coincided with:-
- Policy announcements regarding the funded development of elective centres, with 2 such centres indicated for Lothian.
 - Final outcomes from the Deloitte's work on efficiency and productivity opportunities within NHS Lothian.
 - Finalisation of the delivery for patients 2 workstream which had demonstrated significantly increased demand across a range of specialties, manifested as growth in outpatient demand (and, consequently, increased demand for inpatient and day case treatment).
 - The policy choice within NHS Lothian to withdraw from independent sector provision of surgical capacity.
- 5.4 Mr Hill noted the complex issues in the debate and recognised that there was no optimal solution. He questioned whether part of the issue was because of the lack of synchronicity between elective centres and whether they were intended for inpatient and day case elective work or inpatient and day work needing general anaesthetic and local anaesthetic services and the impact this would have on what was provided at Roodlands Hospital.

- 5.5 Mr Davison advised in respect of elective centres that full clarity was not available about what the SNP Conference statement would translate into on the ground. It was reported as a consequence of demographic changes that demand for elective procedures and conditions of the elderly would continue to outstrip capacity. It was noted that if general anaesthetic (GA) cover was not provided in the new East Lothian facility that this made the business case more affordable although there would be a need to re-provide GA elsewhere and issues around timing and other aspects would need to be considered for instance gas and clear air supplies to theatres.
- 5.6 Mr Ash commented that he recognised there was no optimal solution. He advised however that through the Community Health Partnerships that the community had been advised that the facility would be future proofed with excess space mothballed to address known future demographic changes. He stressed the need not to compromise the potential integrated care facility. The point was made if there were to be no GA provision in Haddington it would be important that East Lothian patients would only have to travel to Edinburgh and not to West Lothian.
- 5.7 Mr Small reported that the approved initial agreement (IA) included GA provision. The position had moved on since the IA particularly in respect of clinical technology development. The point was made that thinking had further developed through the finalisation of the delivery for patients 2 workstream and the fact that NHS Lothian was no longer utilising private theatre capacity which had resulted in an increase in the internal GA capacity requirement. It was noted whilst there were opportunities to bring elective capacity into the system there was currently no timelines around the creation of elective centres and therefore no confidence that the system could cope with all demand.
- 5.8 Councillor Grant commented that the residents of East Lothian had waited a long time for the new hospital and he was concerned to ensure that the issues raised at the meeting did not delay the hospital even further. He recognised however the budgetary impact of providing GA facilities at Roodlands and like Mr Ash would not want to see East Lothian residents having to travel to West Lothian.
- 5.9 Mr Briggs provided the committee with a detailed explanation around the 3 options highlighted in the paper as well as clarifying the impacts these would have on activity delivered at Roodlands which in broad terms would require 700 patients to be re-provided for elsewhere. It was noted that already East Lothian residents travelled to other parts of Lothian for treatment. It was noted that it would be important to understand the knock on effect on other parts of Lothian of not providing GA in East Lothian. At the moment it was noted that no assurance could be given around the ability to absorb additional demand and this was a risk that would need to be managed. It was reported that endoscopy was the best proxy of future demand as determined by demographic changes and work was ongoing to respond to this issue.
- 5.10 The committee noted that the development of the Lothian Hospitals Plan was ongoing and there were a number of streams that would impact on what services were provided at Roodlands. It was reported that the elective orthopaedics plan had previously been signed off by the Strategic Planning Committee and this gave the first steer on how to manage surgical services moving forward which would involve maximising acute inpatient services on the 4 main sites.

- 5.11 The point was made in terms of the clinical policy that there was a need to consider how this fitted with the rest of the strategic direction with there possibly being a compelling need not to have local services because of the operational requirement to centralise resources. It was suggested that the principles would be established by the Strategic Planning Committee which would send out a message about how NHS Lothian needed to use its resources. It was agreed that the quality information agenda would need to underpin these decisions.
- 5.12 Mr Briggs reminded the committee that the proposal had been due to be considered by the Finance and Resources Committee in February 2016 and updated on the financial risks associated with the proposals and options detailed in the circulated paper. This included risks and impacts of changes in elective capacity offset by the productivity challenge. It was noted that there remained a gap of over 8000 cases. Mr Small provided an update on the implications in both cost and financial terms if a decision was taken to reintroduce GA at Roodlands. It was noted that any additional cost would fall back on NHS Lothian and on a worst case revenue scenario this could equate to £1m per annum over 25 years.
- 5.13 Mr Crombie reminded the committee in terms of revenue and capital costs that these costs were only being deferred as there would still be a need to create additional theatre capacity to meet demand.
- 5.14 In terms of protecting the spare capacity at Roodlands and ensuring that it was not used inappropriately in advance of anticipated changes in demography it was reported that the extra space would not be fully equipped and would effectively be 'shelled' to avoid improper use. Oversight of this space would sit with the IJBs. It was noted that over a period of 10 years that the East Lothian development plan made provision for an additional 10,000 houses.
- 5.15 Mr Briggs commented that he would welcome a view from the committee in respect of either option B or C or perhaps a combination of both to include any business case for submission to the Finance & Resources Committee. He advised the key focus was attempting to balance clinical planning with strategic policy and to take account of risks at the East Lothian Community Hospital. There was also a need consider the impact of elective capacity and how this should be managed and provided in future. Mr Davison commented if possible it would be useful if a clear consensus of the committee could be translated into a recommendation to the Finance and Resources Committee.
- 5.16 In terms of clinical capacity it was questioned whether there would be sufficient workforce available to fulfil these new roles in order to avoid risk to patients. Mr Crombie advised that staff and resources were in place. He commented however that there would be revenue consequences of increased capacity requirements. He pointed to elective orthopaedics as a precedent of how to utilise facilities, sites and people to best maximum effect.
- 5.17 Mr Davison commented that currently NHS Lothian did not have the available workforce to meet projected additional capacity. He reported that the Board decision to turn off private capacity would have a bigger impact than the East Lothian Business Case. In that respect there was a need to obtain an urgent decision from the Scottish Government about the provision of elective centres. He

commented that NHS Lothian currently did not have the capital and revenue resources for GA nor the necessary levels of surgical staff.

- 5.18 Mrs Ash suggested that the key issues was about quality and the best outcomes for patients. He felt that option B along with option C would be the likely direction adopted. A key presumption in coming to a view would be that business cases for elective capacity would need to either safeguard or improve outcomes for patients.
- 5.19 Mr Walker commented that IJB Directions should not be regarded as instructions and that there was a need to change service through dialogue. He commented that he was currently not clear what all of the issues were that needed to be resolved and suggested there would be benefit in these being put on the table for further dialogue.
- 5.20 Mr Murray commented that a lot of the initiatives being put in place to reduce demand on elective services might take a significant amount of time to come to fruition. It was noted that whilst he also felt that the best way forward would be a combination of option B and C that there was a need to consider short term elective capacity needs which would need to be managed within the context of there being no elective centre solution currently available.
- 5.21 Mr Ash commented if option B was the preferred way forward then there would be a need to recognise the point on constraints on capacity planning and that the availability of elective centres would go some way to resolving that problem whilst recognising short term issues suggested if elective centres were not an option then there might be a need to refer back to the Scottish Government for authority to increase borrowing limits.
- 5.22 Mr Davison commented on the need to make explicit to the Scottish Government issues around clinical policy and cost and comment on the displacement of activity that needed to be addressed. The fact that Roodlands only reflected a fraction of the capacity that needed to be addressed also needed to be referred to the Scottish Government. He stressed that NHS Lothian could not wait 2½ years for capacity growth. Mr Davison commented if the committee concluded to recommend to the Finance & Resources Committee a combine of options B and C in terms of capacity issues that it would still be possible to use the GA theatres at Roodlands for 2½ years until they were demolished. In terms of the previously referred to 800 cases there would be a need to come up with an interim contingency if no additional capacity had been identified when Roodlands closed. This might be through the use of modular theatres or vanguard type facilities which had been used in past.
- 5.23 Professor McCallum commented on the continuation of, and expansion, of the inhalation sedation option and local anaesthetic as an alternative to full general anaesthetic for frail and elderly patients undergoing procedures was not included. This was a specific issue that has been raised by professionals and would help alleviate anxiety about the functionality of the Unit.
- 5.24 Councillor Grant advised that his preferred option would be for option A although he recognised that there was no support for this from the committee members. He therefore reluctantly supported option B and was grateful to Mr Davison for his comments around mitigation.

5.25 The committee agreed that option B accompanied by option C would be recommended to the Finance and Resources Committee whilst highlighting capacity issues and the implications around the timeframe for the availability of elective centres. It would also be reported that there would be a need for temporary gap bridging solutions over a 2/3 year period to deal with capacity issues.

6. Sexual Health and HIV Services in Lothian

6.1 The committee received a presentation on Sexual Health and HIV Services in Lothian from Mrs D Milne and Dr G Scott copies of which were circulated following the meeting. It was noted that the Scottish Government had published a pregnancy and parenthood in young people strategy which had made a significant impact with teenage pregnancies having reduced since 2008. In addition pilot work was underway at the Royal Infirmary of Edinburgh around post partum issues for women and this would be rolled out with it being suggested through the Scottish Government that this approach might be followed in other parts of Scotland.

6.2 Ms Milne advised that plans were under consideration to move abortion services to the Chalmers Centre and this was felt to be better for the women involved and also freed up hospital space. The committee noted that sexual health work was not carried out in isolation and was considered in conjunction with drug and alcohol services. The committee noted that there was increasing work with sex workers especially looking at sexual exploitation, trafficking and working in saunas. This had resulted in an increased number of people accessing NHS services. It was noted that demand for gender identity clinic demand had increased from 150 to 300 in less than 2 years with a particular focus in a number of teenagers and younger adults coming forward to access services.

6.3 Dr Scott provided an update presentation on preventative work and HIV services where the cost for patients could cost up to £1m over a lifetime. He commented in terms of the HIV drug budget that a lot of drugs were becoming available generically and therefore through aggressive management it should be possible to reduce the level of the drug budget. Dr Scott felt that the introduction of Health and Social Care Integration created significant opportunities and would be key to getting services out to the community. It was noted that prevention in localities would be a key aspect around service delivery in the longer term and the ways this might be delivered was detailed in the presentation.

6.4 Ms Milne commented that the Lothian strategy would not be rewritten and that actions would be taken forward through the updated Scottish Government Sexual Health and Blood Borne Virus (BBV) Framework 2015-20 with clinicians as third sector partner engagement.

6.5 The question was raised about whether concentrating abortion services at the Chalmers Centre ran the risk of the centre becoming seen as an abortion clinic and subject to campaigners which might result in barriers to patients receiving treatment. It was agreed this was an issue although it was difficult to manage

because such demonstrations happened on public streets and could not be prevented.

- 6.6 Mr Small commented in respect of long lasting reversible contraception that NHS Lothian had uncapped the number in 2015/16 on a non-recurrent basis. He felt that even if non recurring support was stopped that there was sufficient funding invested in enhanced service support to meet current demand. The committee noted that this impacted on recommendation 2.2 given that the position was felt to be containable within existing resources. The committee agreed to remove recommendation 2.2 from the paper although activity and need would be monitored.
- 6.7 Mr Ash suggested that the movement of resources was for the individual IJBs to direct although he understood issues around hosted central services. It would be important however to be able to explain the reasons for any resource shift. Dr Scott commented that the challenge going forward would be how services were delivered over the 4 IJB areas.
- 6.8 Professor McMahon questioned where the Programme Board report to in governance terms. It was noted that an annual report was made to the Strategic Planning Committee. In addition some members of local partnerships were NHS Lothian Board members. In terms of communications with the Health and Social Care Partnerships that ownership with and through localities would be important especially given the need to shift resources. Dr Scott felt that ownership was evident and he felt as IJBs evolved this would become more explicit. He commented that through such engagement that disinvestment had occurred in some areas and resources diverted to areas of greater need. Mr Ash commented that the previous point about governance was important in respect of ensuring that the IJBs were content with the approaches being taken. Mr McCulloch-Graham commented whilst the issues under consideration did not at the moment sit within the IJB governance process that the adoption of a pragmatic approach was bearing fruit.
- 6.9 The Strategic Planning Committee agreed the recommendations contained in the circulated paper with the exception of recommendation 2.2 for the reasons highlighted in the body of the minute.

7. Public Health, Community Planning Partnership and Health and Social Care Partnership

- 7.1 Ms Milne commented that the purpose of the circulated report was to update the Strategic Planning Committee on the public health contribution to Community Planning Partnerships (CPPs) and Health and Social Care Partnership (H&SCP) in response to the public health review published in March 2016.
- 7.2 The community noted that in Lothian the response to the public health review was being looked at with a view to seeing how the department could work better with localities in areas like smoking cessation. Appropriate links would continue to be made with planning.

7.3 The Strategic Planning Committee agreed the recommendation contained within the circulated paper.

8. Health and Inequality Strategy

8.1 The committee noted that the Board had previously approved the Health and Inequality Strategy in December 2014. It had been agreed to provide regular updates on progress to the Strategic Planning Committee.

8.2 Dr Douglas advised that the Health and Equality Strategy essentially focussed on 2 areas the first of which identified that NHS Lothian interventions would not in themselves address all health and equality issues and that broader action would be needed with other partners. The second area of focus was on the short term interventions as it was felt that the focus on a three year timeframe would make the most difference.

8.3 The committee noted that the principles in the strategy were challenging in the current financial position. The circulated paper included the full action plan. The role of the NHS around procurement and employability was discussed with it being noted that significant work had been undertaken and was well established in capital projects. It was noted that a 12 month funding stream had been obtained from the Health Foundation to mainstream community benefits clauses within construction. The committee noted that socially responsible recruitment was an overall part of the Health and Equality Strategy.

8.4 In terms of health inequalities training it was noted that significant work had been undertaken with prioritised sessions having been held with Allied Health Professionals on how health inequalities training had impacted on their profession to help people identify appropriate support for patients. It was planned to roll out this approach with other staff groups. The committee noted that it was not intended to undertake a large training programme for all NHS staff. It was noted that advice and support for patients with financial issues was provided from health professionals to point people to appropriate areas for assistance. An overall plan was also being developed in respect of providing Welfare Advice Services with it being recognised that an external funding resource might have to be considered.

8.5 Dr Douglas in response to a question from the Chairman advised that future iterations of the paper would include more fully populated updates in the action plan and particularly in respect of performance indicators and that this would continue to evolve as the implementation of the strategy developed. She commented it was for that reason that she had been keen to highlight the principles of the strategy in her opening comments.

8.6 Mr Hill made reference to a recent University of Glasgow and University of the West of Scotland paper about the failure of public health and health promotion attention in reducing inequalities and this suggested the need to raise the game in this area. Professor McCallum and Dr Douglas concurred with this point advising that this was one of the key reasons why the strategy had developed measureable outcomes.

- 8.7 Mr Murray advise that he had randomly looked at East Lothian and had experienced difficulty in understanding the priority given to health and equalities in general. He questioned therefore to what extent NHS Lothian was pushing that activity in the way described in paragraph 4.1 of the paper. Mr Ash commented a key vehicle moving forward would be the Community Empowerment Bill and it would also be important to recognise the new landscape under which the NHS and local authorities were operating. He commented that the recent input from public health into the IJBs had been welcomed.
- 8.8 Mr Murray felt as a Board there would be merit in revisiting the Christie Commission Report within the context of the establishment of the IJBs and how these issues would affect the thinking of a Board of Governance. Professor McMahon undertook to pick up this request. **AMcM**
- 8.9 Mr Johnston commented that in the same way as schools in isolation would not close the educational gap that the health and inequalities agenda would never be resolved by the NHS in isolation. The pathway for achieving progress would be through Community Health Partnerships, the 4 IJBs and the 4 Local Authorities although they were not currently working effectively together. He felt that the points raised by Mr Murray should be addressed. It was felt that a key role for NHS Lothian was to bring people together in order to get principles agreed. Mr McCulloch-Graham provided details of a school champion approach which had added value when he worked at Tower Hamlets in London. He felt there would be a need for champions to be identified for specific causes and this should be the Strategic Planning Committee or the IJBs.
- 8.10 Mr McCulloch-Graham advised that the City of Edinburgh Council had 350 looked after children and he suggested that the NHS as an employer could target this group as they were easily accessible. It was felt that around 40 of these children were suitable for targeting for employment. Mr McCulloch-Graham advised he would be happy to provide Dr Douglas with contacts at the Council. It was noted that the Board Development Session in October would have a focus on corporate parenting.
- 8.11 The Strategic Planning Committee agreed the recommendations contained in the circulated paper. In addition it was agreed there was a need for Board Development work around the Christie Commission as well as the championing principles at NHS level and IJBs. NHS Lothian representatives on Community Planning Partnerships should ensure appropriate feedback occurred.

9. Royal Edinburgh Hospital Campus Redevelopment

- 9.1 Mr Milne provided the committee with a detailed presentation on the Royal Edinburgh Hospital Redevelopment copies of which were available to members following the meeting. It was noted that phase 2 of the outline business case would be finalised around July or August and would be submitted to the Finance and Resources Committee in late summer.
- 9.2 It was noted that in terms of the design of the building that Capita had been key players in working with stakeholder groups like clinicians to ensure that the building worked in terms of staff and patient flow. It was reported that ongoing

workshops were being held to work through the design of rooms, patient flows dignity, safety and security. Professor McMahon commented that the building was being constructed to state of the art specifications. It was reported that the building was large and orientation work for staff was underway with champions having been recruited to look at how the staff, patients and visitor experience would work.

- 9.3 It was noted in terms of the buildings carbon footprint and sustainable energy use that all of the latest technology was being used with consideration being given on how to feed energy back into the national grid. This would form part of the revenue workstreams. Mr Milne commented that work was also underway with partners to ensure aspects around healthy working lives were addressed as well as issues around perceived stigma.
- 9.4 Mr Davison emphasised the broader strategic context advising that the new facility would provide an adult psychiatric inpatient service and intensive psychiatric care for patients in Edinburgh, East and Midlothian. The new facility would be smaller than the current one as the desire was to achieve shorter acute lengths of stay and to place a greater reliance on treating people at home. The committee noted that the National Brain Injury Unit would be built as part of stage 1. This was strategically important as it facilitated the replacement of the Astley Ainslie Hospital services with the exception of the Smart Centre and the Hospital Based Complex Clinical Care (HBCCC) areas which were being looked at separately. This outcome would allow the disposal of the Astley Ainslie Hospital and create a capital receipt.
- 9.5 The committee were advised that there was space in the plan for a South Edinburgh equivalent of the Royal Victoria Hospital Integrated Care Facility. The footprint allow for 170 beds worth of social care barrier free single room residential care as part of the HBCCC and other residential care workstreams.
- 9.6 Mr Davison commented that the Health Board would need to decide what it called the new campus. It would be important not to lose the name of the Royal Edinburgh Hospital and this should be part of a broader campus. It was noted that a naming process was in place.
- 9.7 Mr Milne advised that great thought had been given to the provision of grassed areas and the need to balance the cost of maintenance with the therapeutic benefits of these types of environment. It was noted that the facility would include the retention of the walled Victorian orchard as well as aspects of Public Social Partnership and other projects to maximise the Community Gardens Green Space Initiative.
- 9.8 Mr Murray sought an update on the Edinburgh PFI Schools Challenge. Mr Milne advised that significant discussions were underway with capital planning and a range of technical advisors about any NHS Lothian implications.
- 9.9 The committee noted the progress report for phases 1 and 2 of the Royal Edinburgh Hospital Campus Redevelopment.

10. Review of Hospital Based Complex Clinical Care

- 10.1 Mr McCulloch-Graham provided an update with the progress being made with the review of Hospital Based Complex Clinical Care (HBCCC) in Edinburgh. It was noted that this review had attached to it significant financial savings for the current year. The review process would need to take into account the availability of capacity in nursing homes. It was noted that the review was in the early stages but would need to move rapidly giving the financial expectations attached to it.
- 10.2 The point was raised about whether similar questions would be posed by other IJBs. It was noted that this would be the case and that part of the role of the Strategic Planning Committee was to develop synergies. The committee noted that this process fitted with the HIS (Healthcare Improvement Scotland) review of beds. There were 450 continuing care beds in Lothian and this referenced back to issues being considered around the Astley Ainslie Hospital and Liberton Hospital.
- 10.3 The need to manage communications around public involvement would be important to ensure that proposals were viewed as the success story that they were. It would also be important to remember that some patients were protected under previous legislation.
- 10.4 The committee noted the approach taken by the Health and Social Care Partnership in Edinburgh, to review the capacity and demand of HBCCC, in the wider context of developing whole systems capacity plans, to provide the right mix of services and support.

11. General Medical Services Contract

- 11.1 Mr Small advised that the purpose of the circulated paper was to provide a brief update as requested at the previous meeting on the General Medical Services (GMS) contract in relation to the vision for developing the new GP contract for April 2017 and the transitional quality arrangements in 2016/17 and to brief the committee on responsibilities.
- 11.2 The committee noted that within Lothian at the current time there were a number of GP practices with restrictions to access to their lists. This was a symptom of the difficulty in recruiting new GPs which was becoming a national issue. It was noted that the new GMS contract in 2017 would change the focus for GPs to become expert clinical generalists focussing on complex care in the community, undifferentiated presentations and whole system quality improvement and clinical leadership.
- 11.3 It was reported that nationally £60m of primary care development funds had been made available over a 3 year period and had been built into budget. This funding had been targeted at national priorities although this had not been able to be used locally to support struggling practices. Transformational funding and primary care had been used to introduce more pharmacists in to practices. An update on the utilisation of phase 1 non recurrent funding of £1m was provided to the committee.

- 11.4 The transitional arrangements for 2016/17 were explained as was work in progress in terms of quality leads and clustering of practices. It was noted that there was a need to work on the priorities set out in the appendix to the paper. A key stakeholder seminar was being held in May 2016 for interested parties looking at community nursing. It was noted that a review of district nursing was being led by Professor McMahon. It was reported that at the moment the 2017/18 details of the contract were not known.
- 11.5 Mr Ash commented that at a previous meeting a former Board member had commented about the possibilities of the direct employment of GPs by the Health Board. It was questioned whether this might be an appropriate direction of travel. The committee were advised that this was currently the fall back position if a practice was in crisis. The feeling was that there might be a move towards more direct employment of practice support staff rather than general practitioners themselves.
- 11.6 Professor McCallum commented that the direction of travel proposed in the new contract would not represent a new way of working for the best practices as this was how they already worked. She felt that there was no reason why high quality independent contractors could not be retained although in future this might be within a mixed economy environment. Professor McCallum undertook to feedback to the committee the outcome of national discussion.
- 11.7 The point was made with particular reference to support workers that there would be a need to consider wider issues around the use of AHPs as currently some services were failing to meet targets for example in musculoskeletal where a different approach had been taken successfully in other Health Board areas. Mr Small advised if bids for mental health funding were successful then the proposal would be to link councillors in to practices.
- 11.8 Professor McMahon commented that colleagues were making a number of assumptions around the nursing workforce. He stressed that nurses could not pick up the workload of GPs and that further discussion was needed around models of care. It was noted that even if agreements in principle were reached then the available workforce might not be in place.
- 11.9 Mr Davison reported that the compounding issues was that the Lothian fill rate for GPs was amongst the worst in Scotland against the current number of trainees.
- 11.10 The committee noted the list of recommendations contained in the circulated paper.

12. East Lothian Children's Integrated Plan

- 12.1 The committee noted that following the joint inspectorate multiagency community planning inspection of services for children of East Lothian during 2013/14 it had been agreed that the partnership would develop a new Children and Young Peoples Service Plan replacing the existing integrated Children's Services Plan 2013/17. It was noted that this plan had been approved by the East Lothian Resilient People Partnership (RPP) on 9 March 2016. It was noted that extensive engagement had been undertaken including with community planning partnership

and it was expected that all contributors would contribute to the implementation of the plan.

- 12.2 Mrs Egan explained the process for updating the plan and the impact of new legislation for the NHS Board. It was noted that the system had worked with the Care Commission as the plan had developed. Extensive engagement had also been held with various appropriate planning foras. The committee noted that the early years named persons legislation and issues around access to Child, Adolescent Mental Health Services (CAMHS) were the key issues to be addressed. The previous inspectorate report criticism had been around child protection and CAMHS services as they had not been as robust as they should have been. It was noted that the NHS Lothian Board would be expected to sign-off a plan in future.
- 12.3 It was noted that in terms of productivity around transformation that the same process was not in place in all off the community planning partnerships. The point was made that ownership by Non Executive Board members made a significant difference. It was suggested that it was appropriate that each local authority should decide its approach around children's services but that NHS Lothian should share good practice.
- 12.4 Mr Hill commented that what had been presented to the committee represented a rich piece of work and was clear in terms of its ambitions and this truly reflected partnership working. He welcomed the fact that one of the underlying values was the move away from doing things to children to that of engaging with them and making changes through their contribution. The committee were advised that the current strategy had been driven by children, families and the Children's Strategic Partnership and Planning and Delivery Subgroup. It was noted that East Lothian were at the forefront of corporate parenting.
- 12.5 The committee endorsed the East Lothian Children and Young Peoples Service Plan 2016/19 and acknowledged the significant engagement of children, young people and parents in the production of the plan and the contribution of the Children's Strategic Partnership and Planning and Delivery Subgroup which had driven this partnership work, overseeing the development and production of the new plan. The committee also acknowledged and applauded Sean Gardiner an advanced higher student at North Berwick High School, who as part of his studies had rebranded and redesigned the plan to create a colourful, interesting, easy read document for all readers.

13. Date and Time of Next Meeting

- 13.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on Tuesday 9 June 2016 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

EAST LoTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP INTEGRATED JOINT BOARD

The minutes of the meeting held on 25 February 2016 are attached.

Key issues discussed included:

- **Member's Code of Conduct** – Discussion took place and it was agreed to approve the amended draft Integration Joint Board Members' Code of Conduct and agreed that all members should abide by the terms on an interim basis, pending approval and formal adoption.
- **Audi Scotland Report: Health & Social Care Integration** – Agreed this report should be remitted to the IJB's Audit and Risk Committee and a response brought back to the IJB for further consideration. A second report in the Audit Scotland series on integration will be published in April 2016 in which East Lothian feature as an exemplar of good practice.
- **Delayed Discharges** – Agreed to note the improving trend on performance and recent actions. The Chief Officer agreed to identify what resources are available to further improve performance and further information to be provided to IJB in relation to the numbers of people who have access to independent advocacy as part of discharge planning and the level of uptake for Self Directed Support.
- **Performance Framework** – Presentation took place and it was agreed a summary report would be prepared and recommendations for consideration at a future meeting of the IJB.
- **Budget Allocations Update** – The current position on the Financial Assurance process for the IJB's proposed budget for 2016/17 was discussed and it was agreed the IJB would receive a report at March meeting laying out a conclusion to this process.
- **Strategic Plan** – Strategic Planning Group had recommended adoption of the Strategic Plan and that directions aligned to the Strategic Plan to be scrutinised by the IJB Audit & Risk Committee in advance of issue to ELC and NHSL and produced as an addendum to the Strategic Plan. Agreed the Strategic Plan to be adopted as the blueprint for transformational change and the delivery of health and social care services in East Lothian.
- **Equalities Legislation and the Integration Joint Board** – Agreed to approve the contents of the report and to embrace and implement the principles of the Equality Act 2010 and its associated Regulations which include the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015 and an Equality Outcomes and Equality Mainstreaming Report will be approved at the IJB meeting on 28 April 2016.
- **East Lothian Community Hospital** – Progress with the business case was discussed and the proposed bed numbers in the hospital were agreed, awaiting the outcome of the review of surgical services and support the ongoing work to close the revenue gap.

- **Update on Actions Deriving from the Integration Scheme** – requested a further more detailed report should be taken to The Audit and Risk Committee to consider what further actions are required and a further updated report should be received by the IJB in the new financial year.
- **Position Statement on Contracted Services – Adult Wellbeing** – Current Section 10 Grants for the 12 months from April 2016 to March 2017 were approved and it was noted that a series of reviews were now underway for funded organisations which will be modelled in line with the ELC Partnership funding review process. Future recommendations on Section 10 grant funding to be considered by the IJB's Audit and Risk Committee.

A handwritten signature in black ink that reads "Donald Grant". The signature is written in a cursive, flowing style.

Councillor Donald Grant

Chair/Executive Lead



MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 25 FEBRUARY 2016
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:

Mr M Ash (Items 3 – 14)
Councillor S Currie
Councillor J Gillies (substitute)
Councillor D Grant
Mr A Joyce
Councillor J McNeil (substitute)
Ms A Meiklejohn
Mr P Murray

Non-voting Members Present:

Ms M Allan
Mr D Binnie (substitute)
Ms F Duncan
Dr R Fairclough
Mr D King
Mr K Maloney
Mr T Miller
Mr D Small

Officers Present:

Ms M Anderson
Ms L Crozier
Ms C Lumsden
Ms J McCabe
Mr A Milne
Ms J Ogden-Smith

Clerk:

Ms F Currie

Apologies:

Councillor S Akhtar
Councillor J Goodfellow
Ms A MacDonald
Mrs M McKay
Mr E Stark
Dr J Turvill

Declarations of Interest:

None

The Chair welcomed everyone to the meeting and noted that Councillors John McNeil and Jim Gillies were attending in place of Councillors Shamin Akhtar and Jim Goodfellow, and that Mr David Binnie was attending in place of Mrs Margaret McKay.

1. MINUTES OF THE EAST Lothian INTEGRATION JOINT BOARD MEETING OF 28 JANUARY 2016 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board meeting of 28 January 2016 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING OF 28 JANUARY 2016

The following matters arising from the minutes of the meeting of 28 January 2016 were discussed:

Head of Adult Wellbeing – the Chair advised members that, at its meeting on 23 February 2016, East Lothian Council gave approval for the Head of Service roles for Adult Wellbeing and Children’s Wellbeing to be combined and for the role of Chief Social Work Officer (CSWO) to remain separate from the Head of Service role. It was noted that the new Head of Service would be in post by April with revisions to the organisational structure of the service to follow shortly thereafter.

Councillor Currie asked whether this option for filling the Head of Adult Wellbeing post had been under consideration prior to the last meeting of the IJB on 28 January. He added that, should the current post holder decide to move on in the future, the Council may find this combined post even harder to fill.

David Small explained that the ‘options paper’ circulated to IJB members following their January meeting had included this proposal. He added that the key consideration for the IJB was to ensure that the CSWO would remain a member of the IJB and this had been achieved. He reminded members that the IJB’s role was strategic rather than operational.

The Chair noted Councillor Currie’s remarks but pointed out that he had also expressed concern at the last meeting that the post should be filled timeously and this had now been achieved.

Alison Meiklejohn asked if, once available, the updated organisational structure could be circulated to members. Mr Small agreed to arrange this.

Sederunt: Mr Ash joined the meeting.

3. CHAIR’S REPORT

The Chair reported that an issue had arisen following the last meeting of the IJB regarding the reappointment of non-voting, stakeholder members of the IJB. It was proposed that the IJB should bring forward the reappointment process from 1 April 2017 to 1 April 2016. This would avoid a clash with the likely change in the Council’s representation following the 2017 local government elections and help to ensure better continuity of membership. The Chair proposed that a report be brought forward to the next meeting of the IJB on 31 March.

Decision

The IJB agreed that a report on reappointment of stakeholder members be presented at its meeting on 31 March 2016.

4. MEMBERS' CODE OF CONDUCT

A report was submitted by the Chief Officer of the IJB to amend the Integration Joint Board Members' Code of Conduct in line with recent legislative changes.

Joanne McCabe presented the report. She outlined the background and advised members that the Standards Commission intended publishing a further Model Code of Conduct for Integration Joint Boards at the end of February 2016 and, as a result, further amendments may be required.

Responding to questions from members, Ms McCabe explained that the IJB had previously agreed that its Chief Officer would undertake the role of Standards Officer and he would be the first contact for any queries regarding the Code of Conduct.

Decision

The IJB agreed to:

- (i) approve the amended draft Integration Joint Board Members' Code of Conduct as detailed; and
- (ii) agree that all members should abide by the terms of the updated draft Integration Joint Board members' Code of Conduct on an interim basis, pending approval and formal adoption.

5. AUDIT SCOTLAND REPORT: HEALTH & SOCIAL CARE INTEGRATION

A report was submitted by the Chief Officer of the IJB to provide a summary of the Audit Scotland report on Health and Social Care Integration.

Carol Lumsden presented the report outlining the key themes of the Audit Scotland review. She advised members that as the report raised a number of issues relating to governance and resources, it would be considered by the Audit & Risk Committee and a further report prepared and brought forward to the IJB.

Mike Ash added that it had become clear that many areas had underestimated the work involved in combining the governance structures of local authorities and health boards.

Peter Murray welcomed the reference in the report to different organisational cultures. He said that failing to take account of the cultures embedded in individual organisations could lead to difficulties; as evidenced during the merger of 8 fire services into the single Scottish Fire Service.

Councillor Currie commented on the challenges of developing robust governance arrangements which would allow the public to have confidence in the IJB and its ability to deliver positive outcomes. He said that the Audit & Risk Committee was currently considering this issue and the challenges involved in combining the different systems of governance within the Council and Health Board.

Keith Maloney referred to the intention of the legislation to increase the involvement of service users, carers and the public in decision making and governance. He said it was important to challenge the existing cultures in both bodies to ensure that this intention was followed through.

Ms Meiklejohn commented on the importance of good governance and scrutiny to assure people the IJB was getting things right. She referred to the broad membership of the Strategic Planning Group but acknowledged that involving such a large group was not always practical.

The Chair welcomed the report which he said gave a helpful overview. He also noted members' comments on the need for robust scrutiny and involvement of the public.

Decision

The IJB agreed:

- (i) to note the Audit Scotland report;
- (ii) to agree that the report should be remitted to the IJB's Audit & Risk Committee and a response brought back to the IJB for further consideration;
- (iii) to note that a second report in the Audit Scotland series on integration will be published in April 2016 in which East Lothian feature as an exemplar of good practice.

6. DELAYED DISCHARGES

A report was submitted by the Chief Officer of the IJB to provide an update on performance on delayed discharges in East Lothian and to ask the IJB to agree further actions.

Mr Small presented the report summarising the key themes and drawing members' attention to recent performance figures and the actions being taken to address the main pressure points. He also responded to a number of questions relating to funding, independent advocacy, the effect of introducing the Living Wage and other factors affecting recruitment and retention of staff for care at home services.

Mr Maloney emphasised the importance of access to independent advocacy services as a way of helping people get the care that they really want and need and thus reduce the risk of readmissions. He said that the Mental Welfare Commission for Scotland would in future be gathering data on the numbers of people who have access to independent advocacy services and he asked if the IJB could be provided with statistics for East Lothian.

Ms Meiklejohn raised the issue of Self Directed Support and why uptake was so low. She suggested that more information was needed to understand this and how SDS could be used as a means to address or reduce the burden in some cases.

Richard Fairclough, Maureen Allan and Thomas Miller all expressed concerns about the ability of both NHS and third sector to recruit and retain enough staff to address the shortage in hours. They debated a number of the possible reasons for this including qualifications, working hours and pay.

Councillor Currie echoed a number of the concerns expressed by other members and agreed that the IJB should be more proactive about seeking the information it needed

to make informed decisions about how best to tackle the problem of delayed discharges.

Decision

The IJB agreed:

- (i) to note the improving trend on performance and recent actions;
- (ii) that the Chief Officer should identify what resources are available to further improve performance;
- (iii) that the Chief Officer develops specific actions to improve care at home capacity within the resources available;
- (iv) that further information is provided to the IJB in relation to the numbers of people who have access to independent advocacy as part of discharge planning and the level of uptake for Self Directed Support.

7. PERFORMANCE FRAMEWORK

Carol Lumsden gave a short presentation to the IJB on the Performance Framework. She provided an overview of the process and concluded by seeking members' views on some of the areas which were still to be agreed.

A short discussion followed during which members offered some suggestions on the frequency of reporting, the type of data which should be gathered/reviewed, whether benchmarking and locality planning would be helpful and the arrangements for financial scrutiny and reporting.

Ms Lumsden thanked members for their contributions and advised that she would prepare a summary report and recommendations for consideration at a future meeting of the IJB.

8. BUDGET ALLOCATIONS UPDATE

A report was submitted by the Chief Finance Officer of the IJB to summarise the current position on the Financial Assurance process for the IJB's proposed budget for 2016/17.

David King presented the report summarising the key points of the financial assurance process, the work carried out to date and the actions still to be completed. He reminded members of the authority delegated to the Chair, Vice Chair, Chief Officer and Chief Finance Officer at the last meeting of the IJB and outlined the discussions which had taken place with the Council and NHS Lothian since that meeting.

Mr Ash indicated that while directions must be issued by 1 April 2016, and these were likely to be based on indicative figures from NHS Lothian, the IJB could decide to issue further directions later in the year when the actual figures become clearer.

Mr Murray commented that while finance was a key component, the IJB needed to adopt a holistic approach to improving services.

Councillor Currie acknowledged the current financial pressures and that the position would likely change later in the year, not least as a result of the comprehensive spending review. However, he said his main concern was to ensure that whatever budget is finally agreed was sufficient to deliver the services and efficiency savings expected from the IJB.

The Chair concurred with the comments of members and said that in future efforts needed be made to bring into synch the budget planning processes of the Council and NHS Lothian, as they relate to the IJB.

Decision

The IJB agreed:

- (i) to note the content of the paper;
- (ii) to be updated on the two matters to which it delegated authority to progress to the Chair, the Vice Chair, the Chief Officer and the Chief Finance Officer at its previous meeting; and
- (iii) to receive a report at its March meeting laying out a conclusion to this process for the 2016/17 budget.

9. STRATEGIC PLAN

A report was submitted by the Chief Officer IJB to provide a synopsis of the development of East Lothian IJB's Strategic Plan for adult services. It supplemented the comprehensive reports of 29 October and 27 August 2015.

Ms Lumsden presented the report which outlined the background to the Plan and its various stages of development. She reminded members that the Plan had to be adopted by 1 April 2016 and that the next stage in the process was for officers to prepare the directions to be contained in the Plan. These directions would be scrutinised by the Audit & Risk Committee before being presented to the IJB on 31 March.

Mr Ash advised that the Strategic Planning Group were happy to commend the draft Plan to the IJB.

The Chair noted that the draft Plan had been greeted enthusiastically following its presentation to members of East Lothian Council at their meeting on 23 February.

Decision

The IJB agreed:

- (i) to note that feedback from a second consultation exercise held between December 2015 and January 2016 had been used to inform the final version of the Strategic Plan;
- (ii) to note that the Strategic Planning Group had recommended adoption of the Strategic Plan;
- (iii) to note that directions aligned to the Strategic Plan will be scrutinised by the IJB Audit & Risk Committee in advance of issue to East Lothian Council and NHS Lothian and produced as an addendum to the Strategic Plan; and
- (iv) to adopt the Strategic Plan as the blueprint for transformational change and the delivery of health and social care services in East Lothian.

10. EQUALITIES LEGISLATION AND THE INTEGRATION JOINT BOARD

A report was submitted by the Chief Officer of the IJB to provide the IJB with an understanding of what was required of them under the Equality Act 2010, the Equality

Act (Specific Duties) (Scotland) Regulations 2012, and the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015.

Lesley Crozier presented the report and highlighted the key issues for the IJB. She referred to the responsibilities placed on public bodies including the requirement to assess and review current policies, gather and review information and report progress on a regular basis. She explained that as the IJB does not, at present, have an Equality, Diversity and Human Rights Officer, this role will be undertaken by East Lothian Council's Corporate Equality, Diversity and Human Rights Officer. The IJB's first Equality Outcome and Equality Mainstreaming report was currently being prepared and would be presented for approval to the IJB's meeting on 28 April 2016.

Councillor McNeil commended the report and the work being undertaken by local and national government as a result of the Equality Act.

Councillor Currie also welcomed the report but expressed concern over future resource implications. He said that it would be important to ensure that the right resources are in place to fully support implementation of the equalities legislation.

Decision

The IJB agreed:

- (i) to note and approve the contents of the report, and to embrace and implement the principles of the Equality Act 2010 and its associated Regulations which include the Equality Act (Specific Duties) (Scotland) Regulations 2012, and the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015; and
- (ii) to note that following this report an Equality Outcomes and Equality Mainstreaming Report will be laid before them for approval at their meeting on 28 April 2016.

11. EAST LOTHIAN COMMUNITY HOSPITAL

A report was submitted by the Chief Officer of the IJB to update the IJB on progress with the business case for the Community Hospital and to ask the IJB to consider key issues.

Mr Small advised members that there would be a short 'fly through' video presentation given by Andrew Milne and Miriam Anderson from NHS Lothian and this would be followed by consideration of the report. He also proposed some minor amendments to the wording of the recommendations contained in the report.

Mr Milne presented the video and outlined the proposals and timeline for development of the new hospital. He also advised members that the planning application would be considered by the Council's Planning Committee on 1 March 2016.

Mr Milne, Ms Anderson and Mr Small answered questions on a number of issues including the decision to choose endoscopy rather than general anaesthetic theatre model, the forthcoming review of surgical services, attracting the right mix and numbers of staff, proposals to address the funding gap, mental health facilities and future-proofing overall bed numbers.

Councillor Currie acknowledged the challenges involved in terms of staffing and bed numbers but said that they should aim to build the best and most flexible facilities possible to allow the hospital to meet the future demands of a growing population.

Dr Fairclough commented on the excellence of the proposals but expressed concern that the hospital may struggle to attract enough clinical staff to get full value out of the facility.

Mr Maloney asked if the ambition of the IJB was to change the balance of care, why it was supporting the creation of additional hospital beds in East Lothian. He wondered if this was encouraging admission rather than moving care into the community.

Mr Small responded by saying that it would be possible to shift the balance of care geographically to bring people closer to home.

The Chair thanked members for their contributions and summed up the debate. He welcomed the proposals but added that, in his view, the new facility should include as many services as possible and it was right to seek further information on the question of surgical services.

Decision

The IJB agreed:

- (i) with the proposed bed numbers in the hospital;
- (ii) to await the outcome of the review of surgical services; and
- (iii) to support the ongoing work to close the revenue gap.

12. UPDATE ON ACTIONS DERIVING FROM THE INTEGRATION SCHEME

A report was submitted by the Chief Officer of the IJB to update the IJB on the actions that East Lothian Council and NHS Lothian must take to support the IJB as laid out in the Integration Scheme.

Mr King presented the report and summarised the main issues for members. He highlighted some of the work which had already been undertaken and indicated that discussions would take place to identify what further actions were required.

Mr Ash welcomed the report which he said was useful to have in governance terms and would help to identify the work that still needs to be done by both partners. He undertook to have further discussions with Ms McCabe and Mr King and to report back to a future meeting of the IJB.

Ms Meiklejohn also welcomed the report and the opportunity to explore any concerns which members may have regarding issues such as governance.

Councillor Currie commented that in future Service Level Agreements would be needed to ensure that directions were carried out. He said that while arrangements may be working at present, it would be wrong to continue to rely on good will to get things done.

Decision

The IJB agreed:

- (i) to note the contents of the report;
- (ii) to request a further, more detailed report to be taken to the Audit & Risk Committee to consider what has been done and what further actions are required; and

- (iii) to receive a further update report at an IJB meeting early in the new financial year.

13. POSITION STATEMENT ON CONTRACTED SERVICES – ADULT WELLBEING

A report was submitted by the Chief Officer of the IJB to inform the IJB of the current position with regard to Section 10 grant awards within Adult Wellbeing and the proposed way forward to ensure compliance with the recommendations of the recent internal audit report.

Mr Small presented the report providing an overview of the contract areas for adult wellbeing services currently managed and commissioned by East Lothian Council. He advised members that the Section 10 grant funding to voluntary sector organisations helped to support the delivery of these services.

Responding to questions from members, Mr Small confirmed that strategic direction of Section 10 grant funding would be a delegated function of the IJB from 1 April 2016 and, it would be for the IJB to satisfy itself that any future funding proposals were in line with the objectives of its Strategic Plan. He acknowledged members' concerns about the procedures for and timing of decision making and added that this would be subject to review over the coming year.

David Binnie welcomed any measures that might assist third sector voluntary organisations in providing continuity of service. He also suggested that less traditional forms of funding such as co-production and 'pathfinder' may allow a more holistic approach to delivery of the IJB strategic objectives.

Councillor Gillies welcomed the decision to fund the organisations listed in the report and he suggested that Parkinson's disease might be an area which would benefit from funding in the future.

Mr Ash reminded members that in future years the IJB could review the list of organisations and make changes where it considered appropriate. He added that changes to the timing of the process and the provision of more detailed reports would allow for better informed decision making in future.

Decision

The IJB agreed:

- (i) to approve continuation of current Section 10 Grants for the 12 months from April 2016 to March 2017 noting the commitment to review all grant funding within that year;
- (ii) to note that a detailed action plan has been developed and agreed with senior management in order to implement the suite of key recommendations from the recent internal audit process;
- (iii) to note that a series of reviews is now underway for funded organisations and will be modelled in line with the ELC partnership funding review process; and
- (iv) to note that future recommendations on Section 10 grant funding will also be considered by the IJB's Audit & Risk Committee.

SUMMARY OF PROCEEDINGS

The IJB agreed to note the private minutes of the meeting of the IJB Audit & Risk Committee held on 21 January 2016.

Signed

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Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

EAST LOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP INTEGRATION JOINT BOARD

The minutes of the meeting held on 31 March 2016 are attached.

Key issues discussed included:

- **Update on Financial Assurance** – Discussion took place regarding the current position of the financial assurance process for the 2016/17 budget setting process. It was agreed that the financial assurance work had been undertaken to date and the recommendations made by the Audit and Risk Committee at its meeting of 23 March 2016 were accepted.
- **Directions – Opening 2016/17 Proposals** – The position for the Directions from the Integration Joint Board for 2016/17 was updated. Noted that the Directions will flow from the IJB's agreed Strategic Plan and the Audit and Risk Committee will scrutinise the process and report their considerations back to the IJB. Financial Values to be revisited after the financial assurance process for 2016/17 is completed.
- **Non Voting Membership** – Agreed to the continuation of the existing non-voting membership and a process for replacement of non voting members.

Key issues on the horizon are: -

- **Non Voting Membership**



Councillor Donald Grant
Chair/Executive Lead

East Lothian
Integration Joint Board



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

**THURSDAY 31 MARCH 2016
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON**

Voting Members Present:

Councillor S Akhtar
Mr M Ash
Councillor S Currie
Councillor J Goodfellow
Councillor D Grant
Mr P Murray

Non-voting Members Present:

Ms M Allan
Dr A Flapan (Items 5 – 7)
Mr D King
Ms A MacDonald (Items 4 – 7)
Mrs M McKay
Mr K Maloney
Mr A Wilson

Officers Present:

Ms C Lumsden
Ms J McCabe
Ms J Ogden-Smith

Clerk:

Ms F Currie

Apologies:

Mr A Joyce
Ms A Meiklejohn
Ms F Duncan
Dr R Fairclough
Mr D Small
Mr E Stark
Dr J Turvill

Declarations of Interest:

None

1. MINUTES OF THE EAST LoTHIAN INTEGRATION JOINT BOARD MEETING OF 25 FEBRUARY 2016 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board meeting of 25 February 2016 were approved subject to a minor amendment to Item 6 requested by Keith Maloney.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING OF 25 FEBRUARY 2016

The following matters arising from the minutes of the meeting of 25 February 2016 were discussed:

Update on Actions Deriving from the Integration Scheme – Mike Ash advised that further discussions had taken place with David Small and work was in progress. An update would be provided to the IJB at its next meeting.

3. CHAIR'S REPORT

The Chair reported that David Small would provide an update at the April meeting on the new management structure for Health & Social Care, including the new Head of Service role.

The Chair advised members that he had attended a very successful Dementia learning event in Haddington that morning. It had been well attended and very instructive with a number of local groups being represented, including the Area Partnerships. He said that the event had demonstrated the commitment that exists within East Lothian to the care of people living with dementia.

Finally, the Chair reminded members that this would be Joanne McCabe's last meeting as she would be leaving the Council in April. On behalf of the members, he thanked Ms McCabe for her significant contribution to the IJB and wished her well for the future.

4. UPDATE ON FINANCIAL ASSURANCE

A report was submitted by the Chief Finance Officer of the IJB to update members on the current position of the financial assurance process for the 2016/17 budget setting process.

David King presented the report summarising the background themes. He also drew to the IJB's attention a matter that was not laid out in his report. He advised members that the Scottish Government have a very clear set of ambitions for the use of the Social Care Fund. The Government wants the fund to support underlying pressures in the Adult Wellbeing budget, addressing the issue of moving to the Living Wage, changes in charging thresholds and also to make resources available for 'additionality'. That being further development and investments to enhance social care services. The proposition from East Lothian Council was developed by the Council and the IJB's Chief Officer (in his role as Director of Social Care) and, as far as is practical, the Council's proposed use of the Fund is reasonable. The Scottish Government have however indicated that they may consider a further 'test' of the use of these funds and, if this happens, Mr King confirmed that he would report that back to the IJB.

He responded to questions from members relating to future pressures on budgets, implementation of the Living Wage, the ability of NHS Lothian to provide a three year

budget forecast, the impact of efficiencies on future budgets and the integration of future budget planning with service design and delivery.

Mr King then advised members that the Audit & Risk Committee had discussed the financial assurance arrangements at its meeting on 23 March 2016 and had made a series of recommendations to the IJB which were contained in the report. He took members through each of the recommendations, expanding on individual statements as required.

In general the members were in agreement with the recommendations; however they noted certain caveats relating to the impact of future Government policy decisions on the Social Care Fund, the provision of further details of efficiency schemes proposed by both the Council and NHS Lothian and arrangements for analysis of financial risk and the effect of any proposed mitigation measures.

Referring to the work of the IJB and the Audit & Risk Committee, Councillor Currie commented that these recommendations were very much a starting point from which to build robust financial assurance processes. He also acknowledged the significant contribution of officers in bringing together these proposals.

The Chair added his thanks to officers and to the members of the Audit & Risk Committee for considering these matters and providing detailed recommendations. He added that it would be important in future years to begin the financial assurance process at a much earlier stage.

Decision

The IJB agreed to:

- (i) note the financial assurance work that had been undertaken to date; and
- (ii) accept the recommendations made by the Audit & Risk Committee at its meeting of 23 March 2016.

5. DIRECTIONS – OPENING 2016/17 PROPOSALS

A report was submitted by the Chief Officer of the IJB to update the position for the issuing of Directions for the Integration Joint Board (IJB) for 2016/17.

Mr King presented the report and tabled copies of the completed Directions for members' information. He summarised the background including the IJB's agreed policy on Directions and the indicative nature of the financial allocation. In seeking members' agreement to delegate authority for issuing Directions on 1 April 2016 on a one-off basis, he confirmed a further update would be provided at the IJB's April meeting.

Mr King and Carol Lumsden responded to a number of questions from members and a short debate followed on a range of matters including the importance of integrating communication and public engagement strategies within the Directions, the high level nature of the Directions and how these related to the outcomes contained within the Strategic Plan.

Several members expressed concern about what they felt was a lack of a clear engagement strategy embedded within the Directions and sought assurances that a further update would be presented to the IJB outlining how this would be taken forward.

The Chair agreed that this was an important issue and that an update would be provided at the next meeting.

Decision

The IJB agreed:

- (i) note the current position on the development of the IJB’s Directions;
- (ii) note that the Directions will flow from the IJB’s agreed Strategic Plan;
- (iii) delegate the authority to issue Directions for 1 April 2016 to the IJB’s Chief Officer on a ‘one-off’ basis only. These Directions will be presented to the IJB at the first meeting in the new financial year and any further Directions will be approved by the IJB prior to issue;
- (iv) ask the Audit & Risk Committee to further scrutinise the process and the Directions and to report their considerations back to the IJB; and
- (v) note the indicative nature of the financial values included in the Directions. These financial values will be revisited after the financial assurance process for 2016/17 is completed.

6. NON VOTING MEMBERSHIP

A report was submitted by the Chief Officer of the IJB to seek members’ agreement to a process for renewing some non-voting members of the IJB.

Mr King presented the report referring to the arrangements for the appointment of non-voting members and summarising the proposals for the extension and reappointment of four positions by May 2016.

Members raised a number of points relating to the role and remit of the Third Sector representative and how these affected the selection process. The Chair agreed to consider these matters against the relevant legislation and to take them into account, where appropriate, during the reappointment process.

Decision

The IJB agreed to the process described in the report and to the continuation of the existing non-voting membership for the meeting on 28 April 2016.

SUMMARY OF PROCEEDINGS

The IJB agreed to note the private minutes of the meeting of the IJB Audit & Risk Committee held on 10 February 2016.

Signed

Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

EAST LoTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP INTEGRATION JOINT BOARD

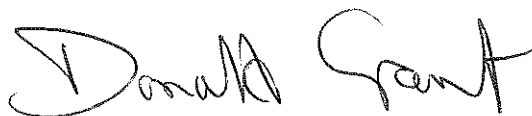
The minutes of the meeting held on 28 April 2016 are attached.

Key issues discussed included:

- **Actions to be delivered by the Partners arising from the Integration Scheme –** Agreed that the Chair would write to the partners and ask them to conclude the actions and report back to the IJB at its June meeting.
- **Financial Strategy – 2016/17 and beyond –** Discussion took place regarding the outline and approach to underpin the IJB's financial strategy for the next three financial years. Options were considered and the support of the management team was indicated. Some of the topics would be considered for potential briefing sessions at future IJB meetings.
- **2016/17 Directions – Update –** Confirmed that both partners had acknowledged receipt of their IJB directions and a further updated would be provided to the IJB on the development of a performance management methodology to monitor delivery of the directions.
- **Membership of the East Lothian Integration Joint Board –** Agreed that the Head of Adult and Children's Service to become a non-voting member
- **Equality Outcomes and Mainstreaming Reports 2016-2018 –** Agreed to approve the contents of the Equality Outcomes and Mainstreaming Reports 2016 – 2018.

Key issues on the horizon are: -

- **Actions to be delivered by the Partners arising from the Integration Scheme**
- **Financial Strategy – 2016/17 and beyond**
- **2016/17 Directions – Update**



Councillor Donald Grant
Chair/Executive Lead



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

**THURSDAY 28 APRIL 2016
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON**

Voting Members Present:

Councillor S Akhtar
Mr M Ash
Councillor S Currie
Councillor J Goodfellow
Councillor D Grant
Mr A Joyce
Ms A Meiklejohn
Mr P Murray

Non-voting Members Present:

Ms M Allan
Ms F Duncan
Mr D King
Ms A MacDonald
Mr K Maloney
Mr T Miller
Mr D Small
Mr E Stark
Dr J Turvill

ELC/NHS Officers Present:

Ms L Crozier
Ms C Lumsden
Ms J Ogden-Smith
Ms S Saunders

Clerk:

Ms F Currie

Apologies:

Mrs M McKay

Declarations of Interest:

None

Following permission from the Chair, Maureen Allan raised on behalf of the East Lothian Independent Sector (ELIS) the issue of uplift on care at home rates paid by the Council. She presented a letter which highlighted the concerns of ELIS members and requested a meeting with the IJB.

The Chair indicated that, before the issue could be debated further, clarity should be sought on whether this issue fell within the IJB's responsibilities. Members agreed that David Small should consider and report back on whether this constituted legitimate IJB business.

1. MINUTES OF THE EAST Lothian INTEGRATION JOINT BOARD MEETING OF 31 MARCH 2016 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board meeting of 31 March 2016 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING OF 31 MARCH 2016

The following matters arising from the minutes of the meeting of 31 March 2016 were discussed:

Audit & Risk Committee – The Chair sought the IJB's agreement to a change of membership on the Audit & Risk Committee. It was proposed that Peter Murray would replace Mike Ash as one of the two NHS representatives on the Committee. The IJB approved the change in membership.

3. CHAIR'S REPORT

The Chair advised members of his attendance at a recent Autism Strategy event. He said that it had been a well-attended and inspiring meeting which had included a number of personal accounts from stakeholders and he looked forward to receiving the formal feedback.

He also reported on his meeting with staff at St Columba's Hospice in Edinburgh who had indicated their willingness to get involved with the work of all four IJBs across Edinburgh and the Lothians.

4. ACTIONS TO BE DELIVERED BY THE PARTNERS ARISING FROM THE INTEGRATION SCHEME

A report was submitted by Chief Officer of the IJB to update members on the actions to be delivered by the IJB's partners (East Lothian Council and NHS Lothian) as laid out in the IJB's integration scheme and to note the current status of these actions.

David King presented the report referring to the detailed review of the Integration Scheme which had been undertaken and those sections that required further action from the partners.

The Members expressed concerns over the lack of progress in certain areas and the implications for the delivery of services and the ability of partners to achieve the required efficiency savings. Mike Ash proposed a change to the report recommendations: that the Chair should write to the Chief Executives of both partners

expressing the IJB's concerns about the lack of progress and asking for a report back on what steps they intend to take to address the gaps. He said that this would be an important step for the IJB in establishing itself in the culture of its partners.

Decision

The IJB agreed:

- (i) To note the content of the paper; and
- (ii) To direct the Chair to write to the partners and ask them to conclude the actions, as detailed, and to report back to the IJB at its June meeting.

5. FINANCIAL STRATEGY – 2016/17 AND BEYOND

A report was submitted by the Chief Finance Officer of the IJB to consider the broad outline and approach to underpin the IJB's financial strategy for the next three financial years.

Mr King presented the report. He summarised the key points and outlined the five broad areas of approach that the IJB was considering to reduce its cost base in line with the reduced resources available. He said that each would require clear actions and a detailed plan to show how the ambitions of the strategic plan could be achieved within the resources now available.

Members debated the issue at length and Mr King responded to a number of questions including how to highlight the key risks to deliverables, how to take a strategic, long-term approach rather than making decisions in isolation and how to review governance structures and embed these in the operational processes in a way that adds value.

Peter Murray said that in order to alter the way in which funding was invested across the sector it was important to encourage partners to get away from a 'silo mentality'. He suggested that a development session for IJB members as a first step.

Councillor Currie emphasised the importance of getting effective governance arrangements in place and in looking at budget-setting over three years rather than one.

Councillor Akhtar welcomed the suggestion of a development session and added that, while work remained to be done, it was important to acknowledge what had already been achieved.

Mr Ash agreed that acknowledging the work already done was very important but he also warned that there needed to be much more of a systems change and it was up to the IJB to decide how things should be done.

Keith Maloney said that the IJB should be engaging with stakeholders and asking them what things would make a difference to them. People should be supported to make an informed and confident contribution to decisions relating to their care.

Ailson Meiklejohn commented on the need to be creative and offer service users choices about their care.

Mr Small advised the members that he and the Chair would be considering some of these issues as topics for potential briefing sessions at IJB meetings over the coming months. He suggested that they begin at the May meeting with a session on tendering of specialist services.

Decision

The IJB agreed:

- (i) To note the contents of the report; and
- (ii) To consider the options and support the approach of the management team.

6. 2016/17 DIRECTIONS - UPDATE

A report was submitted by the Chief Officer of the IJB to update the IJB on the status of its directions to NHS Lothian and East Lothian Council for 2016/17 and to consider the actions to be taken.

Mr King presented the report drawing members' attention to the previous report submitted to the IJB at its meeting of 31 March 2016 which laid out the detail of the directions and delegated authority to the Chief Officer to issue them to the partners. He advised that the IJB required to formally approve these directions and to consider what further actions or amendments might be needed to ensure effective delivery and oversight of services.

Responding to questions from members, Mr Small confirmed that both partners had acknowledged receipt of their IJB directions. Mr King added that a further update would be provided to the IJB on the development of a performance management methodology to monitor delivery of the directions.

Decision

The IJB agreed:

- (i) To formally approve the IJB's initial set of directions for 2016/17; and
- (ii) To note the further actions in development.

Sederunt: Sharon Saunders left the Chamber.

7. MEMBERSHIP OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

A report was submitted by the Chief Officer of the IJB to ask the IJB to agree that the Head of Adult and Children's Services should become a non-voting member of the IJB.

Mr Small presented the report outlining the background and procedural reasons for seeking to include the Head of Adult and Children's Services as a non-voting member of the IJB. He also confirmed that in order to ensure clarity of role professional advisor members of the IJB should be clear when they are speaking in a professional advisory capacity and when in an operational capacity.

Decision

The IJB agreed:

- (i) To the Head of Adult and Children's Service becoming a non-voting member; and
- (ii) To note the need for clarity of role when officers are advising the IJB.

Sederunt: Sharon Saunders returned to the Chamber and joined the meeting.

8. EQUALITY OUTCOMES & MAINSTREAMING REPORTS 2016-2018

A report was submitted by the Chief Officer of the IJB to seek approval for the East Lothian Health & Social Care Partnership's (ELHSCP) Equality Outcomes and Mainstreaming reports 2016 - 2018.

Lesley Crozier presented the report drawing members' attention to the content and purpose of the Equalities Outcomes and Mainstreaming reports and referring to the consequences of any failure to comply with the legislation, including fines and reputational damage. She confirmed that the reports met the legal requirements of the equalities legislation and supported a positive way forward for the East Lothian Health & Social Care Partnership (ELHSCP).

In response to questions from members, Ms Crozier advised that interim reports would be presented to the IJB in advance of the final report in 2018. She commented on the next steps for the drawing up of actions plans and monitoring of outcomes and confirmed that it would be for the IJB to determine what additional actions it wished to identify and include in directions. She also referred to work on information-sharing with a view to identifying the current position in relation to work place conditions to transgender and other groups.

Members also raised the issue of gender equality with the membership of the IJB. Mr Small acknowledged the point and Mr Ash advised that, while balance was not always possible, the IJB had a responsibility to draw this to the attention of the partners.

Decision

The IJB agreed to approve the contents of the Equality Outcomes and Mainstreaming Reports 2016 – 2018.

Signed

Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

The minutes of the meeting held on 11 March 2016 are attached for information.

Key issues discussed included:

- Formal sign off of the Edinburgh Strategic Commissioning plan
- Interface between EIJB and Acute Service
- EIJB support for whole system approach which was being used to develop the Locality Hub model
- Hospital plans presentation and action to fully explore as part of a development session
- Full business case for a complex care homelessness service and the need to find a city centre location for the service
- Community planning arrangements
- All sub group/committees were now established agreed remit, role and membership

George Walker/ Rob McCulloch-Graham

Chair/Executive Lead

Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 11 March 2016

Waverley Gate, Edinburgh

Present:

Board Members: George Walker (Chair), Councillor Elaine Aitken, Shulah Allan, Carl Bickler, Kay Blair, Andrew Coull, Christine Farquhar, Councillor Ricky Henderson, Kirsten Hey, Alex Joyce, Angus McCann, Rob McCulloch-Graham, Michelle Miller, Moira Pringle, Gordon Scott, Ella Simpson, Richard Williams and Councillor Norman Work.

Officers: Kris Aitken, Lynne Barclay, Colin Briggs, Nikki Conway, Wendy Dale, Margaret Gray, Marna Green, Linda Irvine, Margaret-Ann Love, Ian McKay, Gavin King and David Whyte.

1. Deputation – Edinburgh Health Forum

The Joint Board agreed to hear a deputation from Heather Goodare and Helen Ogg on behalf of the Edinburgh Health Forum. The deputation highlighted public health issues in relation to obesity and depression and requested that the Joint Board undertook early intervention within its remit as this would be cost-effective in the longer term.

Decision

To ask the Chief Officer to meet with the deputation to discuss future options.

2. Minutes

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board of 15 January 2016.

3. Appointment of Standards Officer

The Joint Board was required by the Ethical Standards in Public Life (Scotland) Act 2000 (Register of Interests) Regulations 2003 to appoint a Standards Officer with responsibility for advising and guiding members of the Board on issues of conduct and propriety. The Standards Officer would also act as the

Liaison Officer between the Joint Board and the Standards Commission. The Standards Commission would also be required to endorse any appointment and guidance was awaited on the mechanism to do so.

Decision

To appoint Gavin King, Committee Services Manager, the City of Edinburgh Council as the Standards Officer for the Edinburgh Integration Joint Board.

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

4. Financial Regulations

The Joint Board was required by Section 95 of the Local Government (Scotland) Act 1973 to have adequate systems and controls in place to ensure the 'proper administration of their financial affairs', including the appointment of an officer with full responsibility for their governance. Financial regulations that detailed the responsibilities of the Chief Financial Officer, who had been appointed 'Proper Officer', along with the responsibilities of the Chief Officer and Joint Board members were submitted.

Decision

- 1) To adopt the financial regulations as laid out in appendix one to the report by the Chief Officer.
- 2) To delegate the responsibility for preparing the directives and instruction (to support the regulations) to the Interim Chief Finance Officer.

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

5. Financial Assurance

Details on the indicative budget propositions received from both the Council and NHS Lothian and the implications for the Joint Board 2016/17 budget were provided. Based on available information, the draft budget was expected to be £574.4m, with a savings target of £32.4m.

Decision

- 1) To note the report.
- 2) To agree to proceed based on the draft budget outlined in the report.
- 3) To receive the full due diligence report following receipt of final budget settlements from the Council and NHS Lothian.

- 4) To note that the report would be used to inform a detailed financial plan, aligned to the strategic plan, to the next formal meeting of the Joint Board.

(References – minute of the Integration Joint Board 25 September 2015 (item 11); report by the IJB Chief Officer, submitted.)

6. Partnership Tripartite Agreement and Interface Group

A proposed approach for the parties who comprised the Edinburgh Health and Social Care Partnership (Edinburgh Integration Joint Board, NHS Lothian, City of Edinburgh Council) to work together to deliver operationally on the statutory requirements of integration was outlined. This included key principles for joint working and proposals for the formation of an Interface Group for the three parties to come together informally to discuss relevant financial, operational and risk matters.

Decision

- 1) To agree the proposed Tripartite Agreement as a statement of principle and intention for joint working.
- 2) To agree to the purpose, remit and membership of the Interface Group
- 3) To agree that the Interface Group would be reviewed after one year.
- 4) To note that formal Council approval would be sought by report to the Corporate, Policy and Strategy Committee.
- 5) To include an Interface Group update under Joint Board standing reporting items.

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

7. Rolling Actions Log

The Rolling Actions Log for 11 March 2016 was presented.

Decision

- 1) To note the Rolling Actions Log and to approve the closure of items 8(1) and (2), 11, 12 and 16.
- 2) To circulate a programme of visits, including key dates, to the next formal meeting of the Joint Board.
- 3) To note that the Chair, Vice-Chair and Chief Officer would regularly review progress with outstanding actions.

(Reference – Rolling Actions Log – 11 March 2016, submitted.)

8. Strategic Plan – Final Draft

The final draft of the Strategic Plan for Health and Social Care, as required by the Public Bodies (Joint Working)(Scotland) Act 2014 to set out delegated powers from the Council and NHS Lothian, was submitted. Approval was sought for the publishing of the plan and to allow services to be delegated from 1 April 2016.

Decision

- 1) To approve the final draft of the strategic plan, attached as Appendix A to the report by the Chief Officer, for publication as the Strategic Plan for Health and Social Care in Edinburgh 2016-19.
- 2) To note that further information would be provided on special needs housing.
- 3) To thank officers who had worked on drafting the strategic plan and also the engagement of consultees and stakeholders.

(References – minute of the Edinburgh Integration Joint Board 15 January 2016 (item 6); report by the IJB Chief Officer, submitted.)

Declaration of Interests

Kay Blair declared a non-financial interest in relation to housing provision elements of the above item as Chair of the Scottish Housing Regulator.

9. Workforce Strategy - Update

An update was provided on the development of a workforce strategy. Work was ongoing to ensure that organisational structures to deliver integration and change were managed well and that relevant opportunities and engagement with staff and leadership was in place. There was also a focus on ensuring that systems and processes were as integrated as possible and that strong partnerships were in place, in particular with the trade unions.

Decision

- 1) To note the areas of workforce activity to ensure that health and social care integration was delivered in Edinburgh and the next steps in the development of a comprehensive Workforce Strategy aligned to the Joint Board Strategic Plan.

- 2) To give further consideration to information on workforce matters that would provide re-assurance around the workforce agenda going forward.
- 3) That regular updates on specific workforce changes (e.g. capacity, recruitment retention and care roles) be submitted to the Joint Board.

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

10. Hub Test of Change

An update was provided on the approach and actions with regard to the implementation of the Locality Hub model for older people, agreed on a whole system basis as part of Lothian's Winter Plan 2015-16. The model was designed to progress improvements on the whole system pathway and hospital discharges.

Decision

- 1) To note and support the whole system approach that the Edinburgh Partnership was taking to improve the whole system pathway and discharge from hospital.
- 2) To request a further update on the roll out of the locality hub model.

(References – minute of the Integration Joint Board 15 January 2016 (item 2); report by the IJB Chief Officer, submitted.)

11. Delayed Discharge Update

The latest Delayed Discharge Information Services Division (ISD) Census figures and the actions in place to support an increased number of discharges from hospital were outlined. Additional funding, made available from the Scottish Government to enable specific actions associated with increasing the number of discharges supported, was also detailed.

Decision

- 1) To note the position and the actions associated with improving this performance.
- 2) To note the ongoing discussions with the court service with regard to guardianship issues.

(References – minute of the Edinburgh Integration Joint Board 15 January 2016 (item 11); report by the IJB Chief Officer, submitted.)

12. GameChanger Project Update

Decision

To note that the report would be considered at a future meeting of the Joint Board.

13. Hospitals Plan - presentation

Colin Briggs (Site Director, Western General Hospital) provided a presentation on the development of the NHS Lothian Hospitals Plan. The following was highlighted:

- It was important to have a Lothian Hospitals Plan; to set out how specialist hospital services would respond to a range of changes, challenges and improvement agendas; to abide with legislation; as good practice and to fit with changes to the Scottish Capital Investment Manual.
- Principles that had informed the Plan were agreed by the Strategic Planning Group on 10 December 2016.
- The scope of the Hospitals Plan included NHS Lothian hospital services (including specialist and tertiary acute) and functions delegated to Joint Boards.
- Outcomes would include; proposed plans for individual sites (including capital, revenue and workforce), acute and specialist services; clarity with regard to how the balance of care would be shifted; and a clear response to Joint Board Strategic Plans.
- It was hoped that formal consultation on the draft Plan would take place from January to March 2017.
- The move to implementation of projects identified in the plan had begun and this would continue to be progressed.
- Although the plan impacted chiefly upon retained NHS services, there was interdependency between the functions of the NHS Lothian and those of the Joint Board.

Decision

- 1) To note the presentation.
- 2) To include an item on hospital plans in the schedule of Joint Board development sessions.
- 3) To include links to reports on [realistic medicine](#) and [national clinical strategy](#) in the published minutes.

14. Inclusive Edinburgh: Complex Care Homelessness Service Review Update

The 'Inclusive Edinburgh' review had been set up to tackle some of the problems faced by people with complex needs; who struggled with homelessness, unemployment, drug and alcohol problems, mental or physical ill-health, who were sometimes involved in crime, and who were often the

victims of violence. The combined services delivered by the Council, statutory partners and voluntary organisations to this group of vulnerable people were examined. The recommendations coming out of the review were detailed.

Decision

- 1) To note the progress made to develop an innovative, evidence-based 'Getting it Right for Everyone' approach to delivering services for homeless people with complex needs.
- 2) To approve in principle the proposal to:
 - 2.1) Appoint a single manager to integrate and coordinate service delivery.
 - 2.2) Establish a single location for the delivery of an inclusive homelessness service.
- 3) To note that a full business case for the funding, location, management and integration of a Complex Care Homelessness service would be brought back for approval once proposals for a City Centre location were agreed by NHS Lothian's Finance and Revenue Group in May 2016, and then the Council's Property Board.
- 4) That the Professional Advisory Group be consulted on the proposals.

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

15. Health and Social Care Population and Premises - Presentation

David Whyte (Locality Manager, South West) provided an update on population and premises across the Edinburgh Health and Social Care Partnership. The following was highlighted:

- Edinburgh's population was expected to increase by 5000 per year until 2030. This equated to equivalent demand for one new medium-sized General Practitioner (GP) Surgery each year.
- Previous population increases between 1999 and 2013 had been mostly absorbed into existing primary health infrastructure.
- In 2013 the problem was analysed and a number of proposed solutions to increase capacity were implemented.
- Citywide mapping had taken place to establish GP surgeries that were experiencing pressures and where new capacity was expected be required in future years.
- Measures designed to meet capacity needs were ongoing, however, more would be needed in order to meet increasing requirements. An estimated £30-40m would be needed to meet increasing demand over the following five years.

- The consequences of not meeting capacity demands would include, approximately 70% of new citizens being unable to register with a GP Surgery, practice instability/safety concerns, patients travelling considerable distances and a loss of public confidence.

During discussion the following points were raised:

- House developers made a contribution towards local services through section 75 of the Planning etc (Scotland) Act. This was, however, minimal and still left a significant funding gap.
- The integration of health and social care services would provide new flexible opportunities to help solve problems.
- It would be necessary to engage with NHS Lothian and the Council regarding their existing, and the development of, estates to ensure that opportunities were not missed.

Decision

- 1) To note the presentation.
- 2) To note that the Chief Officer would report to a future Joint Board meeting on the scope for utilising the existing NHS Lothian/Council estate.

16. Sub-group updates – verbal updates

15.1 Audit and Risk Committee

Angus McCann advised that work was underway to appoint a Chief Internal Auditor and that a to-do list, including the writing of key documents, had been formulated. Committee membership had been confirmed and training sessions were underway. Meeting dates would be circulated to Committee members early the following week.

15.2 Professional Advisory Group

Carl Bickler advised that an initial meeting had taken place, however, a number of business support and confidentiality requirement issues were still required to be resolved. This would be discussed with the Chief Officer.

15.3 Performance Sub Group

Shulah Allan advised that a remit, membership and date for the first meeting (21 April 2016) had been confirmed. The remit had been drawn from two half day working groups and the membership was wide ranging.

15.4 Strategic Planning Group

Councillor Henderson provided an update on the work of the Strategic Planning Group. Following the submission of the Strategic Plan, a refreshed remit for the group would be considered in May 2016.

Decision

- 1) To note the updates
- 2) That Committee and Sub-Group minutes be circulated to the Joint Board as available.

EDINBURGH INTEGRATION JOINT BOARD

The draft minutes of the meeting held on 13 May 2016 are attached.

Key issues discussed included:

- The requirement to ensure that communications are planned and the need to listen and learn from those we are communicating with;
- Good progress is being made with the 'huddle' test of change, with a key requirement of ensuring family and other carers are involved in the discussions;
- Current position with regard to delayed discharge, and the changes to recording which will give a much better daily picture;
- Assurance around savings plans and ensuring that these are aligned to programmes of work;

Key issues on the horizon are:

- Ensuring clarity around what is include in the 'huddle' with a full project plan for roll out ;
- Lothian wide programme for anticipatory care planning;
- Guardianship and the need to engage with Sheriff Court;

George Walker/Rob McCulloch-Graham

Chair/Executive Lead

Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 13 May 2016

Waverley Gate, Edinburgh

Present:

Board Members: George Walker (Chair), Councillor Elaine Aitken, Shulah Allan, Carl Bickler, Kay Blair, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Councillor Joan Griffiths, Councillor Ricky Henderson, Kirsten Hey, Angus McCann, Rob McCulloch-Graham, Michelle Miller, Moira Pringle, Gordon Scott, Richard Williams, Maria Wilson and Councillor Norman Work.

Officers: Lynne Barclay, Nikki Conway, Eleanor Cunningham, Wendy Dale, Ann Duff, Gohar Khan, Ian McKay, Katie McWilliam and Gavin King.

Apologies: Alex Joyce and Ella Simpson.

1. Minutes

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board of 11 March 2016 subject to the inclusion of notified apologies.

2. Rolling Actions Log

The Rolling Actions Log for 13 May 2016 was presented.

Decision

- 1) To approve the closure of actions 1, 4, 5.1, 5.2, 7.1, 7.2, 8, 10.1, 10.3, 10.4, 11 and 12.
- 2) To otherwise note the Rolling Actions Log.

(Reference – Rolling Actions Log – 13 May 2016, submitted.)

3. Code of Conduct and Standing Orders – May 2016

The Scottish Government had advised Joint Board (IJBs) Chairs that a template code of conduct for members had been prepared and requested that a draft version be approved by the Joint Board and submitted to the Scottish Government by 21 June 2016. The draft Code of Conduct for Edinburgh was submitted.

Many of the Joint Board's Standing Orders applied to Committees as well as the Joint Board, but did not apply to working groups. Approval was sought to amend the Standing Orders so that they no longer applied to Committees.

Decision

- 1) To agree to submit the draft Code of Conduct, as detailed at appendix one to the report by the Chief Officer, to the Scottish Government for approval.
- 2) To delete Standing Order 14.5. (application of the standing orders to Committees)

(References – minute of the Edinburgh Integration Joint Board 15 January 2016 (item 4); report by the IJB Chief Officer, submitted.)

4. Communications and Engagement Strategy 2016 to 2019

A high level plan setting out principles and protocols for the Joint Board's communication and stakeholder engagement activity was submitted. The following comments were raised during discussion:

- It would be important to implement a 'two-way' communications plan that listened and engaged in order to take on board views and ideas.
- The existing stakeholder network should be used as a delivery tool for the Joint Board's communication strategy.
- The use of multiple delivery methods and vehicles, including available technologies, would be vital in delivering the strategy.
- Effective resourcing would be key to ensuring that there was capacity to deliver the plan.
- The plan should address terminology issues surrounding unpaid carers and members of the public.
- Proactive engagement with the media would be desirable.

Decision

- 1) To support a proactive communication approach for the Joint Board and Edinburgh Health and Social Care Partnership's wide range of partners and stakeholders.
- 2) To agree the draft Communication and Engagement Plan for 2016 to 2019.
- 3) To present an implementation plan to the Joint Board once resources had been identified.

(References – minute of the Edinburgh Integration Joint Board 15 January 2016 (item 8); report by the IJB Chief Officer, submitted.)

5. Programme of Visits 2015/16

As previously requested by the Joint Board, a programme of visits to acute and non-acute facilities was submitted.

Decision

- 1) To note the Joint Board's Visit Programme for 2016.
- 2) To ask the Chief Officer to report to the Joint Board on how best to capture comments raised during visits.
- 3) To send a letter of thanks to operational managers who had facilitated Joint Board visits.
- 4) To share any presentation from Joint Board visits with Board Members.
- 5) To note that General Practice visits had been scheduled and would be circulated to the Joint Board.

(References – minutes of the Edinburgh Integration Joint Board 17 July 2015 (item 3) and 25 September 2015 (item 4); report by the IJB Chief Officer, submitted.)

6. Huddle Test of Change

Details were provided of the approach and actions around the implementation of the Huddle model, designed to progress improvements on the whole system pathway and discharge from hospital.

Decision

- 1) To accept the report by the Chief Officer as assurance that the Edinburgh Integration Joint Board was taking a whole system approach to improve the whole system pathway, including discharge from hospital.
- 2) That a project map for the roll out of the localities model, including the hub initiative and a description of the key services be submitted to the Joint Board.

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

7. Delayed Discharge – Recent Trends

An overview of performance in managing hospital discharge, showing the total number of Edinburgh people who were delayed at each monthly census points over the past two years, alongside the target level for 2015-16, was outlined.

The Scottish Government had set a target of 50 delays or less by May 2016 upon which release of additional funding was dependent. Additional workstreams implemented towards this target, following a flow workshop undertaken on 8 March 2016, were detailed.

Decision

- 1) To note the progress in reducing the number of people waiting to be discharged and that a comprehensive range of actions was in place to secure further improvement.
- 2) To request that future reports present a broad spread of data including delays attributed to:
 - 2.1) Guardianship or capacity issues.
 - 2.2) Acute settings.
 - 2.3) X Codes.

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

8. Initial Set of Directions

The Public Bodies (Joint Working) (Scotland) Act placed an obligation on Integration Joint Boards to give a direction to the Council and NHS Board in respect of each function delegated to the Joint Board. The initial set of directions issued to the Chief Executives of NHS Lothian and the Council on 31 March 2016, actions that had taken place following this and proposed next steps were detailed.

Decision

- 1) To note the initial set of directions issued on 31 March 2016 attached at appendix 1 to the report by the Chief Officer.
- 2) To note the work underway to move to a more detailed set of directions.

(References – minute of the Edinburgh Integration Joint Board 15 January 2016 (item 12); report by the IJB Chief Officer, submitted.)

9. Mainstreaming Equalities

In order to meet the obligations placed on public bodies by the Equality Act 2010 and associated regulations, the Joint Board was required to publish a set of equality outcomes. The Joint Board's approval was sought to publish details of how the Public Equality Duty would be mainstreamed into its day-to-day functions.

Decision

- 1) To approve the proposed Equality Outcomes detailed in section 4.2 of the report by the Chief Officer.
- 2) To approve the equalities mainstreaming report attached as appendix 1 to the report by the Chief Officer.
- 3) To agree that progress in delivering the Equalities Outcomes was overseen by the Strategic Planning Group.

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

10. Financial Plan

A financial update, including proposed investments for the Social Care Fund and details of the Joint Board's expected savings programme for 2016/17 was submitted. Details were provided of updated indicative allocated resources from the Council and NHS Lothian; this represented a marginal (0.4% or £2.5m) increase over the levels reported to the Joint Board in March.

Decision

- 1) To note the update to the indicative resources to be allocated to the Joint Board by the City of Edinburgh Council and NHS Lothian, subject to:
 - 1.1) The Chief Officer raising with NHS Lothian its intended response to government directions about making good on the reduction in ring fenced funding for the Edinburgh Drugs and Alcohol Project, including an assessment of the rationale for the national funding cut.
 - 1.2) Further details on the implications of the savings programme for Strategic Partnership outcomes.
- 2) To agree the allocation of the Social Care Fund resources, taking account of Scottish Government requirements.
- 3) To agree the issue of updated directions to the City of Edinburgh Council to reflect the proposed Social Care Fund investments.

(References – minute of the Edinburgh Integration Joint Board 11 March 2016 (item 5); report by the IJB Chief Officer, submitted.)

11. Formal Establishment of the Strategic Planning Group

Approval was sought to formally establish a Strategic Planning Group, as required under the Public Bodies (Joint Working) (Scotland) Act 2014 for the engagement of stakeholders with regard to the production of a strategic plan

and any decisions about significant changes to services to be made without revising this.

Decision

- 1) To approve the proposed remit for the Strategic Planning Group set out in section 4.5 of the report by the Chief Officer.
- 2) To approve the proposed membership of the Strategic Planning Group set out in section 4.6 of the report by the Chief Officer.
- 3) To approve the proposed frequency of meetings set out in section 4.7 of the report by the Chief Officer.
- 4) To approve the proposed arrangements for the payment of expenses set out in section 4.8 of the report by the Chief Officer.

(Reference – report by the IJB Chief Officer.)

12. Sub-group updates

15.1 Audit and Risk Committee

Angus McCann advised the first meeting of the Audit and Risk Committee had taken place and a minute had been circulated. This had considered the remit and work programme of the group, including a list of documents that would require to be produced. The next meeting would consider the Risk Register and a workshop would be scheduled to allow the full Joint Board to feed into this process.

15.2 Professional Advisory Group

Carl Bickler advised that the first formal meeting of the group would take place on 17 May 2016 and a further schedule of meetings would be arranged in due course.

15.3 Performance Sub Group

Outcomes from the first meeting and an update report on the Performance Sub-Group were tabled. Shulah Allan advised that the first session had been productive and had focussed on an assessment of the suitability of the rubric approach as a scoring guide.

15.4 Strategic Planning Group

Councillor Henderson noted that the Strategic Planning Group had been formally established by the report on the agenda. Meeting frequency would be considered with a view to potentially moving to a bi-monthly cycle.

Decision

To note the updates.

13. Resolution to consider in private

The Joint Board resolved, in terms of paragraph 5.9 of the Standing Orders for the proceedings and business of the Integration Joint Board, that the public be excluded from the meeting during consideration of the following item of business on the grounds that it involved the disclosure of private information as defined in paragraph 5.9.2 of the Standing Orders: the business related to the commercial interests of any person and confidentiality was required.

14. Commissioned Services and the Living Wage

The costs arising for the Integration Joint Board in 2016/17, as a result of the need to uplift the contract rates paid in respect of a range of social care services commissioned from independent and third sector providers to facilitate payment by them of the Living Wage to social care workers, were detailed.

Decision

- 1) To approve the uplifts in contract rates paid to independent and third sector providers to facilitate payment of the Living Wage as detailed in the report by the Chief Officer and the allocation of £5,171,000 from the Social Care Fund to meet the associated costs for the period 1 October 2016 to 31 March 2017.
- 2) To agree the basis for consulting and engaging with contracted independent and third sector providers about delivery of the Living Wage in Edinburgh assumed:
 - 2.1) Payment of increases in contract rates to individual provider organisations was conditional upon them voluntarily agreeing to pay their staff the Living Wage Foundation rate of £8.25p per hour for the period 1 October 2016 to 31 March 2017.
 - 2.2) The limit of the Board's responsibility was to facilitate payment of the Living Wage to adult social care workers engaged in the delivery of personal care and support services and that employers would also contribute to the costs of delivering the Living Wage by meeting additional costs arising for them, in terms of increased National Insurance and other employer contributions or those associated with maintaining pay differentials.
 - 2.3) To note that as yet no commitment had been made to continue to allocate the Social Care Fund beyond 31 March 2017 or uplift this to reflect any increase in the Living Wage Foundation rate for 2017/18 and beyond.
- 3) To request further updates to the Joint Board as appropriate.

(Reference – report by the IJB Chief Officer.)

Declaration of Interests

Christine Farquhar declared a non-financial interest in the foregoing item as a Director and Chair of Upward Mobility and as a welfare and finance guardian of a recipient of a direct payment from City of Edinburgh Council.

MIDLOTHIAN IJB

The draft minutes of the meeting held on 11 February 2016 are attached.

Key issues discussed included:

- Health Visiting Services in Midlothian
- Risk Management
- Finance Assurance
- Audit and Risk Committee Membership
- Corporate Governance

Key issues on the horizon are:

- Finalisation of IJB budget
- Pressures in General Practice and Prescribing

Chair - Catherine Johnstone

Chief Officer - Eibhlin McHugh

Minute of Meeting



Midlothian Integration Joint Board

Date	Time	Venue
Thursday 11 th February 2016	2pm	Council Chambers, Midlothian House, Buccleuch Street, Dalkeith EH22 1DN.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Peter Johnston (Vice Chair)
Cllr Bob Constable	Alex Joyce
Cllr Derek Milligan	Alison McCallum
Cllr Bryan Pottinger	John Oates

Present (non voting members):

Eibhlin McHugh (Chief Officer)	Alison White (Chief Social Work Officer)
Dave Caesar (Medical Practitioner)	Patsy Eccles (Staff side representative)
David King (Chief Finance Officer)	Jean Foster (User/Carer)
Margaret Kane (User/Carer)	Ruth McCabe (Third Sector)

In attendance:

Kenneth Lawrie (Chief Executive, Midlothian Council)	Chris Lawson (Risk Manager)
Mike Broadway (Clerk)	

Apologies:

Caroline Myles (Chief Nurse)	Hamish Reid (GP/Clinical Director)

Midlothian Integration Joint Board

Thursday 11 February 2016

1. Welcome and introductions

1.1 The Chair, Catherine Johnstone, welcomed everyone to the meeting of the Midlothian Integration Joint Board.

1.2 The order of business was as set out in the agenda papers.

2. Declarations of interests

2.1 No declarations of interest were intimated.

3. Minutes of Previous Meeting

3.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 10th December 2015 were submitted and approved.

4. Reports

Report No.	Report Title	Presented by:
4.1	Chief Officer Report	Eibhlin McHugh

Executive Summary of Report

The purpose of the report was to (i) describe the progress being made on integration; (ii) describe some of the significant pressures being faced by health and care in recent months; and (iii) highlights some recent or forthcoming key service developments.

Summary of discussion

The Board, in considering the Chief Officer's Report, discussed the work being undertaken in regards to the co-locating of services and maximising the use of buildings. The planned establishment of a 'Recovery Hub' for people who needed to access substance misuse services was welcomed as it would provide a single point of contact for people to access local recovery services. The Board also welcomed work being undertaken towards scoping and planning for future care needs, such as the need for a replacement facility for Highbank Care Home. In terms of service pressures and developments, the Board acknowledged the challenges that had arisen as a result of the poor gradings received from the Care Inspectorate following an unannounced inspection at Newbyres Care Home. The success of the pilot of peer support for substance misuse in a local GP practice and of the 'House of Care' were welcomed, with the Board keen to learn more about both.

Decision

After further discussion, the Board:

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

Midlothian Integration Joint Board

Thursday 11 February 2016

Report No.	Report Title	Presented by:
4.2	Health Visiting Services in Midlothian	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to highlight the key pressures within the Health Visiting Service in Midlothian as a result of significant vacancies, recognising that this was a national problem, which would require a range of actions to address. The report outlined the actions that had already been implemented within Midlothian in order to mitigate the impact and also set out wider work that was being taken forward by NHS Lothian to support children and families in Midlothian.

Summary of discussion

The Board, having heard from the Chief Officer, who responded to questions for Members of the IJB, discussed the current situation and the actions being taken to address matters and mitigate the impact within Midlothian.

Decision

The Board:

- **Noted the specific health visiting pressures within Midlothian and the associated key risks along with the local actions currently underway to mitigate the pressures and to ensure children and families remained safe.**
- **Noted the overarching approach within NHS Lothian to support health visiting services within Midlothian and across Lothian more generally.**
- **Agreed to receive an update reports on Health Visiting services at future Integrated Joint Board meetings.**

Report No.	Report Title	Presented by:
4.3	Pulling Together : Transforming Urgent Care for the People of Scotland	Eibhlin McHugh

Executive Summary of Report

The report sets out the key findings from the national review of Primary Care Out of Hours Services in Scotland and identified the key aspects of the review as they relate to various stakeholders including NHS, Councils and Scottish Government. The report provided details of the plan to bring together key partners within NHS Lothian to review the findings and to develop a plan going forward. To support the engagement of the IJB in this process, the report proposed inviting the Clinical Director of LUCS to a future meeting of the IJB.

Midlothian Integration Joint Board

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Summary of discussion

Having heard from the Chief Officer, the Board welcomed the proposal to invite the Clinical Director of LUCS to a future meeting; discussed the need to balance local needs against any Lothian wide developments; and the need to ensure the involvement of the voluntary sector, carers and the community, in developing the plan to take things forward.

Decision

The Board:

- **Noted the publication of the national review of Primary Care Out of Hours Service.**
- **Agreed that the proposals contained extend beyond Lothian Unscheduled Care Service (LUCS) and Primary Care.**
- **Noted the establishment of a group led by the Director of Health and Social Care, East Lothian to agree the response to the Scottish Government and the implementation of the findings, which would include representation from Midlothian.**
- **Agreed to invite the Clinical Director of LUCS to a future meeting of the Integrated Joint Board to support further engagement and discussion on the review, as well as considering future options within Midlothian.**

Report No.	Report Title	Presented by:
4.4	Performance Information	Alison White

Executive Summary of Report

The report provided information on the performance of the Partnership in three key areas of activity-Delayed Discharges; Hospital Admissions; and Care Homes for Older People. The report explained that measuring how many people were delayed in hospital and for how long was considered to be a key indicator of how well social care and health care worked together and of the efficiency of the whole system. The cumulative effect of delays in Lothian hospitals had been estimated to be in the region of 15% of the total beds available. A delay in hospital was not considered good for patients, whose functioning could begin to deteriorate after 3 days delay. Nor was the cumulative effect of delays good for the wider population as this effectively blocked admission pathways for patients who had a more critical need for hospital care.

Summary of discussion

Having heard from the Chief Social Work Officer, the Board in discussing some of the challenges facing the IJB in establishing a performance framework, commented on:-

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- the importance of the performance data being fit for purpose;
- quality not quantity in terms of the indicators;
- in developing the performance framework seeking input from carers/users, the third sector and others;
- the possibility of broadening out the weather vane indicators to include non hospital related functions; and
- the potential for benchmarking.

Decision

The Board:

- **Note the current performance in these areas of activity**
- **Agreed that the way in which the information had been laid out was helpful in enabling IJB members to carry out their governance role.**
- **Agreed that further work was required to develop the performance and benchmarking data.**

Report No.	Report Title	Presented by:
4.5	Risk Management Policy	Chris Lawson

Executive Summary of Report

The report brought forward a draft Risk Management Policy for the IJB to consider and a proposed set of risks to form the basis of the IJB's risk register.

Summary of discussion

The Board, having heard from the Risk Manager, discussed the draft Risk Management Policy and the work which had gone into its preparation. It was noted that robust Risk Management arrangements would be critical to the capacity of the IJB to function effectively.

Decision

After further discussion, the Board agreed to:

- **Approve the Risk Management Policy**
- **Approve the key risks as part of the IJB's Risk Register**
- **Remit to the Risk and Audit Committee preparation of the risk register, incorporating the key risks highlighted within this report, for consideration by the Board at a future meeting.**
- **To receive further reports on Risks facing the IJB to support informed and effective decision making.**

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Report No.	Report Title	Presented by:
4.6	Finance Assurance Update	David King

Executive Summary of Report

To update the IJB on the financial assurance process including the outline offer from NHS Lothian and an update on the offer from the Scottish Government to Midlothian Council as this offer related to the IJB

Summary of discussion

The Board, having heard from the Chief Finance Officer, who gave an update on the current position, welcomed the work being undertaken in relation to the financial assurance process.

Decision

The Board agreed to:

- **Note the report;**
- **Reply to the offer to the IJB from the NHS Lothian Director of Finance; and**
- **Delegate authority to sign off the use of the IJB's share of the £250m integration fund to the Chief Officer and the Chief Finance Officer in consultation with the Chair and Vice Chair of the IJB.**

Report No.	Report Title	Presented by:
4.7	Audit and Risk Committee Membership	David King

Executive Summary of Report

The purpose of this report was to seek approval in terms of Standing Orders 12.2 and 12.3 of the membership of the IJB's Audit and Risk Committee.

The report explained that the Audit and Risk Committee would be a key part of the IJB's governance and would meet to discuss a range of issues during the financial year and to take a view on the financial assurance process.

Decision

Having heard from the Chief Finance Officer, the Board agreed to:

- **Approve the membership of the IJB's Audit and Risk Committee, as follows:-**
 - **Derek Milligan (Midlothian Council) - Chair**
 - **Bob Constable (Midlothian Council)**
 - **Peter Johnson (NHS Lothian)**
 - **Professor Alison McCallum (NHS Lothian)**

The Chief Finance Officer and the Chief Internal Auditor would attend the meetings along with the Chief Officer.

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- **To approve the suggested appointment of an Independent Member and delegated responsibility to progress this appointment to the Audit and Risk Committee. This appointment to be confirmed at a future meeting of the IJB.**

Report No.	Report Title	Presented by:
4.8	Corporate Governance	Eibhlin McHugh

Executive Summary of Report

The report sought to inform the Board of the advisability of adopting a clear stand-alone Code of Corporate Governance to emphasise the importance of governance in achieving good outcomes for the public and using the IJB resources wisely and efficiently. By working to such a Code the IJB would be in a stronger position to achieve its objectives and make best use of the resources delegated to it.

Summary of discussion

The Board, having heard from the Chief Officer, welcomed the Code of Corporate Governance.

Decision

The Board:

- **Approved in principle the draft Code of Guidance;**
- **Agreed to produce an Annual Governance Statement to be considered by the Audit and Risk Committee**
- **Asked the Chief Officer to carry out a self-assessment exercise during 2015-16 and bring the results of this and any actions required to a future meeting of the IJB**

5. Any other business

No additional business had been notified to the Chair in advance

6. Date of next meeting

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

- | | | |
|--|-----|---|
| • Thursday 17 th March 2016 | 2pm | Special Midlothian Integration Joint Board/Development Workshop on Prescribing |
| • Thursday 14 th April 2016 | 2pm | Midlothian Integration Joint Board |
| • Thursday 19 th May 2016 | 2pm | Development Workshop on tbc |
| • Thursday 16 th June 2016 | 2pm | Midlothian Integration Joint Board |

The meeting terminated at 3.46pm.

Minute of Special Meeting



Midlothian Integration Joint Board

Date	Time	Venue
Thursday 17 th March 2016	2pm	Committee Room, Midlothian House, Buccleuch Street, Dalkeith EH22 1DN.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Peter Johnston (Vice Chair)
Cllr Bob Constable	John Oates
Cllr Derek Milligan	
Cllr Bryan Pottinger	

Present (non voting members):

Eibhlin McHugh (Chief Officer)	David King (Chief Finance Officer)
Hamish Reid (GP/Clinical Director)	Caroline Myles (Chief Nurse)
Patsy Eccles (Staff side representative)	Jean Foster (User/Carer)
Ruth McCabe (Third Sector)	

In attendance:

Kenneth Lawrie (Chief Executive, Midlothian Council)	Graham Herbert (Chief Internal Auditor, Midlothian Council)
Mike Broadway (Clerk)	

Apologies:

Alex Joyce	Alison McCallum
Alison White (Chief Social Work Officer)	Dave Caesar (Medical Practitioner)
Margaret Kane (User/Carer)	

Midlothian Integration Joint Board

Thursday 17 March 2016

1. Welcome and introductions

1.1 The Chair, Catherine Johnstone, welcomed everyone to the Special Meeting of the Midlothian Integration Joint Board.

1.2 The order of business was as set out in the agenda papers.

2. Declarations of interests

2.1 No declarations of interest were intimated.

3. Reports

Report No.	Report Title	Presented by:
3.1	Financial Assurance and Directions 2016/17	David King

Executive Summary of Report

The purpose of the report was to set out the current position in respect of the financial assurance process which was being undertaken by the Midlothian IJB on the resources proposed to be allocated to the IJB by Midlothian Council and NHS Lothian. It also laid out the current position in the preparation of directions to be issued by the IJB to action the IJB's Strategic Plan.

The report explained that the financial allocation from NHS Lothian had not yet been finalised and that further work was required to fully consider the offer from Midlothian Council. It had therefore not been possible to fully complete the financial assurance process at this time and work continued to finalise the directions, especially those directions that were for pan-Lothian services where all four Lothian IJBs would direct their share of these pan-Lothian services.

Summary of discussion

The Chief Finance Officer advised that the process of financial assurance, and the current position regarding directions, had been reviewed by the IJB's Audit and Risk Committee at their meeting earlier in the day.

The Audit and Risk Committee had agreed to:-

- Note the financial assurance work that has been undertaken to date;
- Recommend that the IJB accepts the proposal from Midlothian Council, having been assured by the Joint Director, Health and Social Care that the resources available were sufficient to support the Social Care services delegated to the IJB;
- Recommend that the IJB agrees to Midlothian Council's proposals regarding the use of the Social Care Fund;
- Recommend that the IJB agrees to support an indicative proposition from NHS Lothian based on the current health budget setting model;

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- Recommends that the IJB requests a further analysis of NHS Lothian's budget setting model to review the Midlothian 'share' of the pan-Lothian services and analysis of Midlothian's historic usage of these services;
- Recommends that the IJB agrees to receive a final financial assurance analysis, including appropriate evidence of the financial assurances undertaken by its partners, once the final offer from NHS Lothian had been received after 1st April 2016;
- Recommends that the IJB ensures that the process for financial planning for 2017/18 and thereafter starts more timeously and that the IJB engages with the Scottish Government to review the national health financial planning process; and
- Recommends that the IJB requests that Chief Officer and Chief Finance Officer explore further an appropriate financial risk management agreement.

Decision

After discussion, the Board agreed to:-

- **Accept the recommendations of the Audit and Risk Committee with regard to the financial assurance; and**
- **Accept the recommendation of the Audit and Risk Committee with regard to accepting the propositions from Midlothian Council and NHS Lothian.**

Report No.	Report Title	Presented by:
3.2	Directions – Proposals for 2016/17	David King

Executive Summary of Report

The purpose of this report was to set out the current position with the development of directions and asks the IJB to delegate the authority to issue directions on behalf of the IJB to the IJB's Chief Officer.

The report explained that the IJB's Strategic Plan had a start date of April 1st 2016. By that date the IJB should have received financial allocations from Midlothian and NHS Lothian to resource the functions which had been delegated to the IJB. The IJB would then issues directions effective from 1st April 2016 to Midlothian Council and NHS Lothian. These directions would set out how, in line with the IJB's Strategic Plan the partners will deliver the delegated functions.

Summary of discussion

The Board, having heard from the Chief Finance Officer, who responded to questions for Members of the IJB, discussed the current position, and noted that likely topics for the directions included: Midlothian Community Hospital, Liberton Hospital, Unscheduled care, Primary Care, Community Services to Older People, Prescribing, Learning Disability Services, Community-based Mental Health Services, Substance Misuse Services, Services to Unpaid Carers, Application of Integrated Care Fund & Delayed Discharge Monies.

Midlothian Integration Joint Board

Thursday 17 March 2016

Decision

The Board:

- **Noted the current position on the development of the IJB's Directions;**
- **Noted that the directions will flow from the IJB's agreed Strategic Plan;**
- **Agreed to delegate the authority to issue directions for 1st April 2016 to the IJB's Chief Officer; and**
- **Agreed to receive a further report detailing the directions issued by the Chief Officer at the first meeting of the IJB in the 2016/17 financial year.**

4. Date of next meeting

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

- | | | |
|--|-----|---|
| • Thursday 14 th April 2016 | 2pm | Midlothian Integration Joint Board |
| • Thursday 19 th May 2016 | 2pm | Development Workshop on tbc |
| • Thursday 16 th June 2016 | 2pm | Midlothian Integration Joint Board |

The meeting terminated at 2.46pm.

Minute of Meeting



Midlothian Integration Joint Board

Date	Time	Venue
Thursday 14 April 2016	2pm	Council Chambers, Midlothian House, Buccleuch Street, Dalkeith EH22 1DN.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Peter Johnston (Vice Chair)
Cllr Derek Milligan	Alex Joyce
Cllr Bryan Pottinger	Alison McCallum
Cllr Joe Wallace (substitute for Cllr Bob Constable)	John Oates

Present (non voting members):

Eibhlin McHugh (Chief Officer)	Alison White (Chief Social Work Officer)
Dave Caesar (Medical Practitioner)	Caroline Myles (Chief Nurse)
Patsy Eccles (Staff side representative)	David King (Chief Finance Officer)
Margaret Kane (User/Carer)	Jean Foster (User/Carer)
Ruth McCabe (Third Sector)	

In attendance:

Dr Sian Tucker (Clinical Director, LUCS)	Liz Ribchester (Audit Scotland)
Kenneth Lawrie (Chief Executive, Midlothian Council)	Allister Short (Head of Healthcare)
Tom Welsh (Integration Manager)	Mike Broadway (Clerk)

Apologies:

Cllr Bob Constable	Hamish Reid (GP/Clinical Director)

Midlothian Integration Joint Board

Thursday 14 April 2016

1. Welcome and introductions

- 1.1 The Chair, Catherine Johnstone, welcomed everyone to the Meeting of the Midlothian Integration Joint Board, in particular Councillor Joe Wallace, who was substituting for Councillor Bob Constable, Dr Sian Tucker, Clinical Director, Lothian Unscheduled Care Service and Liz Ribchester, Audit Scotland.
- 1.2 The order of business was as set out in the agenda papers.

2. Declarations of interest

No declarations of interest were received.

3. Presentation

Following discussion of Sir Lewis Ritchie's report, "Pulling Together: Transforming Urgent Care for the People of Scotland" at the 11 February 2016 Midlothian IJB meeting (paragraph 4.3 refers), Dr Sian Tucker, Clinical Director, Lothian Unscheduled Care Service provided a briefing on the work of the pan-Lothian short-life Working Group tasked with developing proposals to implement the proposals contained in the report.

4. Minutes of Previous Meetings

- 4.1 The following Minutes of Meetings of the Midlothian Integration Joint Board were submitted and approved as correct records:
- Thursday 11 February 2016; and
 - Thursday 17 March 2016
- 4.2 Arising from the Minutes of 11 February 2016, the Board noted that it was hoped to be in a position to provide a baseline report on performance in relation to national outcomes (paragraph 4.4 refers) to the next MIJB meeting; it having taken slightly longer than anticipated to draw all the relevant information together. Also with regards the appointment of the Independent Member to the Audit and Risk Committee (paragraph 4.7 refers), it was agreed to approve the recommendation of the Committee and appoint Jane Cuthbert as the Independent Member.

5. Reports

Report No.	Report Title	Presented by:
5.1	Code of Conduct for Members of the Midlothian Integration Joint Board	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to advise the Board of the outcome of the work that had been undertaken in relation to the development of a Code of Conduct for the Midlothian Integration Joint Board.

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Thursday 14 April 2016

The report confirmed that the Scottish Government had prepared a template code in conjunction with the Commissioner for Ethical Standards and the Standards Commission that could be adopted by all IJBs and had written to all IJB Chairs and Chief Officers advising that their expectation was that the Code would be implemented in full across all IJBs.

The template Code of Conduct had been updated to reflect reference to Midlothian Integration Joint Board and was attached in draft format as an appendix to the report along with a copy of the letter from the Scottish Government.

Summary of discussion

Having heard from Chief Officer, who explained that once approved by the Board, the draft Code of Conduct would require to be submitted to the Scottish Government for approval, the Board discussed possible potential conflicts of interests for some IJB members whose professional roles/duties out with their direct involvement in the IJB placed specific legislative requirements on them, which may place them in conflict with the provisions contained in the Code of Conduct.

Decision

The Board:

- **Noted the correspondence from the Scottish Government in relation to the Code of Conduct for Midlothian Integration Joint Board Members;**
- **Approved, subject to seeking and trying to provide guidance on the issue of possible potential conflicts of interests, the draft Code of Conduct for Midlothian Integration Joint Board for submission to the Scottish Government for approval; and**
- **Noted that once the Midlothian Integration Joint Board's Code of Conduct is approved by the Scottish Government it must be published as well as a Register of Members' Interests.**

Report No.	Report Title	Presented by:
5.2	Risk Register	Tom Welsh

Executive Summary of Report

This report introduced a draft Risk Register for the Midlothian Integration Joint Board to consider and a proposed set of risks to form the basis of the Midlothian Integration Joint Board's Risk Register.

The report explained that the work in developing the draft risk register built on the proposals approved at the Midlothian Integration Joint Board meeting held on 20 August 2015 (paragraph 4.6 refers); incorporated the high level strategic risks identified at the Midlothian Integration Joint Board Workshop on 14 January 2016; and also the approval of the Risk Management Policy on 11 February 2016 (paragraph 4.5 refers).

Midlothian Integration Joint Board

Thursday 14 April 2016

Summary of discussion

The Board, having heard from the Integration Manager, discussed the draft Risk Register. It was suggested that it would be useful to add a key explaining the notation used in the Register as it was not very clear what the symbols or numbering represented. It was also felt that a possible briefing for Board Members on the CNORRIS Scheme would be beneficial.

Decision

The Board:

- **Approved the draft Risk Register in principle;**
- **Noted that the register would be considered and finalised by the Audit and Risk Committee on 9th June 2016; and**
- **Agreed to receive regular reports on the risks facing the Midlothian Integration Joint Board to support informed and effective decision making.**

Report No.	Report Title	Presented by:
5.3	Directions	Tom Welsh

Executive Summary of Report

This report explained the development of Directions which had been issued to Midlothian Council and NHS Lothian. The Directions required to be considered in conjunction with the Midlothian Strategic Plan 2016-19, which outlined the direction of travel for the development of health and care services in Midlothian. The Directions were intended to provide greater clarity about the key changes which required to be made during 2016-17 in the delivery of health and care services in Midlothian. A copy of the detailed Directions were appended to the report.

Summary of discussion

Having heard from the Integration Manager, the Board discussed the Directions, welcoming in particular the partnership approach that had been adopted. Consideration was also given to the future role of the Audit and Risk Committee in monitoring the risks associated with the Directions and also the involvement of the third sector in their delivery; in this regard it was acknowledged that whilst headway was being made further work was still required.

Decision

The Board:

- **Noted the Directions as outlined in the Appendix to the report; and**
- **Agreed to receive regular reports on how NHS Lothian and Midlothian Council were putting these Directions into practice.**

Midlothian Integration Joint Board

Thursday 14 April 2016

Report No.	Report Title	Presented by:
5.4	Financial Strategy Outline 2017/18 and Beyond	David King

Executive Summary of Report

The report explained that the Midlothian Integration Joint Board, having agreed its Strategic Plan which also contains its Financial Plan, was facing significant financial pressures and required a financial strategy – which would be used to develop its future financial plans – to manage these pressures. Such a financial strategy would support the achievement of the Strategic Plan by ensuring that the financial resources required to deliver the aims of the Strategic Plan were available. The report also considered the broad options available to the Midlothian Integration Joint Board and laid out the principles which the management team were developing.

Summary of discussion

The Board, in considered the available options and the principles which the management team were developing, heard from the Chief Finance Officer who emphasised the importance of this work in underpinning the MIJB's financial strategy for the next three years. The use of workshop to assist the MIJB in developing its priorities going forward was warmly welcomed and consideration was also given to the process of delegation and to the importance of a clear commitment being given to addressing issue of health inequalities.

Decision

The Board:

- **Noted the contents of the report.**
- **Noted the options being considered and endorsed the approach being developed by the Management Team.**

Report No.	Report Title	Presented by:
5.5	Pressures in Primary Care - Midlothian	Allister Short

Executive Summary of Report

This report sets out the current pressures and challenges within primary care in Midlothian, specifically in relation to General Practice and detailed the developments that had been implemented to date as well as outlining future plans.

The report also highlighted the emerging direction of travel as set out by Scottish Government in relation to the new GP contract and detailed a funding proposal submitted to Scottish Government through the Primary Care Transformation Fund; a copy of the outline proposal was appended to the report.

Midlothian Integration Joint Board

Thursday 14 April 2016

Summary of discussion

Having heard from the Head of Health Care, the Board discussed the current position and the actions being taken or in place to address the pressures in primary care. It was acknowledged that this was another area where the MIJB could not necessarily deal with all the issues in isolation and there were important tie ins to the planning system, for example, to ensure that when new developments were being planned adequate provision was included to ensure health care needs were met, whether that was through the direct provision of new health care facilities or by some other means.

Decision

The Board:

- **Noted the current position and pressures in Midlothian in relation to General Practice;**
- **Noted and endorsed the actions that have been implemented to address these pressures; and**
- **Agreed to receive a future report setting out further proposals in response to the new GP contract and the Transitional Quality Arrangements for general practice.**

Report No.	Report Title	Presented by:
5.6	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 the progress being made on service integration and ongoing service developments.

Following discussion at a recent NHS Healthcare Governance workshop and in recognition of the need to strengthen reporting to the IJBs, the report also detailed proposals to develop the role of the Quality Improvement Team to include it taking on responsibility for direct reporting to the IJB on issues related to both clinical and care governance in the delivery of health and social care services in Midlothian.

Summary of discussion

The Board, in considering the Chief Officer's Report, discussed the potential impacts arising from the introduction of the living wage; the provision of training for staff as part of the transformational activities and the series of reports being produced by Audit Scotland on Health and Social Care integration; it being suggested that this might be a valuable future workshop/briefing session topic.

Decision

The Board:

- **Noted the issues raised in the report.**
- **Agreed to the proposed review of the remit of the Quality Improvement Team and for the Integrated Joint Board to receive regular reports on Clinical and Care Governance from the Quality Improvement Team.**

Midlothian Integration Joint Board

Thursday 14 April 2016

Report No.	Report Title	Presented by:
5.7	Health Inequalities	Eibhlin McHugh

Executive Summary of Report

This report restated the commitment of the Midlothian Integration Joint Board to addressing health inequalities and provided examples of current and planned work that sought to address and contribute to that work. The report also highlighted that the MIJB could not deal with health inequalities in isolation and that it would require all strands of the Community Planning Partnership to demonstrate a commitment to this priority; a view which had been endorsed by the Community Planning Board at its December 2015 meeting.

Summary of discussion

In discussing the importance of tackling issues of health inequalities, the Board, having heard from the Chief Officer, acknowledged that although challenging there was a real opportunity to identify and address some of the underlying causes leading to health inequalities in Midlothian.

Decision

The Board:

- **Noted the report.**

Report No.	Report Title	Presented by:
5.8	Meeting Schedule and Workshop Dates 2016/17	Eibhlin McHugh

Executive Summary of Report

The purpose of this report was to set the dates for the meetings and development workshops for the Midlothian Integration Joint Board for 2016/17.

Summary of discussion

Having heard from Chief Officer, the Board considered the arrangements for the Service Visits, it being felt that there may be merit in re-visiting some of the Services for the benefit of the new Board members.

Decision

The Board:

- **Approved the schedule of meetings of the Midlothian Integration Joint Board as set out in the Appendix hereto;**
- **Approved the schedule of development workshops for the Midlothian Integration Joint Board as set out in the Appendix hereto; and**
- **Noted the approach for service visits for Midlothian Integration Joint Board.**

Midlothian Integration Joint Board

Thursday 14 April 2016

6. Any other business

No additional business had been notified to the Chair in advance

7. Date of next meeting

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

- Thursday 19th May 2016 2pm Development Workshop on Health and Wellbeing Services
- Thursday 16th June 2016 2pm **Midlothian Integration Joint Board**

The meeting terminated at 4.20 pm.

MINUTE of MEETING of the WEST Lothian INTEGRATION JOINT BOARD of WEST Lothian COUNCIL held within COUNCIL CHAMBERS, WEST Lothian CIVIC CENTRE, LIVINGSTON, on 23 MARCH 2016.

Present

Voting Members – Councillors Frank Toner (Chair), Alex Joyce, Danny Logue, John McGinty, Anne McMillan, Alison Meiklejohn (substitute for Julie McDowell), Martin Hill, David Farquharson

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

Apologies – Julie McDowell (Voting Member) and Elaine Duncan, Jane Houston and James McCallum (Non-Voting Members)

In Attendance – Jim Forrest (Director), Rhona Anderson (CHCP Development, West Lothian Council), Carol Bebbington (Primary Care Manager, NHS Lothian), Alan Bell (Senior Manager, Communities and Information, West Lothian Council), Marion Christie (Head of Health Services), James Millar (Standards Officer), David McConnell and Inire Evong (Audit Scotland).

1. ORDER OF BUSINESS, INCLUDING NOTICE OF URGENT BUSINESS

The Board agreed a suggestion by the Chair that the order of business be changed to allow Audit Scotland to present their report earlier in the meeting, and that the remaining items of business be taken in the following order:-

Items 3, 4, 5 and 6 as per the agenda
Item 11 Audit Scotland Annual Audit Plan
Item 8 – Financial Regulations
Item 9 – IJB Financial Assurance
Item 7 – Strategic Plan
Item 10 – JB Directions
Item 12 - Workplan

2. DECLARATIONS OF INTEREST

Councillor Logue declared an interest as an employee of NHS Lothian.

Councillor Toner declared an interest as a Non Executive Director, NHS Lothian.

3. DRAFT MINUTE OF MEETING OF WEST Lothian INTEGRATION JOINT BOARD HELD ON TUESDAY 16 FEBRUARY 2016

The Board approved the minute of meeting of the West Lothian Integration Joint Board held on 16 February 2016 subject to amendments

as undernoted:-

- Include Mary-Denise McKernan as an attendee.
- “Hail” to read “Hill” in list of attendees.

4. DRAFT MINUTE OF MEETING OF WEST Lothian INTEGRATION STRATEGIC PLANNING GROUP HELD ON TUESDAY 23 FEBRUARY 2016

The Board noted the minute of meeting of West Lothian Integration Strategic Planning Group held on 23 February 2016.

5. RUNNING ACTION NOTE

A copy of the Running Action Note had been circulated for information.

Decision

To note the content of the Running Action Note.

6. AUDIT SCOTLAND ANNUAL AUDIT PLAN

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer informing the IJB of Audit Scotland’s 2016/16 annual audit plan.

The Chief Finance Officer presented the report, informing the Board that Audit Scotland’s plan summarised the audit issues and risks and appendix 2 of the plan identified significant audit risks, the related sources of assurance, and the proposed audit work to secure additional investment.

The plan outlined the agreed fee which took into account the risk exposure of the IJB, the management assurances in place and the level of reliance they planned to take from the work of internal audit. As part of this, they had assumed receipt of a complete set of unaudited financial statements and comprehensive working papers package by 30 June 2016.

It was noted that the establishment of the IJB Audit Committee would be considered in a report to the April 2016 meeting of the Board and future annual audit plans would be reported to the IJB Audit Committee.

David McConnell, who had been appointed by the Accounts Commission as the external auditor of West Lothian IJB for 2015/16, spoke briefly in relation to his role. Mr McConnell then responded to questions raised by Board members.

Decision

To note the content of Audit Scotland's 2015/16 audit plan.

7. IJB FINANCIAL REGULATIONS

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer seeking approval of the Financial Regulations to be used by the West Lothian IJB

The Chief Finance Officer advised that, as previously reported, the IJB would take on functions and financial responsibilities for delegated NHS Lothian and Council from 1 April 2016. This would align to the IJB Strategic Plan covering the period 2016/17 to 2018/19.

The proposed Financial Regulations were set out in Appendix 1 to the report. They provided the framework for managing the IJB's financial affairs from 1 April 2016. They applied to IJB members, IJB advisory members and all parties acting on behalf of the IJB. The Chief Finance Officer was responsible for maintaining a continuous review of the financial regulations and submitting any changes to the Board for approval. It was proposed that the financial regulations were reviewed at least once every three years.

The Chief Finance Officer was also responsible for issuing procedures, guidance and advice to underpin the financial regulations, and for investigating any breach of the regulations. The Board was asked to note that the IJB did not directly receive or expend cash via a bank account, or employ staff. As a result the Financial Regulations were relatively high level.

The Board was asked to note the content of the report and approve the Financial Regulations as set out in Appendix 1 to the report.

Decision

1. To note the content of the report; and
2. To approve the Financial Regulations as set out in Appendix 1 to the report.

8. IJB FINANCIAL ASSURANCE

A report had been circulated by the Chief Finance Officer setting out the outcome of the financial assurance process on the currently proposed resources to be delegated to the IJB for 2016/17.

The report described the approach to financial assurance and outlined the matters to be taken into account as part of the assurance process.

The approach described in the report would form the basis of reviewing the 2016/17 resources identified in the report by West Lothian Council and NHS Lothian, subject to the status of each bodies 2016/17 budget

plans and information available. In addition, the West Lothian IJB approved Integration Scheme would also inform the approach taken on financial assurance.

In relation to West Lothian Council Resources, it was noted that West Lothian Council had approved its 2016/17 budget on 23 February 2016, including the 2016/17 level of resources associated with functions delegated to the IJB of £66.685 million. This took account of Scottish Government funding to IJBs, provided in the first instance to Health Boards, of £250 million specifically for social care. For West Lothian, the share of the funding had been confirmed as £7.130 million.

As part of the council's approved budget, a number of assumptions had been made in terms of the £7.130 million, and these were set out in the report.

The report provided a tabling summarising the 2014/15 outturn, forecast 2015/16 outturn and approved 2016/17 budget associated with 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 report went on to examine NHS Lothian Resources.

In relation to NHS Lothian Resources, the Director and Chief Finance Officer advised that:-

- There had been incorrect figures provided by NHS Lothian in relation to the budget allocation and that NHS Lothian had stated that the recalculated figures would be provided to the IJB Chief Finance Officer in the course of the coming week.
- The Strategic Plan and Directions reports (Agenda items 7 and 10) also contained the incorrect figures. The Board was asked to note and agree that the absence of this information created significant problems for the Board in considering and making decisions on these report.

The Board then heard from the Standards Officer who advised that, despite practical difficulties, an adjourned meeting should take place before 1 April to let the Board have the best chance possible of complying with its statutory duties in relation to these reports.

Decision

1. To note the terms of the report.
2. To note advice by the Director and the Chief Finance Officer that:-
 - there had been incorrect figures provided by NHS Lothian in relation to the budget allocation and that NHS Lothian had stated that recalculated figures would be provided to the IJB

Chief Finance Officer in the course of the coming week.

- that the Strategic Plan and Directions reports also contained the incorrect figures.
 - that members should note and agree that the absence of this information created significant problems for the Board in considering and making decisions on these reports.
3. To note advice by the Standards Officer that despite practical difficulties, an adjourned meeting should take place before 1 April to let the Board have the best chance possible of complying with its statutory duties in relation to these report.
 4. Therefore, having considered the problems and advice offered and the options open to it, the Board:-
 - (a) Agreed that a revised report on Financial Assurance be brought to an adjourned meeting to be held on Thursday 31 March 2016 at 2.00 pm.
 - (b) Agreed that as part of the ongoing need for financial assurance, a report would be brought to a subsequent meeting outlining the final resource allocation by NHS Lothian and assessing the impact of the revised figures.

9. WEST LOTHIAN INTEGRATION JOINT BOARD STRATEGIC PLAN 2016-2026

The Board considered a report (copies of which had been circulated) by the Director summarising the progress made in finalising the draft strategic plan, outlining the responses to the consultation on the Strategic Plan and how these had influenced the plan's development.

The Board did not consider the detailed information contained in the report, given that a decision had been taken earlier in the meeting that an adjourned meeting would take place on Thursday 31 March 2016 for consideration of this and other items of business relating to finances.

Decision

To agree to continue the report to the adjourned meeting, given that the figures presented in the report were subject to change.

10. IJB DIRECTIONS

The Board considered a report (copies of which had been circulated) by the Director seeking approval in respect to West Lothian Council and NHS Lothian in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working) (Scotland) Act 2014.

The Board did not consider the detailed information contained in the

report, given that a decision had been taken earlier in the meeting that an adjourned meeting would take place on Thursday 31 March 2016 for consideration of this and other items of business relating to finances.

Decision

To agree to continue the report to the adjourned meeting, given that the Chief Finance Officer considered that the figures provided by NHS Lothian were not accurate enough to allow the Board to issue Directions.

11. WORKPLAN

A copy of the workplan had been circulated for information.

Decision

1. To note the workplan.
2. To agree that the Chair write on behalf of the IJB to the Chair of NHS Lothian expressing the Board's concerns over the financial information provided by NHS Lothian and seeking his support and assurance in providing revised budget allocation figures prior to the adjourned meeting of the IJB on 31 March 2016.
3. To record the Board's appreciation of the work undertaken by Rhona Anderson for the IJB and the CHCP and to wish her well for the future.



**West Lothian Integration Joint Board
31 March 2016**

ACTION NOTE

An adjourned meeting of the West Lothian Integration Joint Board was held on 31 March 2016. The items for action and the allocation of that action are listed below.

If you have any comments or questions, please contact Anne Higgins as soon as possible on 01506 281601.

Present

Voting Members – Councillors Frank Toner (Chair), Alex Joyce, Danny Logue, John McGinty, Anne McMillan, Susan Goldsmith (substitute) and George Walker (substitute).

Non-Voting Members – Marion Barton (substitute for Jim Forrest) Ian Buchanan (Stakeholder Representative), Mairead Hughes (Professional Advisor), Jane Kellock (Chief Social Work Officer) and Patrick Welsh (Chief Finance Officer).

Apologies – David Farquharson, Martin Hill and Julie McDowell (Voting Members) and Jim Forrest, Elaine Duncan, Jane Houston and James McCallum (Non-Voting Members)

In Attendance –Carol Bebbington (Primary Care Manager, NHS Lothian), Alan Bell (Senior Manager, Communities and Information, West Lothian Council), James Millar (Governance Manager, West Lothian Council) and Steve Field.

Item	Title	Decision	Action
001	Apologies for Absence	David Farquharson, Martin Hill, Julie McDowell (Voting Members); and Jim Forrest Elaine Duncan, Mary-Denise McKernan, Martin Murray (Non-Voting Members)	N/a
002	Order of Business, including notice of urgent business	The Board agreed a suggestion by the Chair that the report on IJB Financial Assurance (Agenda Item 9) be taken as the first item of business, followed by the Strategic Plan (Item 7) and IJB Directions (item 10).	N/a

003	Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.	Councillor Logue declared an interest as an employee of NHS Lothian. Councillor Toner declared an interest as a Non Executive Director, NHS Lothian.	N/a
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0009	IJB Financial Assurance	<ol style="list-style-type: none"> 1. To note the financial assurance work undertaken to date; 2. To agree the allocation of the Social Care Fund resources, taking account of Scottish Government requirements; 3. To agree the approved council resources and indicative NHS Lothian resources were allocated back to Partners, via Directions, to operationally deliver and financially manage IJB delegated functions from 1 April 2016; and 4. To agree that a further report on financial assurance would be provided to the IJB following the conclusion of the NHS Lothian 2016/17 budget process. 5. To note advice by the Director of Finance, NHS Lothian that:- <ul style="list-style-type: none"> • the NRAC funding for West Lothian used to balance the change to allocating prescribing budgets in 2016/17 (and ensure no detriment to West Lothian) was recurring and would continue to be provided on a recurring basis for the West Lothian prescribing budget. • it was anticipated that the budget alignment process for NHS could be brought forward to better align with the councils for 17/18, and agree a budget in advance of April. 6. To agree to accept the offer extended by the Director of Finance, NHS Lothian and the IJB Chief Finance Officer that members be provided with information reconciling the current indicative budget figures with those presented to the 23 March meeting, and information about health board budget-setting arrangements and processes. 7. To agree that the IJB write to NHS Lothian requesting that, for future years, NHS Lothian confirm their resource allocation in advance of the financial assurance work being undertaken for the start of the financial year. 	Patrick Welsh/ Carol Bebbington/ Alan Bell
007	West Lothian Integration Joint Board Strategic Plan 2016-2026 - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To note the contents of the report 2. To note the progress made in finalising the Draft Strategic Plan 3. To note how the consultation responses have informed the development of the final draft of the plan. 4. To approve the Strategic Plan 	Patrick Welsh/ Carol Bebbington/ Alan Bell

010	IJB Directions - Report by Director (herewith)	To note the terms of the report; and To agree to issue directions to West Lothian Council and NHS Lothian in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working) (Scotland) Act 2015 as detailed in the appendices to the report.	Jim Forrest/ Alan Bell
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MINUTE of ADJOURNED MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within COUNCIL CHAMBERS, CIVIC CENTRE, LIVINGSTON, on 31 MARCH 2016

Present

Voting Members – Councillors Frank Toner (Chair), Alex Joyce, Danny Logue, John McGinty, Anne McMillan, Susan Goldsmith (substitute) and George Walker (substitute).

Non-Voting Members – Marion Barton (substitute for Jim Forrest) Ian Buchanan (Stakeholder Representative), Mairead Hughes (Professional Advisor), Jane Kellock (Chief Social Work Officer) and Patrick Welsh (Chief Finance Officer).

Apologies – David Farquharson, Martin Hill and Julie McDowell (Voting Members) and Jim Forrest, Elaine Duncan, Jane Houston and James McCallum (Non-Voting Members)

In Attendance – Carol Bebbington (Primary Care Manager, NHS Lothian), Alan Bell (Senior Manager, Communities and Information, West Lothian Council), James Millar (Standards Officer) and Steve Field.

1. ORDER OF BUSINESS, INCLUDING NOTICE OF URGENT BUSINESS

The Board agreed a suggestion by the Chair that the report on IJB Financial Assurance (Agenda Item 9) be taken as the first item of business, followed by the Strategic Plan (item 7) and IJB Directions (item 10).

2. DECLARATIONS OF INTEREST

Councillor Logue declared an interest as an employee of NHS Lothian.

Councillor Toner declared an interest as a Non Executive Director, NHS Lothian.

3. IJB FINANCIAL ASSURANCE

The 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 currently proposed resources to be delegated to the IJB for 2016/17. The report replaced and superseded the previous report issued for the Board meeting on 23 March 2016 which had been adjourned to 31 March 2016.

The report described the approach to financial assurance and outlined the matters to be taken into account as part of the assurance process.

The approach described in the report would form the basis of reviewing the 2016/17 resources identified in the report by West Lothian Council and NHS Lothian, subject to the status of each bodies 2016/17 budget plans and information available. In addition, the West Lothian IJB approved Integration

Scheme would also inform the approach taken on financial assurance.

In relation to West Lothian Council Resources, it was noted that West Lothian Council had approved its 2016/17 budget on 23 February 2016, including the 2016/17 level of resources associated with functions delegated to the IJB of £66.685 million. This took account of Scottish Government funding to IJBs, provided in the first instance to Health Boards, of £250 million specifically for social care. For West Lothian, the share of the funding had been confirmed as £7.130 million.

As part of the council's approved budget, a number of assumptions had been made in terms of the £7.130 million, and these were set out in the report.

The report provided a table summarising the 2014/15 outturn, forecast 2015/16 outturn and approved 2016/17 budget associated with 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.

In relation to NHS Lothian resources, it was noted that given the ongoing work to progress and balance the NHS Lothian 2016/17 budget, the West Lothian IJB position was indicative at this stage. Full financial assurance of the 2016/17 NHS Lothian contribution to the IJB was not possible at this time and given information of IJB related spend in previous years was fully available, the focus of the assurance would be on the current 2016/17 indicative IJB budget and assumptions attached to these resources. The report provided a table showing an indicative 2016/17 contribution of £133.571 million for the IJB from NHS Lothian, reflecting a £3.077 million increase from the 2015/16 base budget associated with IJB delegated functions.

The split of the £133.571 million between the three elements of the NHS Lothian contribution to the IJB was shown in a table within the report. Further details on the indicative £133.571 million was shown in Appendix 2 to the report, including the split of functions between the payment to the IJB and the share of acute set aside.

In respect of the NHS payment (excluding acute set aside) there was an assumption that £2.287 million of low to medium risk savings would be achieved. In addition, further measures of approximately £2.5 million would also require to be identified to manage anticipated spend within the £104.380 million payment to the IJB.

In respect of overall acute services, substantial savings were required to ensure a balanced budget position could be achieved in 2016/17. For the purposes of IJB strategic planning a notional share of resources totalling £29.191 million had been estimated as West Lothian's share of resources associated with delegated acute functions.

The Director of Finance, NHS Lothian amplified aspects of the information contained in the report. In addition, an offer was made to provide Board members with information reconciling the current indicative budget figures with those presented to the 23 March meeting, and information about health board

budget-setting arrangements and processes.

The report then went on to examine the key risk and uncertainties.

Taking account of the budget resources identified in the report, the indicative level of 2016/17 resources associated with IJB functions was £200,256 million.

The Chief Finance Officer went on to advise that a further report on financial assurance would be provided to the Board following NHS Lothian having finalised their 2016/17 budget plans. Any amendments required to the NHS Lothian budget contribution to the IJB would be taken account of as part of this report, and reflected in revised Directions as necessary.

In addition, financial assurance would be ongoing during the year as part of regular financial reporting on the 2016/17 resources associated with IJB functions.

Finally, questions raised by Board members were dealt with by the Chief Finance Officer and the Director of Finance, NHS Lothian.

It was recommended that the IJB:-

1. Note the financial assurance work undertaken to date;
2. Agree the allocation of the Social Care Fund resources, taking account of Scottish Government requirements;
3. Agree the approved council resources and indicative NHS Lothian resources were allocated back to Partners, via Directions, to operationally deliver and financially manage IJB delegated functions from 1 April 2016; and
4. Agree that a further report on financial assurance would be provided to the IJB following the conclusion of the NHS Lothian 2016/17 budget process.

Decision

1. To note the financial assurance work undertaken to date;
2. To agree the allocation of the Social Care Fund resources, taking account of Scottish Government requirements;
3. To agree the approved council resources and indicative NHS Lothian resources were allocated back to Partners, via Directions, to operationally deliver and financially manage IJB delegated functions from 1 April 2016;
4. To agree that a further report on financial assurance would be provided to the IJB following the conclusion of the NHS Lothian 2016/17 budget process.
5. To note advice by the Director of Finance, NHS Lothian that:-
 - The NRAC funding for West Lothian used to balance the change to

allocating prescribing budgets in 2016/17 (and ensure no detriment to West Lothian) was recurring and would continue to be provided on a recurring basis for the West Lothian prescribing budget.

- It was anticipated that the budget alignment process for NHS could be brought forward to better align with the councils for 17/18, and agree a budget in advance of April.
6. To agree to accept the offer extended by the Director of Finance, NHS Lothian and the IJB Chief Finance Officer that members be provided with information reconciling the current indicative budget figures with those presented to the 23 March meeting, and information about health board budget-setting arrangements and processes.
 7. To agree that the IJB write to NHS Lothian requesting that, for future years, NHS Lothian confirm their resource allocation in advance of the financial assurance work being undertaken for the start of the financial year.

4. WEST LOTHIAN INTEGRATION JOINT BOARD STRATEGIC PLAN 2016-2026

The Board considered a report (copies of which had been circulated) summarising the progress made in finalising the draft strategic plan, outlining the responses to the consultation on the Strategic Plan and how these had influenced the plan's development. It was noted that the report replaced and superseded the previous report issued for the Board meeting on 23 March 2016 which had been adjourned to 31 March 2016.

The report recalled that consultation on the Strategic Plan ran from 1 November to 31 December 2015 and included a wide range of stakeholders including health and social care professionals, providers of health and social care, users of health and social care and their carers, providers of social housing and third sector providers. 23 responses had been received: 6 from individuals and 17 on behalf of groups.

Views of respondents had been considered and the Strategic Plan had been substantially revised to take account of the consultation feedback and input from the Strategic Planning Group. The main themes from the consultation were detailed in the consultation response statement in Appendix 2 to the report. Appendix 1 was the final draft Strategic Plan.

It was noted that the plan was a high level plan linked to achieving outcomes and making best use of the resources available through strategic commissioning approaches. The resources accurately reflected the resources associated with West Lothian delegated functions.

The Board was asked to:

- Note the contents of the report
- Note the progress made in finalising the Draft Strategic Plan

- Note how the consultation responses had informed the development of the final draft of the plan
- Approve the Strategic Plan

Decision

1. To note the contents of the report.
2. To note the progress made in finalising the Draft Strategic Plan.
3. To note how the consultation responses had informed the development of the final draft of the plan.
4. To approve the Strategic Plan.

5. IJB DIRECTIONS

The Board considered a report (copies of which had been circulated) by the Director seeking approval in respect of directions to West Lothian Council and NHS Lothian in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working (Scotland) Act 2014.

The Board was asked to note that the report replaced and superseded the previous report issued for the Board meeting on 23 March 2015 which had been adjourned to 31 March 2016.

The report informed the Board that each direction would take the form of a letter from the Director referring to the arrangements for delivery set out in the Strategic Plan. The directions would include a requirement of West Lothian Council and NHS Lothian to work with the Chief Officer and officers of the IJB to develop care group commissioning plans and bring them to the IJB for consideration and approval in accordance with a schedule to be agreed by the IJB at its meeting on 5 April 2016.

It was noted that, for future years, the number of directions and the level of detail provided in them was likely to be developed to reflect the level of detail in the various commissioning plans.

Appendices 1 - 4 to the report detailed the directions to be issued, the purpose, the function to be addressed, the funding associated, the relevant outcomes, and how performance would be monitored and reported back.

It was noted that the financial resources associated with directions represented resources at a point in time. NHS resources were noted as being indicative given work continued to achieve a balanced 2016/17 budget position. Upon approval of the NHS Lothian Local Delivery Plan and associated 2016/17 budget plan, it might be necessary to amend directions to NHS Lothian. Otherwise it was not anticipated that resources associated with directions would be changed for normal minor changes and movements in budget resources, but revised directions might be necessary to take account of material factors such as additional funding received during the course of the

year.

The Board was recommended to agree to issue directions to West Lothian council and NHS Lothian in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working) (Scotland) Act 2014 as detailed in the appendices to the report.

Decision

1. To note the terms of the report; and
2. To agree to issue directions to West Lothian Council and NHS Lothian in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working) (Scotland) Act 2015 as detailed in the appendices to the report.



**West Lothian Integration Joint Board
5 April 2016**

ACTION NOTE

A meeting of the West Lothian Integration Joint Board was held on 5 April 2016. The items for action and the allocation of that action are listed below.

If you have any comments or questions, please contact Anne Higgins as soon as possible on 01506 281601.

Present

Voting Members – Councillors Frank Toner (Chair), Danny Logue, Julie McDowell (Vice-Chair), John McGinty, Anne McMillan, Alison Meiklejohn (substitute), Martin Hill.

Non-Voting Members – Ian Buchanan (Stakeholder Representative), Elaine Duncan (Professional Advisor), Jim Forrest (Director), Jane Houston (Staff Representative), Mairead Hughes (Professional Advisor), Pamela Main (substitute for Jane Kellock), Mary-Denise McKernan (Stakeholder Representative), Robin Strang (Stakeholder Representative), Patrick Welsh (Finance Officer)

Apologies – David Farquharson, Alex Joyce, James McCallum and Martin Murray

In Attendance – Marion Barton (Head of Health Services), Alan Bell (Senior Manager, Communities and Information, WLC), James Millar (Standards Officer)

Item	Title	Decision	Action
001	Apologies for Absence	David Farquharson, Alex Joyce, Jane Kellock, James McCallum and Martin Murray	
002	Order of Business, including notice of urgent business	N/a	N/a
003	Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.	Councillor Danny Logue declared an interest as an employee of NHS Lothian.	N/a

004	Audit Committee - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To note the terms of the report. 2. To approve the revised remit and change of name for the proposed Audit Committee, as set out in the appendix to the report. 3. To agree to appoint the following members to the Committee:- Jane Houston and Martin Murray (non-voting members) Martin Hill and Julie McDowell (voting members appointed by NHS Lothian) Anne McMillan and Danny Logue (voting members appointed by West Lothian Council) 4. To agree that Julie McDowell be appointed as Chair of the Audit Risk and Governance Committee and that Anne McMillan be appointed as Vice Chair. 	James Millar
005	Schedule of Meetings 2016/17 - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To agree to set dates for the next two meetings as undernoted:- 31 May 2016 at 2.00 pm 23 August 2016 at 2.00 pm 	Jim Forrest
006	Standing Orders and Code of Conduct - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To note the terms of the report. 2. To approve the change to Standing Order 9.12 as recommended by the IJB Standards Officer. 3. To approve the changes to paragraphs 5.6 and 5.7 of the interim Code of Conduct as recommended by the IJB Standards Officer. 	Jim Forrest/ James Millar
007	Terms of Reference for Commissioning Plan Working Groups - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To agree the Terms of Reference for Commissioning Plan Working Groups as detailed in Appendix 1 to the report. 2. To note advice by officers concerning branding and to agree that the use of WL Health & Social Care Partnership logo (as shown in Appendix 1 to the report) was appropriate and should continue. 3. To note that a paper showing the overall schedule for the delivery of the commissioning plan would be circulated to Board members. 	Jim Forrest/Alan Bell

008	IJB Member Induction - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To endorse the proposed approach and content of Board member induction as outlined in the report. 2. To agree that plans be developed for two visits; and that a paper would come back to the Board in due course. 	Jim Forrest/Marion Barton
009	Workplan (herewith)	To note the Workplan	Jane Kellock/Anne Higgins

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 5 APRIL 2016.

Present

Voting Members – Councillors Frank Toner (Chair), Julie McDowell (Vice-Chair), Martin Hill, Danny Logue, John McGinty, Anne McMillan, Alison Meiklejohn (substitute).

Non-Voting Members – Ian Buchanan (Stakeholder Representative), Elaine Duncan (Professional Advisor), Jim Forrest (Director), Jane Houston (Staff Representative), Mairead Hughes (Professional Advisor), Pamela Main (substitute for Jane Kellock), Mary-Denise McKernan (Stakeholder Representative), Robin Strang (Stakeholder Representative), Patrick Welsh (Finance Officer)

Apologies – David Farquharson, Alex Joyce, James McCallum and Martin Murray

In Attendance – Marion Barton, Head of Health Services), Alan Bell (Senior Manager, Communities and Information, WLC), James Millar (Standards Officer).

1. DECLARATIONS OF INTEREST

Councillor Danny Logue declared an interest as an employee of NHS Lothian.

2. AUDIT COMMITTEE

The Committee considered a report (copies of which had been circulated) by the Director concerning the establishment of an Audit Committee to assist the Board in compliance with statutory duties and contribute to good governance arrangements for the Board and its committees.

The report recalled that, following a decision on 20 October 2015 that a report should be brought to a future meeting to establish an Audit Committee, the Board had considered the matter on 16 February 2016 when some matters could not be agreed.

The matters still to be agreed related to the remit and name for the proposed Audit Committee, the members of the committee, and the appointment of the Chair and Vice-Chair of the committee.

Appendix 1 to the report was the remit proposed to the Board at its February meeting, and some suggested additions were shown in bold type to make more explicit the committee's role in relation to risk and the wider field of corporate governance.

It was recommended that the Board :-

1. consider and approve the revised remit and change of name for the proposed Audit Committee, as set out in the appendix to the report.
2. agree the remaining members of the committee
3. appoint the chair and Vic-Chair of the committee

Decision

1. To note the terms of the report.
2. To approve the revised remit and change of name for the proposed Audit Committee, as set out in the appendix to the report.
3. To agree to appoint the following members to the Committee:-
 - Jane Houston and Martin Murray (non-voting members)
 - Martin Hill and Julie McDowell (voting members appointed by NHS Lothian)
 - Anne McMillan and Danny Logue (voting members appointed by West Lothian Council)
4. To agree that Julie McDowell be appointed as Chair of the Audit Risk and Governance Committee and that Anne McMillan be appointed as Vice Chair.

3. SCHEDULE OF MEETINGS 2016/17

The Board considered a report (copies of which had been circulated) by the Director outlining a proposed schedule of meetings for the IJB until June 2017.

It was noted that, under Standing Orders, the IJB was required to approve a timetable of ordinary meetings, which should be held at least six times in each financial year.

The Director explained that dates had been drafted after taking into account available date and time opportunities within NHS Lothian and West Lothian Council meeting calendars. The report provided a list of seven meeting dates. It was proposed that the IJB meetings continued to be held in Strathbrock Partnership Centre, Broxburn, as this building met requirements for accessibility, parking and meeting space.

During discussion, the Board noted concerns relating to the availability of NHS Lothian members and noted, in particular, that David Farquharson was not available on a Tuesday and that Martin Hall was not available on the last Tuesday of each month.

The Director undertook to convey the Board's comments to the Chair, NHS Lothian and to report back to the next meeting.

Decision

To agree to set dates for the next two meetings as undernoted:-

- 31 May 2016 at 2.00 pm
- 23 August 2016 at 2.00 pm.

4. STANDING ORDERS AND CODE OF CONDUCT

The Board considered a report (copies of which had been circulated) by the Director seeking approval to make changes to the Board's Standing Orders.

The Standing Orders adopted by the Board on 20 October 2015 were attached as Appendix 3, and the schedule of definitions and terminology had now been populated.

The report proposed one specific change to Standing Orders, and was an issue which had been flagged up on several occasions. The proposed change was shown in bold type in the copy of Standing Order 9.12 in Appendix 1. This related to members disclosing any direct or indirect pecuniary or other interest in relation to an item of business to be transacted at a meeting of the IJB.

Appendix 2 to the report was an extract of the Code of Conduct adopted by the Board, showing the changes proposed.

It was recommended that the Board:-

1. review the Board's Standing Orders (Appendix 3 to the report) and determine if any changes should be made.
2. approve the change to Standing Order 9.12 in relation to amended legislation affecting members declaring interests and withdrawing from meetings (Appendix 1 to the report).
3. approve the changes to paragraphs 5.6 and 5.7 of the interim Code of Conduct in relation to amended legislation affecting members declaring interests and withdrawing from meetings (Appendix 2 to the report).

Decision

1. To note the terms of the report.
2. To approve the change to Standing Order 9.12 as recommended by the IJB Standards Officer.
3. To approve the changes to paragraphs 5.6 and 5.7 of the interim Code of Conduct as recommended by the IJB Standards Officer.

5. TERMS OF REFERENCE FOR COMMISSIONING PLAN WORKING GROUPS

The Board considered a report (copies of which had been circulated) by the Director seeking approval of the Terms of Reference for Commissioning Plan Working Groups as detailed in Appendix 1 to the report.

Appendix 1 set out the remit of the Working Group and it was noted that the group would report to the Strategic Planning Group in accordance with the overall schedule for the delivery of the commissioning plan. The paper showing the overall schedule would be circulated to Board members following the meeting. Appendix 1 also set out proposed arrangements for membership of the group.

It was recommended that the Board agree the Terms of Reference for Commissioning Plan Working Groups as detailed in Appendix 1.

During discussion, officers provided advice concerning branding. On this matter, it was agreed that the use of West Lothian Health and Social Care Partnership logo (as shown in Appendix 1 to the report) was appropriate and should continue.

Decision

1. To note the Terms of Reference for Commissioning Plan Working Groups as detailed in Appendix 1 to the report.
2. To note advice by officers concerning branding and to agree that the use of West Lothian Health and Social Care Partnership logo (as shown in Appendix 1 to the report) was appropriate and should continue.
3. To note that a paper showing the overall schedule for the delivery of the commissioning plan would be circulated to Board members.

6. IJB MEMBER INDUCTION

The Board considered a report (copies of which had been circulated) by the Director setting out a proposal for further progressing induction for IJB members.

The report recalled that induction sessions had been held on 19th August 2015 which provided a broad overview of key themes. A further repeat session was held on 9th February 2016 which targeted and enabled new non-voting members and senior managers to participate in a briefing along similar lines. Appendix 1 to the report was an overview of the topics covered.

In addition to these sessions, it had previously been suggested that Board Members undertake a series of visits and to meet a range of teams in order to familiarise themselves with current service provision and

environments.

It was now proposed that the Board be given the opportunity to potentially undertake planned visits to some of the following areas:-

- Fauldhouse Partnership Centre
- Strathbrock Partnership Centre
- Eliburn Day Centre
- Craigmair or Colineshiel
- East Calder Health Centre
- Forrest Walk, Uphall

Appendix 2 to the report provided further details of the proposed visits.

It was also proposed that the Board consider a session where they could meet with Teams who would present an overview of the care they delivered, and suggested teams were:-

- REACT
- Crisis Care
- Reablement
- DASAT and
- ADP

Although specific dates had not been outlined, it was proposed that the visits and meeting of the Teams followed the themes and timing of areas to be covered at the Board.

The Board was asked to endorse the proposed approach and content of Board member induction as outlined in the report.

Decision

1. To endorse the proposed approach and content of Board member education as outlined in the report.
2. To agree that plans be developed for two visits, and that a paper would come back to the Board in due course.

7. WORKPLAN

A copy of the Workplan had been circulated for information.

Decision

To note the Workplan.

Board Meeting
22 June 2016

Chairman

SCHEDULE OF BOARD AND COMMITTEE MEETINGS FOR 2017

1 Purpose of the Report

- 1.1 The purpose of this report is to invite the Board to agree the dates for Board and Committee meetings in 2017 detailed in Appendix 1.

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

2 Recommendations

- 2.1 Agree the dates for Board and Committee meetings in 2017.

3 Discussion of Key Issues

- 3.1 The attached list of proposed Board and Committee dates includes deadlines for the submission of papers for consideration at the relevant meetings. For the convenience of Board members efforts have been made to minimise the clustering of meetings in any one week. Relevant Committee Chairs have been consulted on the proposed Committee dates. A calendar version of the dates is also attached as Appendix 2.

4 Key Risks

- 4.1 If meetings of the Board's Committees are not held in 2017 then the Board will fail to discharge some of its statutory responsibilities.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Resource Implications

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

Peter Reith
Secretariat Manager
23 May 2016
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: List of dates and deadlines for Board and Committee meetings in 2017
Appendix 2: Calendar version of dates for Board and Committee meetings in 2017

2017

BOARD AND COMMITTEE DATES AND DEADLINES

The dates of Board and Committee Meetings for 2017 are shown below together with the deadlines for submission of papers in digital format for formal business meetings.

LOTHIAN NHS BOARD

Board Meetings are normally held on the **first Wednesday of alternate months at 9:30 a.m.**

Board Meetings	Deadline for Papers	Development Days
1 February 2017	12 January 2017	11 January 2017
5 April 2017	15 March 2017	1 March 2017
21 June 2017*	31 May 2017	17 May 2017
2 August 2017	12 July 2017	19 July 2017
4 October 2017	13 September 2017	6 September 2017
6 December 2017	15 November 2017	1 November 2017

* Annual Accounts Meeting

FINANCE & RESOURCES COMMITTEE

Meets **six** times a year normally on the **second Wednesday of alternate months, at 9:00 a.m.**

Date of Meeting	Deadline for Papers - close of business on:
18 January 2017	9 January 2017
15 March 2017	6 March 2017
10 May 2017	28 April 2017
12 July 2017	3 July 2017
20 September 2017	11 September 2017
15 November 2017	6 November 2017

STAFF GOVERNANCE COMMITTEE

Meets **four** times a year normally on the **fourth or fifth Wednesday of the month at 9:30 a.m.**

Date of Meetings	Deadline for Papers - close of business on:
25 January 2017	16 January 2017
26 April 2017	17 April 2017
26 July 2017	17 July 2017
25 October 2017	16 October 2017

HEALTHCARE GOVERNANCE COMMITTEE

Meets **six** times a year normally on the **fourth Tuesday of every second month at 9:00 a.m.**

Date of Meeting	Deadline for Papers - close of business on:
31 January 2017	17 January 2017
28 March 2017	14 March 2017
23 May 2017	9 May 2017
25 July 2017	11 July 2017
26 September 2017	12 September 2017
28 November 2017	14 November 2017

AUDIT & RISK COMMITTEE

Meets **five** times a year normally on a **Monday** at **9:00 a.m.**

Date of Meetings	Deadline for Papers - close of business on:
27 February 2017	13 February 2017
24 April 2017	10 April 2017
21 June 2017*	14 June 2017
28 August 2017	14 August 2017
4 December 2017	20 November 2017

* *Annual Accounts Meeting*

REMUNERATION COMMITTEE

Meets **five** times a year normally on a **Tuesday** at **10:00 a.m.**

Date of Meetings	Deadline for Papers - close of business on:
21 February 2017	13 February 2017
11 April 2017	3 April 2017
18 July 2017	10 July 2017
17 October 2017	9 October 2017
12 December 2017	4 December 2017

STRATEGIC PLANNING COMMITTEE

Meets six times a year normally on the **second Thursday** of every **second month** from **9:30 a.m.**
- 12:00 p.m.

Date of Meetings	Deadline for Papers - close of business on:
9 February 2017	31 January 2017
13 April 2017	4 April 2017
8 June 2017	30 May 2017
10 August 2017	1 August 2017
12 October 2017	3 October 2017
14 December 2017	5 December 2017

ACUTE HOSPITALS COMMITTEE

Meets five times a year normally on a **Tuesday** at **2:00 p.m.**

Date of Meetings	Deadline for Papers - close of business on:
14 February 2017	6 February 2017
18 April 2017	10 April 2017
13 June 2017	5 June 2017
15 August 2017	7 August 2017
21 November 2017	13 November 2017

Board & Committee Meetings Calendar 2017

January							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
52							1
1	2	3	4	5	6	7	8
2	9	10	11	12	13	14	15
3	16	17	18	19	20	21	22
4	23	24	25	26	27	28	29
5	30	31					

February							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
5			1	2	3	4	5
6	6	7	8	9	10	11	12
7	13	14	15	16	17	18	19
8	20	21	22	23	24	25	26
9	27	28					

March							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
9			1	2	3	4	5
10	6	7	8	9	10	11	12
11	13	14	15	16	17	18	19
12	20	21	22	23	24	25	26
13	27	28	29	30	31		

April							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
13						1	2
14	3	4	5	6	7	8	9
15	10	11	12	13	14	15	16
16	17	18	19	20	21	22	23
17	24	25	26	27	28	29	30

May							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
18	1	2	3	4	5	6	7
19	8	9	10	11	12	13	14
20	15	16	17	18	19	20	21
21	22	23	24	25	26	27	28
22	29	30	31				

June							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
22				1	2	3	4
23	5	6	7	8	9	10	11
24	12	13	14	15	16	17	18
25	19	20	21	22	23	24	25
26	26	27	28	29	30		

July							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
26						1	2
27	3	4	5	6	7	8	9
28	10	11	12	13	14	15	16
29	17	18	19	20	21	22	23
30	24	25	26	27	28	29	30
31	31						

August							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
31		1	2	3	4	5	6
32	7	8	9	10	11	12	13
33	14	15	16	17	18	19	20
34	21	22	23	24	25	26	27
35	28	29	30	31			

September							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
35					1	2	3
36	4	5	6	7	8	9	10
37	11	12	13	14	15	16	17
38	18	19	20	21	22	23	24
39	25	26	27	28	29	30	

October							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
39							1
40	2	3	4	5	6	7	8
41	9	10	11	12	13	14	15
42	16	17	18	19	20	21	22
43	23	24	25	26	27	28	29
44	30	31					

November							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
44			1	2	3	4	5
45	6	7	8	9	10	11	12
46	13	14	15	16	17	18	19
47	20	21	22	23	24	25	26
48	27	28	29	30			

December							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
48					1	2	3
49	4	5	6	7	8	9	10
50	11	12	13	14	15	16	17
51	18	19	20	21	22	23	24
52	25	26	27	28	29	30	31

Public Holidays 2017

2 January	New Year's Day	17 April	Easter Monday	25 December	Christmas Day
3 January	New Year	1 May	May Day Holiday	26 December	Boxing Day
14 April	Good Friday	18 September	Autumn Holiday		

Board Meeting	Development Day	Finance & Resources	Audit & Risk	Acute Hospitals
Healthcare Gov	Staff Governance	Remuneration	Strategic Planning	Public Holidays

Board Meeting
22 June 2016

Chairman

COMMITTEE MEMBERSHIPS & TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the following appointments to Committees and amendments to the Terms of Reference of the Finance & Resources Committee.

- West Lothian Integration Joint Board - Lynsay Williams to replace Julie McDowell; Susan Goldsmith to replace David Farquharson; Martin Hill to be nominated as Vice Chair of the Integration Joint Board.
- Finance & Resources Committee - to confirm Peter Johnston as Vice Chair and member of the Committee.
- Healthcare Governance Committee - to confirm Richard Williams as Chair from 1 February 2016.
- Finance & Resources Committee - to amend the membership to “at least” seven Non-Executive Board Members.
- Acute Hospitals Committee - to delete “Royal Victoria Hospital” from the list of hospitals for which the Committee provides governance oversight of the clinical and non-clinical functions.

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

2 Recommendations

- 2.1 To appoint Lynsay Williams to West Lothian Integration Joint Board, replacing Julie McDowell.
- 2.2 To appoint Susan Goldsmith to West Lothian Integration Joint Board, replacing David Farquharson.
- 2.3 To nominate Martin Hill as Vice Chair of West Lothian Integration Joint Board.
- 2.4 To confirm Peter Johnston as Vice Chair of the Finance & Resources Committee and ex-officio member.
- 2.5 To confirm Richard Williams as Chair of the Healthcare Governance Committee from 1 February 2016.
- 2.6 To agree amended Terms of Reference for the Finance & Resources Committee (Appendix 1).
- 2.7 To agree amended Terms of Reference for the Acute Hospitals Committee (Appendix 2).

3 Key Risk

- 3.1 If appointments are not made to the West Lothian Integration Joint Board NHS Lothian may not be adequately represented.

4 Risk Register

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

5 Impact on Inequality, Including Health Inequalities

5.1 Not required as this is an administrative matter.

6 Involving People

6.1 The members and Committee Chairs involved have been consulted by the Chairman.

7 Resource Implications

7.1 There are no resource implications.

Peter Reith

Secretariat Manager

14 June 2016

peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Finance & Resources Committee Revised Terms of Reference

Appendix 2: Acute Hospitals Committee Revised Terms of Reference

FINANCE & RESOURCES COMMITTEE

Remit:

Financial Governance

- As part of the Board's system of risk management, to provide particular oversight to the risks associated with the Board's responsibilities for financial governance, including the delivery of the statutory financial targets.
- To review the development of the Board's Financial Strategy and recommend approval to the Board
- To undertake scrutiny of individual topics that from time to time have a material impact on the Board's financial performance
- To oversee the arrangements that are put in place by management to ensure that NHS Lothian remains financially a going concern over the long term, with due regard to changes in the Lothian population, the demand for healthcare services, and the trends in the Board's income and expenditure. Related to this, the Committee shall have oversight of the development of shared services and will have an interest in the wider integration agenda.
- To be assured that NHS Lothian has robust arrangements in place to deliver effective Procurement, and that associated policies and procedures are fully implemented.
- With regard to independent contractors (family health services), to provide oversight to the activities of the Primary Care Contracting Organisation. In the event of there being an ongoing dispute with a contractor, the Committee has delegated authority from the Board to determine the Board's position on the matter.

Property and Asset Management Strategy

- To ensure that the Property & Asset Management Strategy is aligned with the Clinical Strategy, and is:
 - supported by affordable and deliverable Business Cases;
 - supported by detailed Project Plans;
 - delivered within agreed timescales and resources to secure modern, well designed, patient-focussed services and facilities
- To ensure that the Board's Property and Asset Management Strategy is developed and supported and maintained and that it meets the strategic service plans needs;
- To ensure that the Board's property and asset base is effectively utilised in support of the clinical strategy
- To ensure that the property portfolio of NHS Lothian and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework;
- To ensure that all aspects of major property and land issues are dealt with in accordance with due process
- To ensure there is a robust approach to property rationalisation
- To oversee the management of risk associated with individual projects

Strategic/Capital Projects

- To review overall development of major schemes including capital investment business cases and consider the implications of time slippage and / or cost overrun. Instruct and review the outcome of the post project evaluation;
- To approve the appointment of consultants and contractors for Capital Schemes whose value exceeds £5m ;
- To receive and review reports on significant Capital Projects and the overall Capital Programme;
- To ensure appropriate governance in respect of risks associated with major Capital Projects;
- To receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), CEIs, audit reports and other Scottish Government Guidance

Whilst addressing the above three core elements of its remit, the Committee shall require assurance that relevant legal requirements are satisfied in the conduct of business. These requirements include:

- Equality Act 2010
- Climate Change (Scotland) Act 2009
- Public Services Reform Act 2010
- Public Contracts (Scotland) Regulations 2012
- NHS (Charges to Overseas Visitors) Regulations 2011 (as amended)
- Ancient Monuments and Archaeological Areas Act 1979

Membership:

The membership of the Committee shall consist of **at least** seven non-Executive Board members, made up of:-

- One appointed by the Board as the Chair of the Committee
- One appointed by the Board as the Vice-Chair of the Committee
- The Board member who is the stakeholder member nominated by the University of Edinburgh.
- The Board Chairman
- Three other non-Executive members appointed by the Board to the Committee.
- Chief Executive, NHS Lothian
- Director of Finance, NHS Lothian
- Medical Director, NHS Lothian
- Nurse Director, NHS Lothian

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

Frequency of Meetings:

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. In any event, meetings shall normally be held six times a year.

Quorum:

No business shall be transacted at a meeting of the Committee unless at least three non-executive Board members are present. Any Non-Executive Board member may deputise for another non-Executive member of the Committee at any meetings.

Reporting Arrangements:

The Committee will report to the Board by means of submission of minutes to the next available Board meeting.

The Committee will also produce an annual report on its activities, which can be used to:

- Provide the required assurance to the Audit & Risk Committee to support the review and preparation of the Governance Statement in the annual accounts, and;
- Support the Board's review of its own effectiveness, with regard to the effectiveness of the Finance & Resources Committee.

Approved 23 October 2013

ACUTE HOSPITALS COMMITTEE

Remit:

The Committee is to provide governance oversight of the clinical and non-clinical functions (required to make these hospitals operational and fit-for-purpose) that are provided within the following hospitals:

- Royal Infirmary of Edinburgh
- Western General Hospital
- Royal Victoria Hospital
- Liberton Hospital
- St John's Hospital
- Lauriston Building (excluding the Edinburgh Dental Institute, which is in the remit of the West Lothian Community Health and Care Partnership)
- Princess Alexandra Eye Pavilion
- Royal Hospital for Sick Children
- Any non-NHS facility that has been engaged to provide additional capacity for functions that would otherwise have been provided in one of the above hospitals.

Functions that are excluded from this Committee's remit are:

- Primary care contracting with independent contractors (GPs, dentists, ophthalmologists and pharmacists)
- Any other clinical or care function that is within the remit of the Community Health Partnership Sub-Committees or the West Lothian Community Health and Care Partnership Board (or their successor bodies)

The Committee shall discharge its remit by addressing the three elements of the Board's system of corporate governance; Assurance Needs, Performance Management and Risk Management, taking into account the need for an equitable approach to prevention, treatment and care.

- Assurance Needs (Internal Control and Quality)

The Committee's assurance needs should address the following key areas:

- The quality and safety of clinical services, and their contribution towards reducing harm.
- The Staff Governance Improvement Plans for the Royal Infirmary of Edinburgh, the Western General Hospital, and St John's Hospital.
- Efficient and effective use of resources.
- The processes to gather intelligence on patient experience and outcomes, and how these processes inform organisational learning and improvement.

The Committee shall develop a comprehensive list of the functions and services within its remit. The Committee shall then develop its Statement of Assurance Needs so as to satisfy the assurance needs of the Healthcare Governance Committee, Staff Governance Committee, Finance & Resources Committee, and the Audit & Risk Committee.

Once the Statement of Assurance Needs is developed, it shall be used to inform the following aspects of the Committee's work:

- Commission reports from management and other sources in order to arrive at an opinion on each assurance need.
- Where the Committee concludes that the assurance provided is less than "satisfactory", seek confirmation from management that the issue is on the appropriate risk register, and an action plan is in place.
- Seek assurance that all relevant Board policies, procedures, protocols etc are implemented as intended.
- Follow-up on any areas that require further management action.
- Report any areas of concern to other relevant Board Committees, or the Board itself.
- Performance Management (Outcomes)
 - Review regular reports on the delivery of relevant operational performance targets, corporate objectives, and outcomes, e.g. waiting times, unscheduled care performance, contribution to HEAT targets.
 - Review regular reports on patient and staff safety, quality of care, patient experience, and staff experience.
 - Review regular reports on the delivery on efficiency & productivity targets, and overall financial control.
 - Investigating areas where performance is less than what is required, and understanding the contribution of the hospital functions to that performance result.
 - Where the performance is off trajectory, seek confirmation from management that the issue is on the appropriate risk register, and an action plan is in place to get to the required level of performance on a sustainable basis.
 - Where the causes or solutions to an issue lies beyond the functions in the remit of this Committee, to refer the matter to the appropriate committee or the Board itself.
- Risk Management
 - Regularly review the relevant risk registers and develop a clear understanding of the risks.

- Seek assurance that there is a process to ensure that all existing and emerging risks are identified, properly assessed and scored, and recorded on the risk registers.
- Seek assurance that risk is being managed within the Board's Risk Appetite and Tolerances, and that the exposure to risk is reduced as a consequence of risk management activities.

Relationship to Other Groups/ Committees

In the interests of the Committee being informed of all matters pertinent to its remit and for these matters to be assessed holistically, the Committee shall routinely receive a summary from the chair of each of the following groups, highlighting the key issues from every meeting :

- University Hospital Services Clinical Management Group
- Scheduled Care senior management team
- Unscheduled Care senior management team and Unscheduled Care Board.
- Local Partnership Forum
- Health & Safety Committees within University Hospital Services sites
- University Hospitals Infection Control Committee
- Any other groups that the Committee thinks fit.

This will not disturb the established relationships between the above and the committees/ groups/ directors that they already report to. The above groups shall be providing a brief summary to the Acute Hospitals Committee in addition to where they normally report to.

A chart illustrating the relationships is at the end of these terms of reference.

The Committee may refer or highlight issues to other Board committees or groups or directors, so as not to duplicate governance activities. Similarly the chairs of other committees may refer issues to the Committee. .

Lothian NHS Board has a Strategic Planning Committee and an established process for the review and approval of capital business cases. The Committee will require directors to keep it apprised on any strategic or capital developments in Board strategy which may have a bearing on the Committee's remit.

Membership:

The Board will make all appointments with due regard to the current membership of CH(C)Ps sub-committees/ board, or any subsequent integration joint monitoring committee/ integration joint board that may be established in the future.

The Committee will consist of six non-executive Board members (one of whom shall be the Employee Director), the Medical Director and the Nurse Director. One of the

four non-executive Board members shall chair the Committee. All Board members shall have the right of attendance and have access to papers.

The following people shall routinely be invited to attend the meeting: Director of Unscheduled Care; Director of Scheduled Care; Director of Finance (or nominee); Director of Human Resources & Organisational Development (or nominee); Director of Strategic Planning, Performance Reporting and Information; Medical Director- University Hospital Services; Medical Director- Patient Safety and Quality Improvement; and Deputy Director of Nursing.

Joint Directors of Health and Social Care / Chairs of Health and Social Care Partnerships will be invited to attend as required to report on progress associated with delayed discharge, patient pathways, demand management etc.

Frequency of Meetings:

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. In any event, meetings shall normally be held six times a year, in advance of full Board meetings, to allow a report to be submitted to the following full Board meeting.

Quorum:

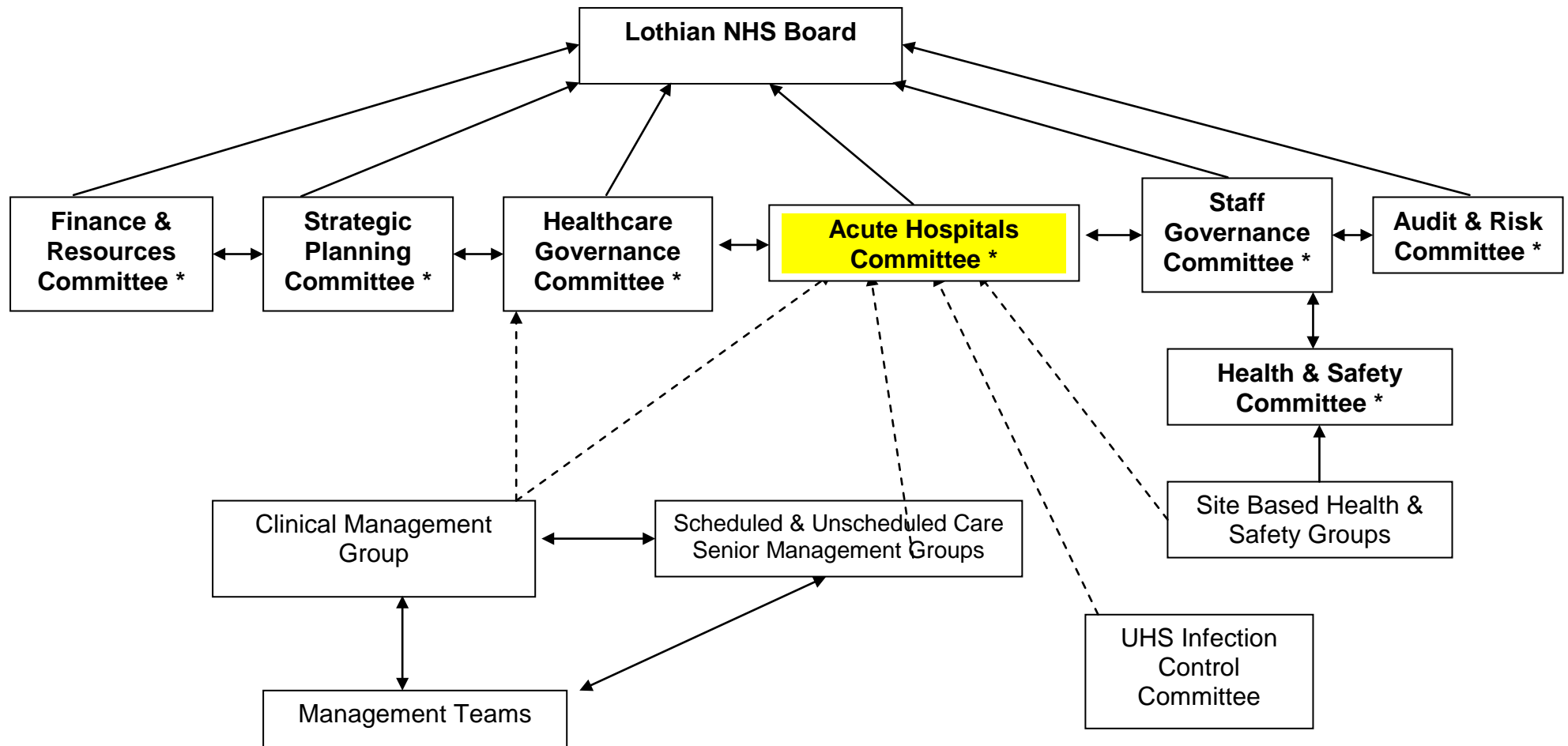
No business shall be transacted at a meeting of the Committee unless at least two non-executive members are present. Any non-executive Board member may deputise for a non-executive member of this Committee.

Reporting Arrangements:

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

The Committee shall also share the output from work on its Statement of Assurance Needs with other governance committees, so as to inform the conclusions of those committees on the NHS Lothian position on assurance needs.

NHS Lothian Acute Hospitals Committee Structure



Notes

1. * Governance Committees
2. Dotted lines/arrows – exchange a summary of key issues for information purposes
3. Solid lines/arrows – bodies directly communicate with each other to carry out their role
4. Board committees can request direction to respond to enquiries at any time

Approved 25 June 2014

NHS Lothian

Board Meeting
22 June 2016

Director of Finance

NHS Lothian Patients' Private Funds - Annual Accounts 2015/16

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 2016 for Lothian NHS Board be approved. These accounts were presented to the Audit and Risk Committee for recommendation on 20 June 2016. The Audit and Risk Committee agreed that the accounts were to be presented to the Board.

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

2 Recommendations

- 2.1 Agree the draft Patients' Private Funds accounts for the year-ended 31 March 2016.
- 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 2016.

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 the abstract of accounts which have been prepared on the basis required by the NHS Scotland Manual of Accounts, presents fairly the sate of the funds administered by the Board on behalf of its patients, as at 31 March 2016. Their full audit report on Patients' Private Funds is attached.

The report identifies no errors in their receipts and payments testing and made two recommendations through their site visits. The recommendation identified does 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 new additions to the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 There is no impact assessment needed for this report.

7 Involving People

7.1 Not applicable.

8 Resource Implications

8.1 There are no resource issues arising from this paper.

Susan Goldsmith

Director of Finance

15 June 2016

susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Patients' Private Funds Year Ended 31 March 2016

Appendix 2: Management Letter

LOTHIAN NHS BOARD



Patients' Private Funds Year Ended 31 March 2016

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 2015 to 31 March 2016 and in preparing the abstract of receipts and payments.

..... (Chairman)
Brian Houston

..... (Chief Executive)
Tim Davison

22 June 2016

NHS Lothian

SFR 19.0

PATIENTS PRIVATE FUNDS

FOR THE YEAR ENDED 31 MARCH 2016

2015 £		TOTAL £
	RECEIPTS	
	Opening Balances:	
25,275	Cash in Bank	50,500
16,775	Cash on Hand	16,775
1,221,967	Other Funds	979,923
<u>1,264,017</u>		<u>1,047,198</u>
1,443,162	From or on behalf of Patients	1,411,167
2,703	Interest on Patients' Fund Account	1,295
<u>2,709,882</u>	Total Receipts	<u>2,459,660</u>
	PAYMENTS	
1,662,684	To or on behalf of Patients	1,276,154
0	Extra Comforts etc.	0
	Closing Balances:	
50,500	Cash in Bank	25,000
16,775	Cash on Hand	16,775
979,923	Other Funds	1,141,731
<u>1,047,198</u>		<u>1,183,506</u>
<u>2,709,882</u>	Total Payments	<u>2,459,660</u>
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
1,047,285	Credit Balances	1,183,721
(87)	Less: Debit Balances	(215)
<u>1,047,198</u>		<u>1,183,506</u>
0	Interest Received but not Credited	0
<u>1,047,198</u>	Total Closing Balance	<u>1,183,506</u>

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 22 June 2016

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

Chief Executive

Date 22 June 2016

**NHS Lothian
Patients' Private Funds
Year ended 31 March 2016**

Notes to the Abstract of Receipts and Payments

Note 1

The Scottish Government Health and Social Care Directorate requires 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 2015-16 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 2016.

Scott-Moncrieff
Registered Auditors

Exchange Place 3
Semple Street
Edinburgh
EH3 8BL



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

24 May 2016

Our Ref: GD/MXL/RAG

Dear Sirs

**NHS Lothian – Patients' Private Funds
Management Letter for year ended 31 March 2016**

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 2016.

In the course of our audit of the abstract of receipts and payments of patients' private funds for the year ended 31 March 2016 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 £1,183,506 as at 31 March 2016.

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.

Exchange Place 3
Semple Street
Edinburgh EH3 8BL

T +44 (0)131 473 3500
F +44 (0)131 473 3535
dx ED 217

25 Bothwell Street
Glasgow
G2 6NL

T +44 (0)141 567 4500
F +44 (0) 141 567 4535
dx GW 209

10 Ardross Street
Inverness
IV3 5NS

T +44 (0)1463 701940
F +44 (0)1463 232205

Managing Partner: Stewart MacDonald
Partners: Nick Bennett, David Boyd,
Chris Brown, Mhairi Callander, Scott Craig,
Pamela Coyne, Gary Devlin, Gillian Donald,
Allison Gibson, Mike Harkness,
Bernadette Higgins, Robert Mackenzie,
Gareth Magee, Mark McRae,
Paul Renz, Marc Shenken,
Wemyss Stewart, Morag Watson.



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The Board of Directors

24 May 2016

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: Astley Ainslie (McCallam), Learning Disabilities (Primrose Lodge), Royal Edinburgh (Craiglea and Mireside), St John's (Maple Villa) and Ellens Glen (First).

The total of the patients' funds as at 31 March 2016 was £1,183,506 of which our testing was based at individual wards within areas holding £667,300 (56% of the total). We are pleased to report that we found no 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 two following recommendations to further improve controls:

Issues and recommendations:

1. Standard practice is that all completed cashbooks should be returned to the Patients' Funds Office at the end of each quarter. One ward we visited had not returned a completed cashbook to the Patients' Funds Office on a timely basis. The Board should ensure that all wards return completed cashbooks to the Patients' Funds Office in a timely manner.
2. Standard practice is that all patients' funds are separately identifiable. However, in one ward visited funds were not held on a patient by patient basis. The Board should ensure that all patients' funds held are separately identifiable.

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



Partner

NHS Lothian

Board Meeting
22 June 2016

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.

<ul style="list-style-type: none"> The purpose of this report is to inform the Board of the risks on the corporate risk register, and the current performance against its risk appetite and tolerances. Board members have provided feedback that they would prefer a different approach to reporting risk at the Board, as well as the need to improve the quality of papers generally. In light of this feedback this report presents high level information relating to risk management in a different way. There will be further developments and refinements to Board reporting, and feedback from the Board members is welcomed to inform that continuous process. The table within this report includes a cross-reference (and hyperlinks where the reports are available) to other relevant reports within the Board pack. 	<p>3.3-3.6, 2.1</p>
<ul style="list-style-type: none"> The report also includes a recommendation from the Audit & Risk Committee to revise the risk tolerance measure relating to the stroke bundle. This is being referred to the Board because within the Standing Orders, one of the matters reserved to the Board is: "The Board shall define its risk appetite and associated risk tolerance levels." 	<p>3.7-3.9, 2.2</p>

Alan Payne
 Corporate Governance Manager
 15 June 2016
alan.payne@nhslothian.scot.nhs.uk

NHS Lothian

Board Meeting
22 June 2016

Medical Director

NHS Lothian Corporate Risk Register

1 Purpose of the Report

- 1.1 The purpose of this report is to inform the Board of the risks on the corporate risk register, and the current performance against its risk appetite and tolerances.
- 1.2 The Board is also invited to review its risk tolerance measure relating to stroke. This is being referred to the Board because within the Standing Orders, one of the matters reserved to the Board is: "The Board shall define its risk appetite and associated risk tolerance levels."

Board members have provided feedback that they would prefer a different approach to reporting risk at the Board, as well as the need to improve the quality of papers generally. Table 1 presents the corporate risks and the associated performance against the risk tolerance levels in a different way. There will be further developments and refinements to Board reporting, and feedback from the Board members is welcomed to inform that continuous process.

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

2 Recommendations

- 2.1 Review the Corporate Risk Register and consider whether this revised presentation is helpful in improving the quality of reporting to the Board, and offer feedback to inform future developments.
- 2.2 Review the appropriateness of the current risk tolerance measure for stroke, and consider the recommendation of the Audit & Risk Committee to amend the Risk Appetite/Tolerance for stroke care from just one evidence-based measure of access to a stroke unit to total bundle compliance.

3 Discussion of Key Issues

Recent Reports to the Audit & Risk Committee

- 3.1 The Audit & Risk Committee received a report on risk management on 20 June 2016. This included a briefing on the risks on the corporate risk register, as well as the "very high" and "high risks" on the risks registers for University Hospitals and Support Services, Royal Edinburgh and Associated Hospitals, and the four health and social care partnerships. There was an update on the performance against the Board's risk appetite reporting framework. The report also provided an update on the progress made on the risk management improvement plan, which had been developed using the Audit Scotland Best Value Toolkit for risk management.
- 3.2 The Audit & Risk Committee also received the Risk Management Annual Report 2015-16. The annual report summarised the development work carried out during

2015-16. The annual report also highlighted the priorities for 2016-17 as being further development of management of adverse events, and embedding risk management at operational level. There is also a commitment to align reporting on risk appetite and tolerance with the Board's Quality & Performance Report. The Risk Management Annual Report has informed the drafting of the Governance Statement, which is part of the accountability report within the Board's annual accounts which have been presented to the Board today.

Corporate Risk Register

3.3 There are 13 risks in total (set out in Table 1), with one risk HAI being reduced from Very High (20) to High (16) since the last quarter.

3.4 The Board'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."*

Table 1

Risk Title	Jan-Mar 2016	Current Risk Tolerance Measures (if applicable)	Link to current performance in the Quality & Performance Improvement Report or other Board paper
The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	Very High 20	In the preceding month (May 2016), the monthly overspend against the total core budget for the month is not more than 0.5%	Please refer to the Financial Update as at 31 st May 2016 report.
		For the year to date (to 31 May 2016), the overspend against the total core budget for the year to date is not more than 0.1%	Please refer to the Financial Update as at 31 st May 2016 report.
Achieving the 4 hour emergency target (Set out in Performance Report)	Very High 20	98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%	Please refer to the Four Hour Unscheduled Care page within the Quality & Performance Improvement Report
Achieving the Delayed Discharge targets at 2 and 4 weeks	Very High 20	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	Please refer to the Delayed Discharge page within the Quality & Performance Improvement Report
		No patients will wait no more than 28 days to be discharged from hospital by April 2015 with an appetite of 28 days and a tolerance of 30 days	Please refer to the Delayed Discharge page within the Quality & Performance Improvement Report
General Practice Sustainability (new risk - October 2015)	Very High 20	No measure	No paper for this Board meeting

Risk Title	Jan-Mar 2016	Current Risk Tolerance Measures (if applicable)	Link to current performance in the Quality & Performance Improvement Report or other Board paper
Medical Workforce Sustainability	High 16	No measure	Please refer to the report on the Royal College of Paediatrics and Child Health Review of Medical Paediatric Inpatient Services in Lothian
Healthcare Associated Infection	High 16	<u>Staphylococcus aureus Bacteraemia</u> Achieve a rate of no higher than 0.24 per 1,000 bed days (no more than 184 incidences) with a tolerance of 95% against target. n=193 to 184	Please refer to Summary Position within the Quality & Performance Improvement Report
		<u>Clostridium difficile Infection</u> Achieve a rate of no higher than 0.32 per 1,000 bed days (aged 15+) (no more than 262 incidences) with a tolerance of 95% against target. n=275 to 262	Please refer to Summary Position within the Quality & Performance Improvement Report
Patient Safety - Delivery of four SPSP Work streams.	High 16	Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015	Please refer to Summary Position within the Quality & Performance Improvement Report
		Scotland target to reduce acute hospital mortality by 20% with a tolerance of 15-20% by Dec 2015	Please refer to Summary Position within the Quality & Performance Improvement Report
		Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015	No paper for this Board meeting. The performance level is taken from the Patient Safety Programme Annual Report (July 2015)
		90% of all stroke patients to be admitted to stroke unit on day of admission following a stroke with a tolerance of 85-90%	Please refer to the Stroke Bundle page within the Quality & Performance Improvement Report

Risk Title	Jan-Mar 2016	Current Risk Tolerance Measures (if applicable)	Link to current performance in the Quality & Performance Improvement Report or other Board paper
Achievement of National Waiting Times Targets	High 16	90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Please refer to the Referral to Treatment (18 weeks) page within the Quality & Performance Improvement Report
		95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%	Please refer to the Cancer (62 days) page within the Quality & Performance Improvement Report
Patient Experience - Management of Complaints and Feedback	High 16	Patients would rate out of 10 their care experience as 9.5, with a tolerance of 9	Please refer to the Patient Experience page within the Quality & Performance Improvement Report
Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015)	High 16	No measure	No paper for this Board meeting
Health & Safety - Management of Violence & Aggression. (Reported at H&S Committee, via Staff Governance Committee Minutes)	High 15	No measure	No paper for this Board meeting
Nursing Workforce – Safe Staffing Levels (new risk - October 2015)	High 12	No measure	No paper for this Board meeting
Roadway / Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee, via Staff Governance Committee Minutes)	High 12	No measure	No paper for this Board meeting

3.3 The risk appetite reporting framework currently contains performance on the following risk tolerance measures, but they do not directly correlate to risks that are on the corporate risk register. Nevertheless they are still pertinent to the Board's objectives and the risks being managed.

Current Risk Tolerance Measures	Link to current performance in the Quality & Performance Report or other Board paper
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).	Please refer to the Smoking Cessation (quits) page within the Quality & Performance Improvement Report
At least 80% of women in each SIMD percentile will be booked for antenatal care by 12 th week of gestation, with a 10% tolerance (69.3-77%)	Please refer to Summary Position within the Quality & Performance Improvement Report
Staff absence below 4% with a 5% tolerance (4-4.2%)	Please refer to the Staff Sickness Absence page within the Quality & Performance Improvement Report

- 3.4 The Risk Management Steering Group (RMSG) is currently examining the very high risks in detail to assess the risks both individually and across the number of very high risk.

Review of the Risk Tolerance Measure relating to Stroke

- 3.5 The Audit & Risk Committee in April 2016 agreed to make a recommendation to the Board to amend the Risk Appetite/Tolerance for stroke care from just one evidence-based measure of access to a stroke unit to total bundle compliance. The stroke bundle covers a number of evidence-based measures which seek to improve outcome and patient experience. The new measure would be an appetite of 80% compliance with the new Scottish Stroke Care Bundle with a tolerance of 75% from April 2016 to March 2017. This would reflect national reporting and alignment with the quality and performance reporting at the Board.

- 3.6 The Audit & Risk Committee agreed to the above recommendation after considering a stroke improvement plan relating to this particular risk tolerance measure.

- 3.7 The Audit & Risk Committee minutes captured the following:

“The Committee noted and commended the work to date however it could not take assurance until it had sight of the figures produced under the new target. It was agreed that a report on the new target would be brought back to the September meeting for consideration.”

“The Committee agreed to recommend to the Board a revised stroke appetite/tolerance measure from just stroke unit to total bundle compliance, with a bundle appetite of 80% and tolerance of 75% from April 2016 to March 2017.”

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 Inequality, including 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 Involving People

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

8 Resource Implications

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

Alan Payne

Corporate Governance Manager

15 June 2016

alan.payne@nhslothian.scot.nhs.uk

FINANCIAL POSITION TO 31 MAY 2016**1 Purpose of the Report**

- 1.1 The purpose of this report is to provide an update on the financial performance of NHS Lothian against the recently submitted LDP.
- 1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

- 2.1 Members are asked to accept the paper and note the following:
 - NHS Lothian has submitted the 2016/17 Local Delivery Plan (LDP) to the Scottish Government identifying the requirement to deliver a further £20.9m of savings / resources to achieve financial balance. A final update to the Plan shows a marginal reduction of this gap to £20.1m;
 - The financial position as at May 2016 is reporting a deficit of £4.4m;
 - Ongoing actions are being progressed to reduce the predicted financial deficit in order to achieve a year-end balanced position.

3 Discussion of Key Issues**2016/17 NHS Lothian Local Delivery Plan**

- 3.1 NHS Lothian has submitted its LDP for 2016/17 to the Scottish Government on 31 May showing that the Board requires to identify a further £20.9m of resources and/or savings in order to breakeven by 31 March 2017.
- 3.2 A subsequent update to the plan improved this position marginally to £20.1m. This represents a slight improvement from the previously reported position and the key movements recognise an increased level of financial recovery plans proposed, offset by a further deterioration in the forecast primary care prescribing position, based on estimated growth levels.
- 3.3 All areas of NHS Lothian are continuing to review services, staffing levels and ongoing areas of pressure in order to achieve financial sustainability, and this is acknowledged within the budget sign off process currently underway, where it is recognised that services require to remain within available budget in order to achieve a break even position by year-end.

- 3.4 The Board is not being asked to reconsider high risk schemes as insufficient assurance could be given at this stage that these would not impact on patient safety and quality.
- 3.5 This position is worse than expected when compared with the LDP's forecast expenditure for the year. Assuming no further benefit from financial recovery plans an overspend of circa £3.5m could have been expected.

Financial Position as at May 2016

- 3.6 After 2 months of the financial year, NHS Lothian is reporting a £4.43m overspend position against the Revenue Resource Limit. Pay expenditure, representing 61% of the year to date overspend, is the most significant driver of the month 2 position, as set out in Table 1. Nursing, medical and support service costs are the main driver of the pay overspend.

Table 1: Financial Position to 31st May 2016

	YTD Variance £000's
Pay	(2,696)
Non Pay (incl GP Pres)	(123)
Income	410
Efficiency Savings	(2,021)
YTD Total	(4,430)

- 3.7 In terms of nursing the table below presents a comparison of Nursing Expenditure, showing a reduction in the use of agency compared to last month and against the average for six months of last year. However, a similar overall level of supplementary staffing continues to be used. Permanent nursing is showing a small reduction on last year's costs (last year's costs being adjusted for pay inflation rates in order to compare).

Table 2: Nursing and Supplementary Staffing Analysis

	Uplifted Apr - Sept 15/16 Ave £000's	Apr 16 £000's	May 16 £000's
Agency Nursing	314	412	232
Bank Nursing	2,133	2,098	2,237
Total Supplementary	2,447	2,511	2,469
Permanent Nursing	30,810	30,701	30,607

- 3.8 There is a particular focus on nurse staffing expenditure this financial year, given the £5m pressure reported in 2015/16 and significant levels of supplementary and in particular, agency staffing, used. The Interim Director and Assistant Director of Nursing, accompanied by the Deputy Director of Finance have established monthly meetings with Chief Nurses to review key metrics with the intention of reducing overall nursing expenditure position to within budgeted levels whilst maintaining

and improving quality and safety. However sickness levels in May were higher than previous months.

- 3.9 The medical staffing overspend of £0.7m is driven for the most part from the continued pressure on junior medical staffing within acute services (£0.5m). This was a late cost pressure identified within the financial plan and as a consequence the initial work is focussing on what management action is required to address this. The level of overspend experienced after the first two months of the year reinforces the requirement for urgent management action.
- 3.10 Non pay costs overall, after two months, are largely in balance, reporting a small overspend of £123k.

Primary Care Prescribing

- 3.11 As there is no updated volume or price information available at present for 2016/17 (due to the two month time lag in receiving information), the variance (£0.8m) reported to May reflects the national phasing percentage (16.28%) of the estimated prescribing year-end outturn taking into account 2015/16 baseline pressures and 2016/17 expected growth. The current prescribing outturn is predicting a £5.4m overspend at year end and is part of the overall £20.1m gap in the financial plan.

Financial Recovery Plans

- 3.12 Within the 2016/17 Financial Plan, £30.4m of recovery plans have been identified as low and medium risk in terms of the ability of management to deliver against these plans. Schemes defined as high risk, either because of the financial risk associated with them or the potential impact on services, have been excluded from delivery estimates at this stage although there is a clear expectation that business units will continue to progress these schemes. Due to the complexity of some of the plans and absence of detail for others, the monitoring and reporting of achievement of the recovery actions is currently evolving but the impact of recovery plan delivery will be the subject of detailed analysis as part of the quarter one review and will be reported on monthly thereafter.
- 3.13 Incorporated within the overall position for 2016/17 are unmet efficiency savings carried forward from previous years totalling circa £13m. Services recognise the importance of eliminating these historical savings targets at an early stage as recovery actions release local flexibility. £2m of the £4.4m overspend reported for the year to date relates to carry forward efficiency targets yet to be removed and these will continue to be phased in on a monthly basis as part of the overall position.

Other Actions to Achieve Financial Sustainability

- 3.14 There are a number of additional financial recovery initiatives underway across NHS Lothian with the aim of reducing expenditure in order to achieve financial balance for 2016/17. As highlighted above, the 2016/17 financial plan has a £20.1m deficit against available resources and there is a requirement to continue to review opportunities to reduce this gap during the year in order to give certainty that a break even position for 2016/17 is achievable.

- 3.15 The NHS Lothian Clinical Quality Approach is in its early stages; however, NHS Lothian has committed resources and manpower to progress this new methodology. Already there are a significant number of Quality initiatives in various stages of development which are expected to have a subsequent financial benefit.
- 3.16 NHS Lothian is currently undertaking an external review of primary care prescribing with support from colleagues across the health board to review further opportunities to reduce the overall level of growth and maximise savings opportunities.
- 3.17 The Quarter 1 review will provide an opportunity to give early consideration to the anticipated year-end position, and progress from services in terms of financial recovery plans and achievement of a balanced position. Quarterly meetings have been established led by the Director of Finance to allow regular dialogue on progress across business units in delivering a balanced outturn position across Lothian. Any variation from plans will be discussed, with actions identified to support the achievement of a balanced Lothian position by the year-end. Some of these actions may require further discussion with the Board prior to approval.
- 3.18 NHS Lothian has been in regular dialogue with the SGHSCD around our financial position and this will continue, recognising the financial risk to breakeven.

4 Key Risks

- 4.1 At this stage, elements of assumed funding in the Financial Plan are still to be confirmed, for example proposed reductions to values in Bundles and ADP funding have still to be formally notified to the health board in full, and assumptions have necessarily been made around operational budgets prior to confirmation.
- 4.2 A risk schedule was prepared within the financial plan paper to the Board on the 6th of April, and this will be reviewed as part of the Quarter 1 forecast.
- 4.3 The Board paper on the corporate risk register identifies two key measures within risk appetite for Finance relating to tolerance levels around the level of overspend. At this stage, both of these tolerance measures have been breached.

5 Risk Register

- 5.1 There is nothing further to add to the Risk Register at this stage, although this will be reassessed as part of the Q1 review. Board members should however note that the Risk appetite for Finance is currently being breached.

6 Health and Other Inequalities

- 6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Involving People

- 7.1 The implementation of the financial plan and the delivery of a breakeven outturn will 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.

Susan Goldsmith

Director of Finance

15 June 2016

susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Income & Expenditure Summary 31 May 2016

Appendix 2: NHS Lothian Summary by Operational Unit to 31 May 2016

NHS Lothian Income & Expenditure Summary to May 2016

Description	Annual			YTD
	Budget	YTD Budget	YTD Actuals	Variance
	(£k)	(£k)	(£k)	(£k)
Medical & Dental	232,296	39,859	40,575	(716)
Nursing	384,544	65,075	66,612	(1,537)
Administrative Services	86,247	14,109	14,022	87
Allied Health Professionals	60,694	10,129	10,287	(157)
Health Science Services	37,129	6,109	6,023	87
Management	9,616	1,623	1,432	191
Support Services	51,781	8,532	9,094	(561)
Medical & Dental Support	7,613	1,262	1,399	(136)
Other Therapeutic	24,529	4,365	4,271	94
Personal & Social Care	2,430	428	469	(41)
Other Pay	(1,879)	(261)	(256)	(5)
Emergency Services	10	7	7	0
Pay	895,011	151,238	153,933	(2,696)
Drugs	123,720	19,852	19,618	234
Medical Supplies	84,736	14,977	14,924	54
Maintenance Costs	5,667	921	1,125	(204)
Property Costs	39,878	6,683	6,092	591
Equipment Costs	24,946	4,458	5,111	(653)
Transport Costs	9,582	1,646	1,589	57
Administration Costs	126,369	13,847	13,634	213
Ancillary Costs	11,648	1,958	1,973	(15)
Other	21,411	(1,737)	(2,181)	444
Service Agreement Patient Serv	96,731	18,260	18,421	(161)
Non-Pay	544,687	80,864	80,305	559
Gms2 Expenditure	110,144	17,225	17,187	38
Ncl Expenditure	3	0	0	0
Other Primary Care Expenditure	87	15	20	(5)
Pharmaceuticals	147,486	24,580	25,252	(672)
Primary Care	257,719	41,820	42,458	(638)
Other Non-Pay	(1,338)	(218)	(174)	(44)
Income	(1,720,195)	(44,795)	(45,204)	410
Capital Charges	0	0	0	0
Revenue Resource Limit	(31)	0	(1)	1
Extraordinary Items	0	0	0	0
Savings Target Non-Pay	(13,893)	(2,021)	0	(2,021)
TOTAL	(38,039)	226,888	231,318	(4,430)

NB. The above table relates to Core Services only. There is £38.039 m of Non Core Budget not shown above that balances the annual budget to zero.

NHS Lothian Summary by Operational Unit to March 2016

Description	University Hosp Support Serv (£k)	Edinburgh Partnership (£k)	East Lothian 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)	Total (£k)
Annual Budget	666,086	341,928	80,544	56,305	123,277	151,791	88,607	2,563	(1,576,962)	27,823	(38,039)
Medical & Dental	(267)	(79)	(116)	10	(196)	(1)	41	(109)	0	0	(716)
Nursing	(1,086)	(443)	8	37	(38)	(8)	9	(16)	0	0	(1,537)
Administrative Services	149	(31)	(24)	(0)	(13)	(19)	44	(18)	0	0	87
Allied Health Professionals	(263)	57	18	11	43	(2)	(19)	(1)	0	0	(157)
Health Science Services	34	57	2	0	31	0	(37)	(0)	0	0	87
Management	(6)	86	14	(0)	1	7	86	2	0	0	191
Support Services	(50)	8	(7)	0	(13)	(481)	(18)	(1)	0	0	(561)
Medical & Dental Support	(115)	0	0	0	(20)	(0)	(2)	0	0	0	(136)
Other Therapeutic	15	33	2	(8)	10	(2)	44	(0)	0	0	94
Personal & Social Care	(10)	(17)	(2)	0	0	(0)	(11)	0	0	0	(41)
Other Pay	20	0	0	0	0	(25)	(0)	0	0	0	(5)
Emergency Services	0	0	0	0	1	(0)	0	0	0	0	0
Pay	(1,579)	(328)	(105)	50	(195)	(532)	137	(143)	0	0	(2,696)
Drugs	352	18	(34)	(23)	(12)	(1)	(29)	(37)	0	0	234
Medical Supplies	67	(44)	(29)	(6)	(8)	100	(26)	(0)	0	0	54
Maintenance Costs	(40)	(37)	(12)	(0)	(5)	(101)	(8)	(1)	0	0	(204)
Property Costs	(55)	68	(29)	(4)	35	559	18	(0)	0	0	591
Equipment Costs	(307)	(35)	(27)	(3)	21	(87)	(213)	(1)	0	0	(653)
Transport Costs	23	21	3	15	12	20	(22)	1	(14)	0	57
Administration Costs	14	(113)	66	(3)	165	(66)	15	82	53	0	213
Ancillary Costs	35	(22)	(4)	2	9	(33)	(2)	(2)	0	0	(15)
Other	8	35	153	0	(62)	80	231	0	0	0	444
Service Agreement Patient Serv	17	(7)	(3)	(15)	77	134	(120)	498	(743)	0	(161)
Non-Pay	115	(116)	83	(37)	231	604	(156)	540	(705)	0	559
Gms2 Expenditure	(0)	45	(76)	(7)	78	(0)	(2)	0	0	0	38
Ncl Expenditure	0	0	0	0	0	0	0	0	0	0	0
Other Primary Care Expenditure	(5)	0	0	0	0	0	0	0	0	0	(5)
Pharmaceuticals	(1)	(173)	(22)	(204)	(273)	0	0	0	0	0	(672)
Primary Care	(6)	(128)	(97)	(211)	(194)	(0)	(2)	0	0	0	(638)
Other	0	(3)	0	0	(42)	0	1	0	0	0	(44)
Income	411	(57)	(6)	2	13	56	(43)	32	2	0	410
Capital Charges	0	0	0	0	0	0	0	0	0	0	0
Revenue Resource Limit	0	0	0	0	0	0	1	0	0	0	1
Extraordinary Items	0	0	0	0	0	0	0	0	0	0	0
Savings Target Non-Pay	(1,360)	(550)	57	33	143	(87)	(194)	(63)	0	0	(2,021)
TOTAL	(2,419)	(1,183)	(68)	(164)	(44)	41	(255)	366	(703)	0	(4,430)

NB. The above table relates to Core Services only. There is £38.039 m of Non Core Budget not shown above that balances the annual budget to zero

NHS Lothian

Board Meeting
22 June 2016

Interim Nurse Director

SUMMARY PAPER - QUALITY AND PERFORMANCE IMPROVEMENT

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

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

Key Points	Paragraph
Overall of the 35 assessed, 11 standards were met, while 24 were not.	Table 1 , Page 4
That conversations with the Board Committee structure, particularly Healthcare Governance, have continued to reflect upon the alignment of metrics to committees proposed previously for assurance. As those discussions are yet to conclude, a full set of proformas are provided for those measures where expectations have not been met.	3.2
Data continuity issues need to be taken into account when considering April's reported position for outpatient and diagnostic waits. The Acute Hospitals Committee has been briefed on these areas.	3.4

Katy Dimmock
Analytical Services
17 June 2016

katy.dimmock@nhslothian.scot.nhs.uk

Andrew Jackson
Analytical Services

andrew.c.jackson@nhslothian.scot.nhs.uk

NHS Lothian

Board Meeting
22 June 2016

Interim Nurse Director

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 measures.
- 1.2 Any member wishing additional information on a particular measure should contact the lead director, identified in section 4 of the paper, for that performance information in advance of the meeting. Matters relating to the monitoring and assurance changes proposed should be directed towards the Interim Nurse Director.

2 Recommendations;

- 2.1 The Board is invited to accept this report as assurance that performance on 11 measures, including those relating to the Hospital Scorecard, are currently met.
- 2.2 The Board to consider whether the exceptions proformas (in Section 4) for the measures currently not met provide assurance that the reasons for the current performance are understood, and that a satisfactory action plan is in place.

3 Process and Recent Performance

- 3.1 This paper draws together those measures historically featuring in the Quality Report with those from the Performance Reporting paper in line with the process agreed by the Board in December 2015. Where a standard 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 In April 2016, the Board received proposals outlining the alignment of metrics to its committees for the purposes of assurance. These proposals have been subject to further reflection within the committees, particularly at Healthcare Governance. These arrangements are currently being finalised. In the interim the Board itself will continue to receive the individual proforma for areas where expectations are not met until approved by the Board.
- 3.3 Each standard is assessed as to whether it meets the target, and if not, trend in recent performance is considered. NHS Lothian's comparative position against overall Scottish performance is also set out. Positive assessments are graded green, those which are not red. [Table 1](#) sets out compliance - whether the target is met, recent trend and comparative position, and allows assessment of variation from standards. Those targets not met are covered in further detail in section 4. Of

those considered, 11 were met whilst 24 were not. Assessment will not be possible for the Dementia standard until further national work is concluded.

- 3.4 Members should note two issues affecting continuity in reported measures. Firstly, a review of tests to be included when assessing performance against the diagnostic standard has led to those patients waiting for cardiac MRI to be incorporated into the return. This has resulted in an apparent rise in long waits for the examination. Secondly, software problems at the Edinburgh Dental Institute, which uses a stand alone system for patient administration, has led to the exclusion of waits from that location when assessed the overall waiting time position for April. The issue also impacted on the figure reported for March, increasing the number of patients reported over 12 weeks by approximately 100. The Acute Hospital Committee has been briefed on both of these issues and actions.
- 3.5 As during April standards were met for both HAI measures, no proformas are included in this report. However notification had just been received at the time of writing that HAI performance has fallen short of the desired level in May. It was not possible to incorporate a proforma to reflect this change in status in the timescales available, although [Table 1](#) has been updated appropriately. The Scottish Government Reporting Template relating to this standard is attached as an appendix for members' consideration.

Table 1: Summary of Performance Position

Measure ¹	Type ²	Status ³	Trend ⁴	Published Status vs. National Position ⁵	Target/Standard	Current	Current Reporting Date	Data Updated since Last Cycle ⁶	Proforma Narrative Updated Since Last Cycle ⁷	Lead Director
Safe										
Cardiac Arrest	Quality	Not Met	N/A	Not Applicable	0.95 per 1,000 discharges (median)	1.58 (median)	Apr 2016	*	✓	DF
Falls With Harm	Quality	Met		Not Applicable	0.24 per 1,000 occupied bed days (median)	0.22 (median)	May 2016	✓	Not Applicable	DF
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)	LDP	Not Met ⁸	↓	Worse	0.32 (max) (<262)	0.38 (53)	12 th June 2016	✓	Not Applicable	DF
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)	LDP	Not Met ⁸	↓	Better	0.24 (max) (<184)	0.26 (35)	12 th June 2016	✓	Not Applicable	DF
Hospital Standardised Mortality Ratios (HSMR) (20% reduction)	Quality	Met		Better	All sites within HS Limits & <=1	RIE – 0.73; SJH – 0.79; WGH – 0.65	Dec 2015	*	Not Applicable	DF
Timely										
Four hour Unscheduled Care (% seen)	LDP	Not Met	↑	Worse	95% (min)	93.3%	May 2016	✓	✓	JC
48 Hour GP Access – access to healthcare prof	LDP	Not Met	↓	Worse	90% (min)	85%	Mar 2016	✓	*	DS
48 Hour GP Access – GP appt	LDP	Not Met	↓	Worse	90% (min)	75%	Mar 2016	✓	*	DS
Alcohol Brief Interventions (ABIs)	LDP	Met		Better	9,757 (Annual)	28,972	Mar 2016	*	Not Applicable	AMcM
CAMHS ¹⁰ (18 Weeks)	LDP	Not Met	↓	Worse	90% (min)	60%	Apr 2016	*	✓	AMcM
Cancer (31-day) (% treated)	LDP	Not Met	↓	Better	95% (min)	93.6%	Apr 2016	*	✓	JC
Cancer (62-day) (% treated)	LDP	Not Met	↓	Better	95% (min)	89.0%	Apr 2016	*	✓	JC
Diagnostics (6 weeks) - Gastroenterology/ Urology Diagnostics									✓	
Diagnostics (6 weeks) - Radiology		Not Met	↓	Worse	0 (max)	1,513	Apr 2016	*	✓	JC
Diagnostics (6 weeks) - Vascular Labs									✓	
Drug & Alcohol Waiting Times (3 weeks)	LDP	Not Met	↓	Worse	90% (min)	79.6%	Dec 2015	*	✓	AMcM
IPDC Treatment Time Guarantee (12 weeks)	LDP	Not Met	↓	Better	0 (max)	404	Apr 2016	*	✓	JC
IVF (12 months)	LDP	Met		Equal	90% (min)	100%	Apr 2016	*	Not Applicable	JC
Outpatients (12 weeks)	LDP	Not Met	↑	Worse	95% (min)	85% (7,912)	Apr 2016	*	✓	JC
Psychological Therapies (18 Weeks)	LDP	Not Met	↑	Worse	90% (min)	72%	Apr 2016	*	✓	JF
Referral to Treatment (18 Weeks)	LDP	Not Met	↑	Worse	90% (min)	83%	Apr 2016	*	✓	JC
Stroke Bundle (% receiving)	Quality	Not Met	↓	Not Applicable	80% (min)	56.3%	Apr 2016	✓	✓	JC
Surveillance Endoscopy (past due date)		Not Met	↓	Not Applicable	0 (max)	2,715	Apr 2016	*	✓	JC
Effective										
Delayed Discharges (over 2 weeks) – East Lothian IJB									✓	DS
Delayed Discharges (over 2 weeks) – Edinburgh IJB									✓	RMG
Delayed Discharges (over 2 weeks) – Midlothian IJB		Not Met	↓	Better	0 (max)	60	May 2016	*	✓	EM
Delayed Discharges (over 2 weeks) – West Lothian IJB									✓	JF
Efficient										
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days	Quality	Met		Not Applicable		RIE – 32.5; SJH – 21.4; WGH – 21.9; NHS L – 25.4	Sep 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days	Quality	Met		Not Applicable		RIE – 59.7; SJH – 30.2; WGH – 47.7; NHS L – 45.4	Sep 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Standardised Medical Readmission rate within 7 days	Quality	Met		Not Applicable		RIE – 50.0; SJH – 55.7; WGH – 60.4; NHS L – 51.5	Sep 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Standardised Medical Readmission rate within 28 days	Quality	Met		Not Applicable		RIE – 119.8; SJH – 128.2; WGH – 116.1; NHS L – 115.2	Sep 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Average Surgical Length of Stay - Adjusted	Quality	Met		Not Applicable		RIE – 0.89; SJH – 0.83; WGH – 1.14; NHS L – 0.9	Sep 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Average Medical Length of Stay - Adjusted	Quality	Met		Not Applicable		RIE – 0.89; SJH – 1.4; WGH – 1.3; NHS L – 1.2	Sep 2015	Not Applicable	Not Applicable	DF
Staff Sickness Absence Levels (<=4%)	LDP	Not Met	↑	Better	4% (max)	4.57%	Apr 2016	✓	*	AB
Equitable										
Early Access to Antenatal Care (% booked)	LDP	Met		Better	80% (min), for each SIMD quintile ¹¹	Lowest SIMD is 5 – 90.8%	Mar 2016	✓	Not Applicable	AMcM
Smoking Cessation (quits)	LDP	Not Met	↑	Better	293 (min)	282	Dec 2015 – Feb 2016	✓	✓	AKM
Person Centred										
Complaints (Three-Day)	Quality	Not Met	↑	Worse	100%	82%	Mar 2016	*	*	AMcM
Complaints (20-Day)	Quality	Not Met	↑	Worse	80%	52%	Mar 2016	*	*	AMcM
Detecting Cancer Early (% diagnosed)	LDP	Not Met	↑	Better	29% (min)	26.2%	2013 & 2014	*	*	AKM
Dementia	LDP	TBC ¹²	N/A	Not Applicable	100% (1 Year (Min))	5.3	Apr 2016	✓	✓	JC
Patient Experience (9.5/10 – Overall Experience)	Quality	Not Met	↓	Not Applicable	9.5/10	8.72	Apr 2016	✓	✓	AMcM

¹ Much of this reporting uses management information and is therefore subject to change

² LDPS – Local Delivery Plan Standard.

³ **Status** – describes where Current meets or does not meet Target.

⁴ **Trend** - '↑', '↓', '-' - describes Improvement or Deterioration for Current, where Status is 'Not Met', against an average of the last two relevant reported data points. 'N/A' indicates Trend is not applicable for this measure. Black shading indicates that Trend is applicable but that status is 'Met'.

⁵ **Published Status vs. National Position** – describes most recent published Lothian position against the most recent (directly comparable) published national position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Current.

⁶ **Update** – Current performance figure, Status, Trend and Published Status updated, where applicable, since last reporting cycle. Updates on comparative performance following publication not indicated.

⁷ **Update** – Current performance figure, Status, Trend and Published Status updated, where applicable, since last reporting cycle. Updates on comparative performance following publication not indicated.

⁸ CDI is 'Not Met' for this reporting Cycle but due to late availability of data an exceptions proforma has not been able to be sourced

⁹ SAB is 'Not Met' for this reporting Cycle but due to late availability of data an exceptions proforma has not been able to be sourced

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>

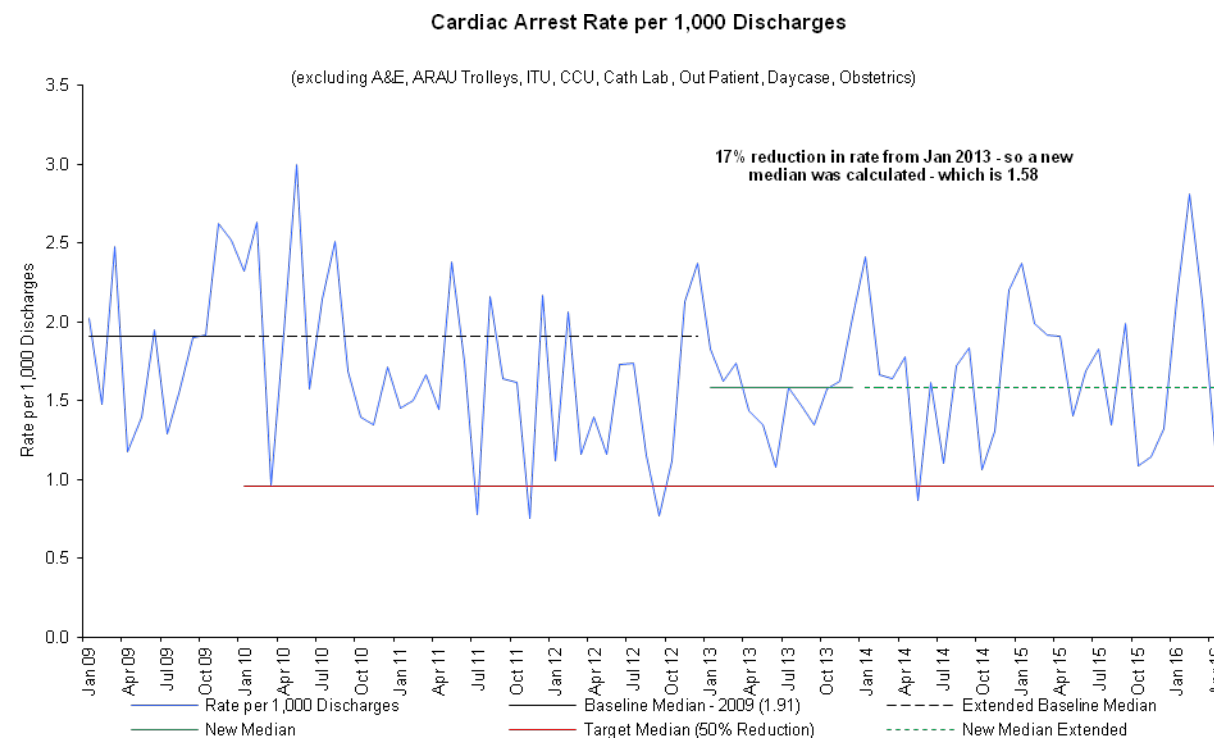
¹² The data published by ISD on the dementia standard reports the rate of referral for post diagnostic support based on 100,000 per population. We are currently awaiting confirmation from ISD regarding what the expected rate would be in order to evaluate performance against the standard. Please also see [Exception Proforma](#)

4 Exceptions Proformas (for Performance Areas where Status is 'Not Met', or 'TBC')

Cardiac Arrest									
Healthcare Quality Domain: Safe									
Target/Standard:									
<ul style="list-style-type: none"> 50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2015 from February 2013 (1.9 per 1,000), baseline. 									
Responsible Director[s]: Executive Director: Medical Director									
Performance:-									
Status	Trend		Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met		N/A	Not Applicable	0.95 per 1,000 (median)	1.58 per 1,000 (median) ¹³	Apr 2016	No	Yes	DF
Summary for Committee to note or agree									
<ul style="list-style-type: none"> NHS Lothian have achieved a 17% reduction and the median is 1.58 which is below the Scottish median of 1.61 and across Scotland the reduction has been 17%. 									

Recent Performance – 17% against Standard

Figure 1: NHS Lothian Cardiac Arrest Rates



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.
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.	Rolled out April/May 2016 as part of NEWS implementation for acute sites. Monthly monitoring and reporting to the service.
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.	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.	Not yet implemented, actual benefit would be a reduction in cardiac arrest rate	Rolled out April/May 2016 for Acute sites. Planning rollout in inpatient sites in Primary Care.
Implementation of sepsis screening and management using NEWS, sepsis boxes, education, training and simulation.	June 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	Rollout of NEWS acute sites and educational support in place.
In NHS Lothian pilot areas >80% of patients have advanced conditions and are at risk of deterioration and dying & 51% of cohort died within 12 months. Development of anticipatory care planning with patients and families nearing the end of their lives to discuss potential future deterioration & facilitate shared decision making with reliable documentation. This is informed by policy context and baseline data including cardiac arrest reviews which demonstrate need for 'upstream' engagement with patients & families. Prototyping of a structured review and testing implementation is taking place. Evolving themes include the need for concurrent MDT communication skills education & patient/carer engagement in the testing & implementation.	Prototyping phase with September 2016	<ul style="list-style-type: none"> Avoidance of cardiopulmonary resuscitation for patients who either do not want or will not have a good outcome to CPR; Person centred decision making and optimal engagement with patients and families with effective communication of these decisions; Clear communication of plan for deterioration to facilitate a bespoke Structured Response in the event of deterioration; Timely transition to end of life care; Support appropriate identification of patients with anticipatory care planning needs; Closely linked with Deteriorating patient work-stream and the development of the Structured Response Tool. 	Data from small tests in 8 MoE/Stroke wards (c.200 patients) demonstrate sustained improvement in documented discussions with patients & their families regarding future wishes & plan for further deterioration. (>80% of patients have documented AnCP/future wishes discussion). In test areas data demonstrates improved access to Key Information Summary on admission & improved AnCP information within discharge documentation.	Prototyping testing with input from AnCP forum including expert palliative care, primary & secondary care input. Next steps include MDT communication skills workshops and test of structured review tool within MAU & an oncology ward. December 2016
Exploring electronic observation systems including electronic track & trigger.	Dec 2016	NHS Fife have 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	Bought hardware, e.g. monitors. Exploring how it interfaces with TRAK to provide timely data to the service.
Comments				
Reasons for Current Performance				
The Cardiac Arrest rate for the three major acute hospitals is low, and below the Scottish rate. All three sites are approximately the same rate and do not give cause for concern. The HIS 50% reduction from our low baseline rate by December 2015 was ambitious and we now predict that our cardiac arrest rate could be reduced by a further 10% by 2020. In order for us to achieve this, identification and management of deterioration and greater numbers of earlier anticipatory care plans and DNACPR will need to be in place reliably in the above plans across all three acute sites.				

4-Hour Unscheduled Care

Healthcare Quality Domain: Timely

Target/Standard: 95% of patients are to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. NHS Boards are to work towards 98%.

Responsible Director[s]: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Worse	95% (min)	93.3%	May 2016	Yes	Yes	JC

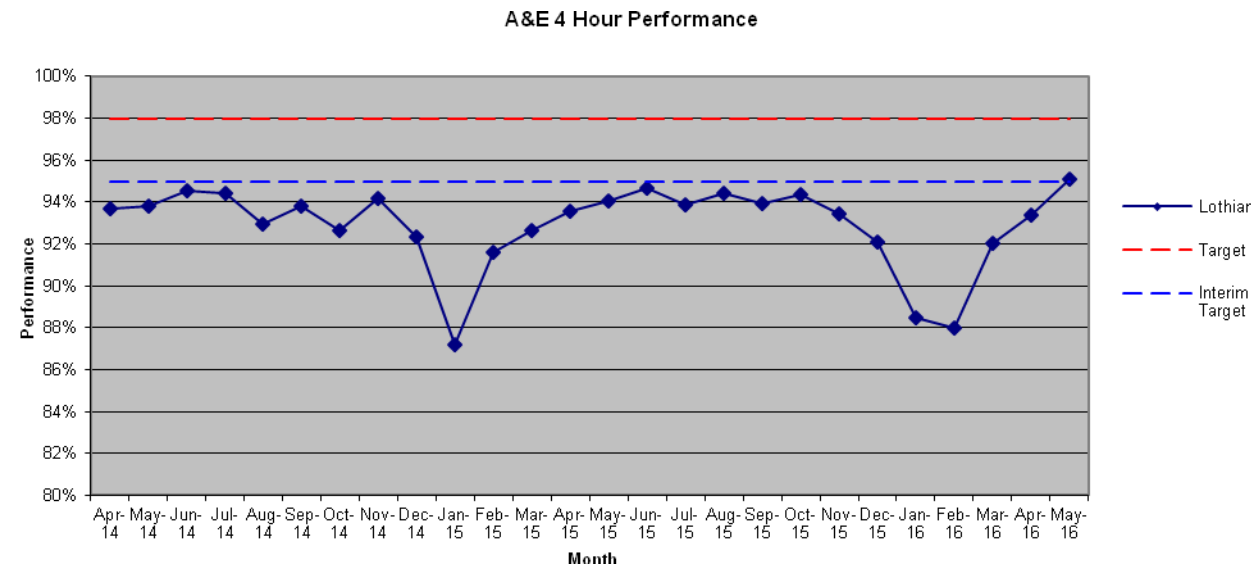
Summary for Committee to note or agree

Focus on recruitment of unscheduled care Improvement Managers to progress 6 essential actions.

Edinburgh locality model continues to evolve; focusing on admission avoidance and ensuring timely discharge from hospital.

Recent Performance – Numbers over 4 hour standard

Figure 1: Trend in A&E Performance



Timescale for Improvement				
Various actions for improvement with timescales outlined in table below.				
Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
Deliver on Lothian's winter plan that includes protecting first two weeks of January for 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 will help promote primary care services and move away from hospital admission being considered as the 'default' position	<ul style="list-style-type: none"> • Winter Plan approved October 2015. • Winter debrief held on 18th May 2016. • Winter de-brief workshop with IJB Directors planned for 6th July 2016 	Improved patient flow and improved 4-hour performance	NHS Lothian 4-hour performance for January – March 2016 was 89.49%	First planning event for winter 2016 due in July.
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.	<ul style="list-style-type: none"> • September 2016 	Improved 4-hour performance.	April '15 to March '16 - 4-hour performance was 92.75% compared with 92.81% for same period during 2014/15.	Service improvement manager for each 3 sites improvement plans under development
Implement recommendations from the Deloitte report around Frailty pathways and Length of Stay.	<ul style="list-style-type: none"> • June 2016 (Project Board and sub groups established). 	Improved admission avoidance and discharge. Improved 4-hour performance.	Programme Board currently scoping planned benefit.	On target – recruitment to project team underway.
Implement SEFAL work stream shifting discharge curve to earlier in the day and avoiding more unnecessary admissions.	<ul style="list-style-type: none"> • September 2016 	Improved 4-hour performance		On target
Comments				
Reasons for Current Performance				
Focus on recruitment of unscheduled care Improvement Managers to progress 6 essential actions.				
Each site is currently developing improvement plans for the year.				
Edinburgh locality model continues to evolve; focusing on admission avoidance and ensuring timely discharge from hospital.				

48 Hour GP Access

Healthcare Quality Domain: Timely

Target/Standard:

- At least 90% of people should have 48-hour access to the appropriate healthcare professional;
- at least 90% of people should be able to book an appointment with a GP more than 48 hours in advance.

Responsible Director[s]: Executive Director: Medical Director

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
1. Not Met	↓	Worse	90% (min)	85%	March 2016	Yes	No	DS
2. Not Met	↓	Worse	90% (min)	75%	March 2016	Yes	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 results for 2015/16 have just become available. The survey does not directly address the issue of whether 90% has been achieved but does provide useful information on satisfaction with access. It is planned to provide a high level summary of findings for the next report.

Recent Performance – Numbers against Standard

Please see above.

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 soon to be stopped Quality Outcomes Framework there is no longer any local monitoring of 48 hour access. Alternative data will be available through the National Health and Care Experience survey which reports in May 2016.

Child & Adolescent Mental Health Services (CAMHs)

Healthcare Quality Domain: Timely

Target/Standard: 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.

Responsible Director[s]: Nursing Director/ Strategic Planning

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	90% (min)	60%	Apr 2016	No	Yes	JF

Summary for Committee to note or agree

- 60% of patients who were seen for a 1st treatment appt were seen within 18 weeks (compared to 70% in March)
- More people with long waits were seen for 1st treatment this month, 100 children and young people waiting over 18 weeks were seen in April in comparison to 63 in March.
- The number of people seen for a 1st treatment appt increased by 39 (247 compared to 208 in March)
- The total number of patients waiting increased by 7 (2,085 compared to 2,078 in March)
- The number of patients waiting over 18 weeks increased by 43 patients (931 compared to 888 in March)
- The number of patients waiting over 1 year has decreased from 97 in March to 91 in April. Each team has an action plan to see those children and young people waiting over 52 weeks as urgently as possible.

Recent Performance – Performance against 18 Week Standard

Table 1: CAMHs Performance Trend

Figures from April 2015 have been revised due to inclusion of Tier 4 data from April onwards

	Mar-15	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
Percentage seen within 18 weeks	62%	58%	57%	60%	71%	76%	59%	61%	54%	65%	56%	73%	70%	60%
Revised Trajectory*														
Total waiting at end of month	1,704	1,687	1,709	1,708	1,737	1,737	1,668	1,677	1,826	1,900	1,929	2,060	2,078	2,085
Those waiting more than 18 weeks	445	478	472	509	639	694	680	730	687	709	747	815	888	931

(* Note: Revised Trajectory to be agreed end of June following agreement of additional investment)

Table 2: Patients Seen for First Treatment

Number seen	within 18 wks	over 18 wks	% within 18 wks	% over 18 wks
247	147	100	60%	40%

Table 3: Patients Still Waiting at Month End

Number waiting	within 18 wks	over 18 wks	% within 18 wks	% over 18 wks
2,085	1,154	931	55%	45%

Figure 1: Number of Children & Young People Waiting Over 18 Weeks

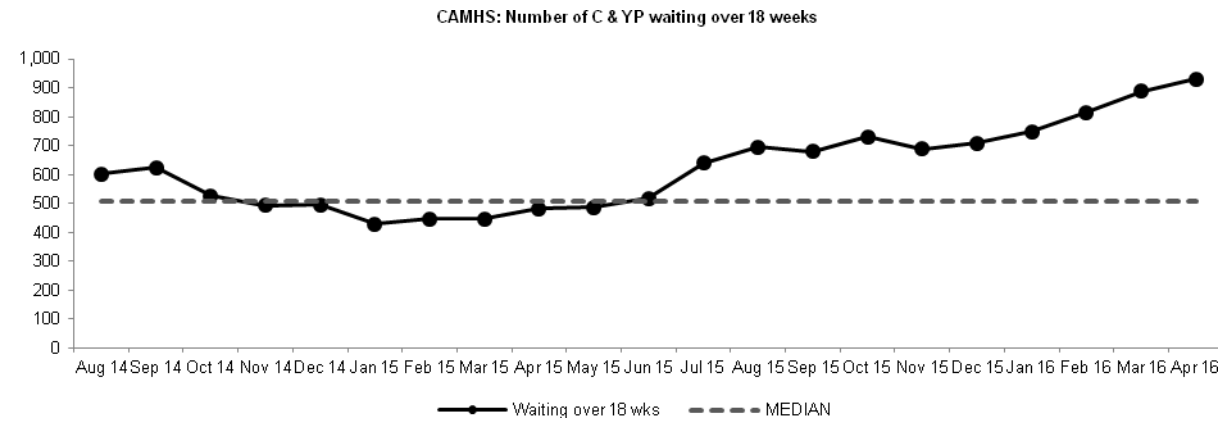
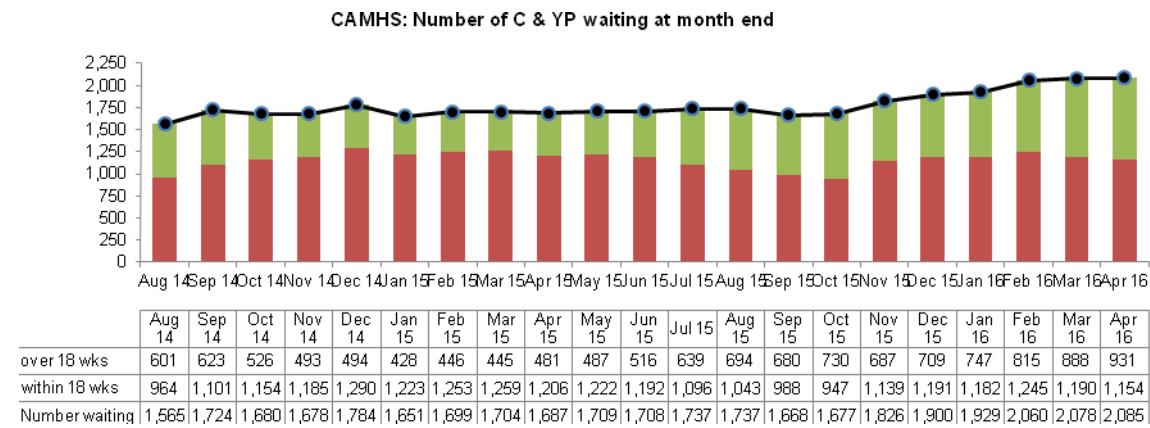


Figure 2: Number of Children & Young People Waiting at Month End



Timescale for Improvement

The CAMHS Executive Management Team are due to sign off a revised trajectory by end of June reflecting the actions planned and the anticipated impact.

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
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 monitored via CAMHS Executive and REAS CMT.	Transparency of progress; alignment of TRAK work; reporting of progress formally to the management teams enabling escalation and resolve of issues.	Completion of TRAK tasks has enabled improved performance.	Amber
Development of a single implementation plan for the introduction of Patient Focused Booking across CAMHS.	To be reviewed as part of the June Action Plan	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appts. Improved compliance with waiting times rules related to reasonable offer, unavailability and clock resets		Amber
Development of a single implementation plan for the introduction of Text Reminder system CAMHS.	Expected implementation: June 2015.-	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appts.		Amber
Completion of updated Demand Capacity Activity Queue (DCAQ), for CAMHS whose data is recorded and reported from TRAK.	1 st April 2016 Completed To be refreshed periodically.	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand and activity.	Baseline established.	Amber
Review of current referral thresholds and ratio of accepted referrals. Plan to liaise with NHS GG&C to compare practice and adopt relevant learning.	June 2016.	Improvement in management of demand to reduce capacity used in relation to inappropriate referrals.		Amber
A proposal to reduce the community development role of CMHW in CAMHS teams for 12 months and thus increase the direct clinical capacity of these staff is being considered.	June 2016 –	Provide additional capacity to reduce long waits. Initial scoping suggests around an additional 25 new patient appts would be available each month. Risks of stopping community capacity building thus further increasing referral rates to specialist CAMHS is being considered as part of the Risk Assessment.		Amber
Reduce combined median DNA and CNA for first appointments from 23% by 5% by end of June and by 10% by end of September 2016	30 th June 2016.	Improved use of clinical capacity which will mean more patients can be removed from the waiting list per wte per month	This test of change has been highly successful by end of May 2016 weekly median has reduced from 23 to 18.5 which is a reduction of 19.5%	Amber
Comments				
Reasons for Current Performance Increased demand – 20% increase year on year for last three years. Referrals increased from 4,608 to 5,970. This is an additional 1,362 patients comparing end of March 14 to March 16.				
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. Using TRAK data to identify GP practices with high referral rates - Link workers identified to liaise with the GPs regarding suitable referrals/updates on CAMHS. Too soon to see if this intervention impacts on referral rates. Review of Emotional Wellbeing and Children and Young People's Mental Health Services underway in Edinburgh sponsored by the Edinburgh Integrated Children's Service Partnership Board. Proposal to increase capacity for direct clinical contact of CMHWs in CAMHS teams for 12 months.				
Reduced capacity A number of staff on short term contracts funded by non-recurring funding have ended.				

Cancer - 31-day

Healthcare Quality Domain: Timely

Target/Standard: 31-day target from decision to treat until first treatment for all cancers, no matter how patients were referred. For breast cancer, this replaces the previous 31-day diagnosis to treatment target.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	95% (min)	93.6%	Apr 2016	No	Yes	JC

Summary for Committee to note or agree

- Performance for 31 day standard has reduced in March;
- There were 249 patients eligible for the 31 day standard in April. 233 started treatment within the target period with 16 patients out-with the target. In the areas where the standard was not attained, 30 out of 33 Colorectal (screened and screened excluded patients), 7 out of 9 Head and Neck Patients, 2 out of 3 Ovarian patients and 22 out of 32 Urological patients were seen within the standard.

Recent Performance – Percentages achieved towards standard

Table 1: 31-Day Performance

	Dec 14	Jan 15	Feb 15	Mar 15	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
Cancer Type	Percentage that started treatment within 31 days																
All Cancer types	97.4%	93.3%	94.1%	96.2%	97.2%	96.2%	95.8%	96.7%	96.3%	97.1%	96.9%	97.3%	96.2%	94.7%	94.5%	93.9%	93.6%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	80.0%	100.0%
Cervical (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	n/a	0.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Colorectal (screened excluded)	96.3%	86.4%	94.4%	96.0%	95.2%	88.9%	100.0%	96.2%	90.6%	100.0%	100.0%	96.3%	97.1%	90.3%	96.9%	100.0%	89.3%
Colorectal (screened only)	87.5%	75.0%	80.0%	100.0%	100.0%	100.0%	75.0%	100.0%	50.0%	88.9%	81.8%	100.0%	66.7%	83.3%	83.3%	100.0%	100.0%
Head & Neck	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	77.8%
Lung	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Melanoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurological - Brain and Central Nervous System (CNS)	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper Gastro-Intestinal (GI)	100.0%	95.8%	100.0%	95.8%	95.2%	100.0%	95.2%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urological	90.7%	75.9%	73.1%	82.4%	89.5%	85.5%	84.6%	85.5%	92.9%	90.3%	90.4%	87.2%	85.4%	82.0%	77.8%	73.0%	68.8%

Timescale for Improvement

A recovery trajectory has not been agreed with SGHD. Health Boards are expected to deliver the 31 day target.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
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	Business case approved by F&R committee in May 2016. Procurement process underway – order for the robot was placed with the company 13th June and the training programme for staff is anticipated to commence in July.

Comments**Reasons for Current Performance**

Capacity pressures within Urology have contributed to the performance declining.

Mitigating Actions

The problems within the urological pathway have been well documented nationally and are referenced in the new national cancer strategy which references a forthcoming national review on urology services and planned Government investment in robotic prostatectomy within NHS Lothian as one of 3 centres in Scotland. An additional urologist will be taking up appointment in May 2016. The business case for a robot to support laparoscopic prostatectomy has been supported by NHSL, Scottish Government and Prostate Scotland. Procurement is now underway and it is anticipated that the robot will be in operation before the end of 2016.

Increased service team focus on cancer escalation and pathways will support improvement. Ongoing capacity planning work linked to overall service capacity will also ensure cancer capacity is better understood.

Replacement urology consultant appointed – commenced June 2016.

Cancer – 62-day

Healthcare Quality Domain: Timely

Target/Standard: 62-day target from receipt of referral to treatment for all cancers. This applies to each of the following groups:-

- any patients urgently referred with a suspicion of cancer by their primary care clinician (for example GP) or dentist;
- any screened-positive patients who are referred through a national cancer screening programme (breast, colorectal or cervical);
- any direct referral to hospital (for example self-referral to A&E).

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	95% (min)	89.0%	Apr 2016	No	Yes	JC

Summary for Committee to note or agree

- Performance in April related to 118 eligible referrals under a 62 pathway for all tumour types. 105 of these started treatment within 62 days while 13 referrals did not achieve the standard.
- Tumour groups where the standard was not achieved were Colorectal, Head & Neck, Melanoma, Upper GI and Urological.

Recent Performance – Percentages achieved towards standard

Table 1: 62-Day Performance

Cancer Type	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
	Percentage that started treatment within 62 days																		
All Cancer types	96.8%	92.9%	96.5%	94.5%	93.1%	95.6%	96.1%	93.4%	92.3%	95.7%	93.4%	89.3%	94.7%	93.6%	90.5%	94.3%	89.4%	93.0%	89.0%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	100.0%	50.0%	66.7%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	n/a	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	n/a	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Colorectal (screened excluded)	81.3%	93.8%	93.3%	78.6%	85.7%	87.5%	91.7%	100.0%	84.2%	93.8%	85.7%	90.9%	94.4%	86.7%	84.2%	88.2%	80.0%	91.3%	77.8%
Colorectal (screened only)	100.0%	100.0%	71.4%	100.0%	66.7%	100.0%	100.0%	100.0%	71.4%	100.0%	50.0%	75.0%	81.8%	80.0%	33.3%	83.3%	66.7%	80%	40.0%
Head & Neck	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	87.5%	66.7%	100.0%	75.0%	100.0%	87.5%	100.0%	50.0%	0%	100%	80.0%
Lung	100.0%	100.0%	100.0%	100.0%	94.4%	94.1%	93.3%	93.3%	100.0%	100.0%	100.0%	78.9%	100.0%	100.0%	89.5%	100.0%	94.7%	100%	100.0%
Lymphoma	80.0%	71.4%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	71.4%	100.0%	80.0%	85.7%	75.0%	100.0%	100.0%	100.0%	100.0%	60%	n/a
Melanoma	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50%	100%	83.3%
Neurological – Brain and Central Nervous System (CNS)	n/a	n/a	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	50.0%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper Gastro-Intestinal (GI)	100.0%	91.7%	100.0%	100.0%	90.9%	100.0%	100.0%	83.3%	83.3%	92.9%	100.0%	86.7%	88.9%	81.8%	83.3%	100.0%	90.9%	100.0%	85.7%
Urological	95.2%	87.5%	94.4%	87.0%	80.0%	82.6%	85.2%	78.6%	92.3%	73.7%	85.2%	77.8%	88.6%	82.4%	78.3%	88.9%	77.8%	80.6%	76.9%

Timescale for Improvement

An improvement trajectory has not been agreed with Scottish Government however additional weekly monitoring of performance is being introduced which will continue until there are two successive quarters of performance above 95%.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
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	Business case approved by F&R committee in May 2016. Procurement process underway – order for the robot was placed with the company 13th June and the training programme for staff is anticipated to commence in July.

Comments**Reasons for Current Performance**

Colorectal and Upper GI performance has been affected by capacity pressures within these services – most specifically relating to endoscopy and colonoscopy capacity. Pressures in these areas are linked to rising numbers of OP referrals on the overall service which have put pressure on the overall available capacity within the pathway for these tumour groups. The numbers breaching the standard in colorectal were 7 out of 23 total patients. The remaining 6 patients who breached were distributed across the other 4 tumour groups.

The problems within the urological pathway have been well documented nationally and are referenced in the new national cancer strategy which references a forthcoming national review on urology services and planned Government investment in robotic prostatectomy within NHS Lothian as one of 3 centres in Scotland. An additional urologist will be taking up appointment in May 2016. The business case for a robot to support laparoscopic prostatectomy has been supported by NHSL, Scottish Government and Prostate Scotland. Procurement is now underway and it is anticipated that the robot will be in operation before the end of 2016 with a phased training programme for 2 surgeons within NHSL and 1 surgeon in NHS Fife. It is worth noting that across Scotland other Health Boards are facing significant pressures with Urology.

Replacement urology consultant appointed – commenced June 2016.

Diagnostics – Gastroenterology/ Urology Diagnostics

Healthcare Quality Domain: Timely

Target/Standard: A six week maximum waiting time for eight key diagnostic tests (four for Gastroenterology/ Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs - please see separate proformas for Radiology, and Vascular Labs data)), from 31st March 2009.

Responsible Director[s]: Chief Officer

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	1,513	Apr 2016	No	Yes	JC

Summary for Committee to note or agree

- Analysis of demand and capacity has identified a gap in capacity for patients referred for endoscopy procedures;
- Patients referred via the Bowel Cancer Screening Programme or as an urgent patient with 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;
- Improvement in the Flexible Cystoscopy performance is notable.

Key Diagnostic Tests - Gastroenterology/ Urology Diagnostics

The four diagnostic tests in Gastroenterology/Urology Diagnostics are Colonoscopy, Upper Endoscopy, Flexible Sigmoidoscopy (Lower Endoscopy - excluding Colonoscopy) and Flexible Cystoscopy.

Recent Performance: Numbers against Standard

Table 1: Gastroenterology/ Urology Diagnostics - Numbers over 6 Week Standard

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Colonoscopy	49	25	151	100	51	285	303	421	654	674	680	639	406	457	418	210	229	448
Upper Endoscopy	72	36	261	288	367	654	761	841	978	846	778	850	592	497	504	389	433	552
Flexible Sigmoidoscopy (Lower Endoscopy)	17	13	99	115	87	262	284	294	310	278	235	246	171	162	173	142	162	209
Flexible Cystoscopy	602	514	495	288	237	247	224	296	410	470	487	571	179	46	28	27	37	43
Total	740	588	1,006	791	742	1,448	1,572	1,852	2,352	2,268	2,180	2,306	1,348	1,162	1,123	768	861	1,252

Timescale for Improvement

Recent DCAQ work has supported the development of a trajectory until end September 2016.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Continue to support evening lists via NHS	January onwards	This number has reduced since end of April to 14 per month due to staff availability	14 additional slots per month	Ongoing on a reduced basis over Summer months
To maximise use of Regional Endoscopy unit (REU) at QMH for routine repeats. Introduce Patient Focus Booking for this unit	Commence 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	Ongoing and being measured and monitored
Introduce the full time nurse validation and telephone screening model for repeat endoscopies.	1 st June 2016	45% reduction in total numbers validated then telephone screened was achieved within NHS Lanarkshire, same model we are implementing. This was largely driven by patient choice. These patients may historically have been DNAs and therefore 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	Newly implemented :stats on all patients validated being gathered
Progress Faecal Calprotectin workstream to reduce demand on the service	July 2016	Significant reduction in referral to outpatients and ultimately reduction in endoscopy procedure		Progressing this work – currently engaging with stakeholders about new referral pathway
Introduced band 2 contacting pts in the evening to confirm attendance at procedure	May 2016	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.	May, June, July initially
Introduce a pt letter that advises direct access pts that they have been added to waiting list for procedure	July 2016	Reduce DNA rate improved patient experience with better communication		System problems implementing letter resulted in delay in implementation
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 less errors	On going
Introduction of monthly Endoscopy Service NHS Lothian wide operational meeting	June 2016	All SCNs, bookers and management team face to face meeting to discuss issues and opportunities for sharing good practice and efficiencies. Opportunity to tackle and resolve issues that ultimately resulted in inefficiencies		1 st Meeting 9 th June 2016

Comments - Gastroenterology/Urology Diagnostics

The level of demand for endoscopy tests are outstripping core provision resulting in an ongoing reliance on external capacity. Additional capacity had been arranged to bridge this shortfall and reverse the trend in increasing numbers waiting over 6 weeks. Although much improved at performance at the end of December fell short of the level agreed with SGHD. The withdrawal from private sector since 1st April 2016 resulted in a deteriorating position

Reasons for Current Performance

Demand continues to outstrip capacity despite optimal utilisation of all capacity. Additionally there is no longer capacity through independent providers. The increased focus on planned repeats backlog and introduction of nurse validation means that capacity has to be prioritised for these patients. Whilst we are maximising capacity both at REU and internally with some initiatives this will mean the new capacity may be impacted. There has been a significant reduction in the numbers of evening sessions possible and there was no appetite for morning lists which did not materialise.

Mitigating Actions

Additional internal sessions have been organised to maximise utilisation of internal core resource. Reviews of referrals continue to be completed 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.

Diagnostics - Radiology

Healthcare Quality Domain: Timely

Target/Standard: A six week maximum waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs from 31st March 2009. Please see separate proformas for Gastroenterology/Urology Diagnostics, and Vascular Labs data).

Responsible Director[s]: Chief Officer

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	1,513	Apr 2016	No	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 - Numbers over 6 Week Standard¹⁴

	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
CT	0	0	0	0	0	2	3	15	8	6	12	9	9	3	2	6	2	5	6	7
MRI	0	1	0	1	1	0	2	108	123	106	60	38	111	77	6	11	12	17	16	204
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Ultrasound	1	7	21	67	90	40	15	23	13	30	4	5	10	1	5	5	3	9	3	3
Total¹⁵	1	8	21	68	91	42	20	146	144	142	76	52	130	81	13	22	17	31	25	214

Timescale for Improvement against Target/Standard - Radiology

30th June 2016

Actions Planned and Outcome - Radiology

Action	Due By	Planned Benefit	Actual Benefit	Status
External provision of CT and MRI – 8 CT and 19 MRI mobile van days	End of June 2016	650 patient examinations per month	Sustain TTG	As planned
Additional US and CT sessions booked where staff availability permits	End of June 2016	Pending staff availability	Sustain TTG	Ongoing
Review of Cardiac MRI criteria for referral and backlog cleared at TEC	End of June 2016	Now manage within existing capacity at RIE	Sustain TTG	Completed
Reduce reporting beyond 6 weeks (weekly report to consultants to highlight long waits and overall position)	End of June 2016	Improved scan to report times	Sustain TTG	Ongoing

Comments - Radiology

Reasons for Current Performance
 150 patient Radiology examinations tripping the 6 weeks referral to unverified report at end **May 16**.
 148 are MRI. PH and scanner downtime resulted in lost capacity.
 Backlog of reporting for MRI in particular cardiac which require cardiologist input.
 RHSC MRI patients requiring GA are tripping 28 days so time to report reduced.
 Demand for MRI Lumbar spine still a pressure requiring external provision and reporting.

¹⁴ From Oct 15 inclusive onwards, Vascular Labs figures are not included in 'General Ultrasound' but are reported on the separate Vascular Labs proforma;

¹⁵ Minus Vascular Labs, from Oct 15 inclusive onwards.

Diagnostics – Vascular Labs

Healthcare Quality Domain: Timely

Target/Standard: A six week maximum waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs. Please see separate proformas for Gastroenterology/Urology Diagnostics, and Radiology data)), from 31st March 2009.

Responsible Director[s]: Chief Officer

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	1,513	Apr 2016	No	Yes	JC

Summary for Committee to note or agree

- A national shortage of Healthcare Scientists (HCS) has resulted in a vacancy being unfilled and a reduction in service capacity;
- The service has increased productivity, and in May 2016 brought in staff from out with NHS Lothian to support a reduction in waiting times;
- The service is also prioritising training to develop the HCS workforce and to support the service in the longer term.

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 Labs - Numbers over 6 Week Standard

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Vascular Labs	11	22	29	55	27	29	47

Timescale for Improvement against Target/Standard - Vascular Labs

This continues in light of the capacity shortfall as a result of the national shortage of HCS

Actions Planned and Outcome - Vascular Labs

Action	Due By	Planned Benefit	Actual Benefit	Status
External Vascular Scientist input being brought into service in order to reduce waiting times	End of May 2016	Reduction in patients waiting over 6 weeks	As planned	Complete (as per performance above)
Increase productivity by increasing patient facing direct clinical care workload and offering overtime to staff	End of August 2016	Increase capacity in vascular laboratory	As planned	Ongoing

Comments - Vascular Labs

Reasons for Current Performance

A national shortage of Healthcare Scientists (HCS) has resulted in a vacancy being unfilled and a reduction in capacity.

Drug & Alcohol Waiting Times

Healthcare Quality Domain: Timely

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]: Director of Strategic Planning, Performance Reporting & Information

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	90% (min)	79.6%	Dec 2015	No	Yes	AMcM

Summary for Committee to note or agree

- Overall across Lothian performance remains below target but individually Mid and East Lothian are above 90%; whilst Edinburgh & West Lothian are less than 90%. It is partly performance within NHS substance misuse services (SMS) in Edinburgh and West Lothian & partly the Scottish Prison Service that are bringing the averages down;
- Edinburgh and West Lothian NHS SMS are below target but respectively have improved by 2% in Edinburgh and 9% in West from Q2 to Q3;
- Following a Productivity Day on 11th Feb with the Drug Policy Unit (SG), who agreed with local approach and actions, they are focussing on a pilot across 2 areas (West Lothian & North West Edinburgh) to enhance productivity and capacity within the teams;
- The forecasted Q4 figures should continue to show an improvement and progress towards the targets for Edinburgh and West Lothian.

Recent Performance – Numbers Against LDP Target

Table 1: % Seen within 3 Weeks

	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
NHS Lothian	90.6	85.8	87.1	83.2	82.8	79.6
Edinburgh City Alcohol & Drug Partnership (ADP)	87.1	79.3	80.8	79.9	80.3	75.6
Midlothian and East Lothian ADP (MELDAP)	96.6	98.0	96.8	92.2	95.6	93.4
East Lothian	98.8	100.0	96.7	91.4	96.9	90.3
Midlothian	94.6	96.3	96.9	93.3	94.5	96.9
West Lothian ADP	96.3	94.3	97.3	86.0	81.0	81.5

Timescale for Improvement

Discussions ongoing with Edinburgh ADP and currently addressing pressures in South East Edinburgh as well as aiming to build consistency and increase productivity & capacity across all areas. Further work still to take place re individual localities and revised trajectory once budgets for 16/17 are agreed.

The review of residential services necessary due to the reduction in funding may have implications for the performance against the LDP Standard.

Actions Planned and Outcome					
Objective	Action	When by	Responsibility	Progress	Measured by
1. Improve accuracy and consistency of performance and activity data	1.1 Review joint monthly data between NHS Lothian and EADP looking at referrals and discharges and compare this with waiting times figures to ensure accuracy	End Nov 2015	J Shanley	Monthly monitoring in place Marked decrease in long waits % of errors reduced	Percentage of errors
	1.2 Set up Business Objects (BOXI) report to present activity data on a weekly basis	End Nov 2015	J Shanley	In place Daily team reports reviewed by team managers	Report automated and running
	1.3 Ensure timely submission of contact sheets by all clinical staff	End Nov 2015	SMD CORE	Improved access across all areas	Increased data accuracy, reduction in erroneous WT breaches
2. Improve response to referrals approaching the 21 days waiting time threshold	2.1 Set up BOXI report as above	End Nov 2015	J Shanley	As 1.2	Report automated and running
	2.2 establish process to track referrals on a weekly basis to identify those approaching 21 day threshold	End Nov 2015	J Shanley	In place	Process in operation
	2.3 Train managers to implement tracking and activate ISD log-ins as required	End March 2016	P Burns	Currently being managed by J Shanley	Reduction in long waits
	2.4 Revise allocation process to allow greater flexibility of care provider type	15 Dec 2015	P Burns	In the NW clients seen by nurses and then Consultant if required not straight to Consultant	Significant reduction in long waits for first medical appointment
3. Ensure staffing capacity is maximised	3.1 Resolve fixed term contracts issue	End Dec 2015	T McKigen	Unable to resolve until funding agreed more than one year	Higher proportion of SMD staff on permanent contracts, much lower staff turnover
	3.2 Recruit to all funded staffing vacancies from April 2016	End Feb 2016	T McKigen	Unable to resolve until funding agreed more than one year	Teams have fewer vacant posts; higher activity, reduction in WT breaches
	3.3 Maximise opportunities to cover vacant posts through use of Staff Bank, particularly in NE locality	From 16 Nov 2015 onwards	P Burns	Appropriate use of skilled bank staff to support teams	Activity is maintained as far as possible
Objective	Action	When by	Responsibility	Progress	Measured by
4. Seek to revise model of assessment and care	4.1 Discussion with ISD and SG DPU to seek resolution on models of care and assessment	End Apr 2016	SMD CORE		Not to be progressed
	4.2 Continue to develop new models of assessment and treatment via the Hub Alliance	End Apr 2016	SMD Core	ISD consulted and no opportunity to change current recording	Not to be progressed
5. Improve capacity, activity levels and productivity of SMD services in Edinburgh, potentially with support from Meridian	5.1 Develop agreed norms for clinical and non-clinical interventions across all localities, implementing learning from Meridian programme	End Apr 2016	P Burns/I Davidson	Productivity day arranged for 11.02.2016 facilitated by Tracy Mcfall DPU Outputs from the day will be agreed and documented Outputs will be mapped against trajectory..	Norms identified and agreed
	5.2 Develop improved referral allocation procedures and activity planning	End Apr 2016	P Burns/I Davidson	As 5.1	New allocation process in place
	5.3 Establish robust activity monitoring system taking learning from Adult CMHTs, including delivery of training for all staff and managers	End Apr 2016	P Burns/I Davidson	As 5.1	Monitoring tools established and in operation across all services
	5.4 Implement all productivity measures, identifying appropriate alternative uses of capacity realised	End Jun 2016	P Burns/I Davidson	As 5.1	Activity increases, particularly in areas where demand mismatch is highest. Reduction in WT breaches in all areas

6. Improve capacity, activity levels and productivity of contracted services in primary care/Third Sector	6.1 Review role of PCFT to ensure resources used to maximum benefit across SMD service	End March 2016	F Watson	Planned review of PCFT role and resources	Availability of discharge destinations from SMD increases. Activity levels increase within SMD and across Partnership. A11 performance improves
	6.2 Implement model of key working and locality approaches to working more closely with GPs	30 th June 2016	EADP Commissioner	Key working model due to implemented 1.4.16 pending SMD treatment pathway	Those discharged to the GP have a clear recovery plan, preventing the need for re-referral to clinical services within the Hub.
	6.3 Ensure there is capacity within the 3 rd sector to case manage and support those referred by SMD	Ongoing	EADP Commissioner	Tender completed. New contract commences 1.4.16	Treatment pathways are more linked to new processes within SMD and are mutually supportive. Activity levels across Partnership increase. A11 performance improves
7. Improve capacity within the system of care	Develop a stepped care model for interventions across the system of care	TBC Is there a date for this	Local Partners		Clinical pathways are reflective of the level of stability and needs of the clients and based on efficiency.

Comments

Reasons for Current Performance

SMD performance in the City of Edinburgh has been below 90% for some months and pulls the average for all services in NHS Lothian down (across health, social care and the voluntary sector). There have been pressures in other areas, but these have been short term and resolved.

Reasons for the pressures in the city are:-

1. Short term contracts for EADP funded posts, which constitute the majority of staff – this results in high levels of staff turnover, whose caseloads need to be absorbed by remaining staff, who are then unable to take on new cases from the waiting list. We have asked that the organisation (*REAS*) take the redeployment risk of giving permanent contracts to staff, to reduce turnover;
2. Contracting budgets – reductions yet to be quantified in the budgets from April 16 onwards may make delivery difficult;
3. Bottlenecks in the patient pathway, reducing capacity for discharge to primary care, which reduces the SMD capacity to take on new cases. Several GP practices in the city are receiving direct support from HSCPs as they have excess activity for the resources available to them. Approximately 30% of GP practices currently have restricted lists.

The SMD SMT will use the productivity work in the actions above to maximise capacity.

Inpatient & Day Case (IPDC) Treatment Time Guarantee (TTG)

Healthcare Quality Domain: Timely

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]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	0 (max)	404	Apr 2016	No	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

Table 1: Treatment Time Guarantee Patients waiting beyond standard at month end

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Urology	109	68	63	108	97	137	123	92	104	133	143	116	76	33	23	37	59	122
Orthopaedic Surgery	64	49	89	107	53	88	86	60	55	62	40	32	24	25	28	42	52	73
General Surgery	39	18	14	27	22	48	39	18	29	21	15	18	9	12	25	30	51	51
Neurosurgery	2	5	7	5	6	6	12	14	8	6	5		6	14	24	39	35	45
Ear Nose and Throat	49	62	90	102	46	39	38	33	13	28	19	13	15	4	16	18	31	37
Plastic Surgery	184	196	256	215	145	114	106	89	86	95	79	55	36	23	15	13	16	22
Vascular Surgery			4	4		1		1	2	1		1	2	1	13	16	21	18
Others	51	49	69	81	57	67	72	42	50	52	44	42	25	15	17	26	24	36
Total	498	447	592	649	426	500	476	349	347	398	345	277	193	127	161	221	289	404

Table 2: Treatment Time Guarantee Patients seen beyond 12 weeks

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
TTG Seen	448	397	427	406	564	692	476	463	389	314	314	368	293	276	207	163	219	297	297

Figures on Inpatient list size and unavailability are shown in the following table (Table 3). The use of unavailability and choice codes in Lothian remains low.

Table 3: List Size and Unavailability

Inpatients	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Total List Size (TTG)	9,832	9,961	9,600	9,481	9,140	8,941	8,692	8,642	8,421	8,599	8,826	8,820	8,944	9,140	9,216	9,809	8,814	8,625
Available	8,733	8,784	8,714	8,576	8,174	7,911	7,644	7,453	7,264	7,543	7,907	8,070	7,952	8,081	8,518	8,332	7,949	7,727
Unavailable	1,099	1,177	886	905	966	1,030	1,048	1,189	1,157	1,056	919	750	992	1,059	698	757	865	898
Percentage Unavailable	11.2%	11.8%	9.2%	9.5%	10.6%	11.5%	12.1%	13.8%	13.7%	12.3%	10.4%	8.5%	11.1%	11.6%	7.6%	7.7%	9.8%	10.4%
Non-TTG	572	620	1,069	1,144	1,197	1,180	1,244	1,246	1,187	1,048	1,023	1,013	1,012	1,069	1,110	1,090	1,063	976

Timescale for Improvement

Following recent DCAQ work a trajectory has been developed for TTG until end September

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
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.	Initial output end Jan 2016. Quarterly meetings established with each service. First series of meetings held April 2016.	Improved performance against agreed efficiency targets, example improved Day Case rate.		Quarterly meetings established with services to monitor performance.
Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams to improve theatre efficiency.	Full implementation by December 2016	Overall improved theatre efficiency Reducing cancellations Redesigning pre-op assessment		
Service review of all booked theatre lists one week in advance to ensure optimum booking and theatre efficiency.	Ongoing	Maximise theatre utilisation	See comments below	
Implement a phone reminder to all booked patients in advance of TCI date. Pilot in Head & Neck for two months and monitor impact. Commences February 2016.	End of March 2016	To reduce late cancellations enabling the slot to be backfilled reducing wasted theatre time. Year To Date (YTD) (Apr-Nov) Theatre cancellations within 24 hours – 396 cases. YTD Theatre utilisation hours used – average 85%.	See comments below	Ongoing
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.	End April 2016	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.		
Develop new trajectories and detailed actions maximising internal capacity; End of March trajectory agreed with SG. New trajectories build up from, DCAQ work, meeting with SG early May to sign off process	May 2016	Optimise internal capacity and maintain focus on delivery of TTG		

Comments

Reasons for Current Performance

Winter bed pressures resulted in a high volume of elective cancellations particularly within orthopaedics, vascular, general surgery and DCN. The performance shows these specialities continues to suffer from this effect beyond the normal "winter" period due to sustained pressure on beds

Demand for services is greater than core capacity.

Cessation of independent sector

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.

Head and Neck Pilot results:

We introduced the following steps to help reduce No. Of cancellation / DNA's

- TCI's less than 2 weeks are phoned and offered their surgery Date
- Patients booked out with 2 weeks are lettered, then contacted Via Phone to confirm they will be attending for surgery
- Patients who we are unable to contact Via Phone we send them a reminder letter
- Weekly meeting with WLO / team lead & co-ordinators to go through The planned V Actual

ENT remains under 90% despite the above actions, On 3/05/16 we introduced a 6 week Pilot where we will drill down to patient level information, looking at the following details:

- Has patient confirmed / if not has review letter been sent
- Date pt confirmed
- Cancellations / replacement of pt's
- Total number of hours booked per theatre
- End of week review / confirmation of full list.
- Looking back at previous week / reflect on Planned V Actual
- Take actions

Theatre Utilisation

	Oct	Nov	Dec	Jan	Feb.	march
Ent	84%	76%	84%	83%	83%	86%
OMFS	96%	87.80%	85.20%	105%	108%	92%
Plastics	81%	83.90%	86.20%	84%	97%	91%

pt's cancelled within 24 hours

	Oct	Nov	Dec	Jan	feb	march
pt's cancelled within 24 hours	59	69	41	56	47	35

Outpatients

Healthcare Quality Domain: Timely

Target/Standard: 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.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Worse	95% (min)	85% (7,912)	Apr 2016	No	Yes	JC

Summary for Committee to note or agree

Due to a software issue at the Dental Institute, patients over 12 weeks are excluded from the headline figure reported.

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

Table 1: Trend in Outpatients over 12 weeks – Key Specialties (April 2016 excludes Edinburgh Dental Institute)

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Trauma And Orthopaedic Surgery	408	459	647	775	517	515	665	558	912	1,291	1,623	1,847	1,982	2,165	2,366	2,166	1,916	2,201
Gastroenterology	263	198	210	252	323	477	671	902	1,208	1,334	1,360	1,375	1,292	1,439	1,445	1,547	1,617	1,845
General Surgery (Excl Vascular)	352	288	506	596	342	454	583	632	854	1,036	1,141	1,197	1,110	1,120	1,387	1,535	1,375	1,684
Ear, Nose & Throat (ENT)	292	295	272	269	320	431	504	541	872	1,093	1,040	681	478	373	394	390	345	492
Urology	339	358	378	339	315	398	438	321	606	648	542	525	390	377	407	404	353	386
Vascular Surgery	6	6	49	65	23	21	23	21	28	93	182	281	293	308	341	326	296	333
Ophthalmology	288	285	335	481	296	336	378	326	475	395	412	335	212	157	192	188	121	189
Gynaecology	98	112	341	284	97	256	266	216	283	379	446	583	481	524	322	308	178	180
Paediatrics	15	13	6	15	34	57	94	80	82	32	32	22	13	14	18	47	102	136
Dermatology	63	13	7	5	6	13	19	14	19	49	68	44	29	41	217	222	157	80
Others	578	645	640	540	409	509	620	581	748	583	582	601	499	624	736	853	748	386
Total over 12 Weeks	2,702	2,672	3,391	3,621	2,682	3,467	4,261	4,192	6,087	6,933	7,428	7,491	6,779	7,142	7,825	7,986	7,208	7,912

Table 2: List Size and Unavailability

Outpatients	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Total List Size	43,004	42,639	41,721	42,861	43,694	46,547	48,672	50,243	53,046	52,040	50,788	50,850	48,845	47,999	47,199	48,434	48,836	51,876
Available	42,085	41,527	41,000	41,987	42,878	45,843	47,951	49,004	51,930	50,867	49,746	50,011	47,890	46,516	46,319	47,485	48,039	51,227
Unavailable	919	1,112	721	694	816	704	721	1,239	1,116	1,173	1,042	839	955	1,483	880	949	797	649
Percentage Unavailable	2.1%	2.6%	1.7%	1.6%	1.9%	1.5%	1.5%	2.5%	2.1%	2.3%	2.1%	1.6%	2.0%	3.1%	1.9%	2.0%	1.6%	1.3%

Timescale for Improvement

Following recent DCAQ work an out-patient trajectory has been developed until end September.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
<p>Review of Acute Services' available capacity and demand undertaken to inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue (DCAQ) exercise examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties.</p> <p>Move from data collection and analysis to performance monitoring and improvement trajectories.</p> <p>Cessation of independent sector capacity from April 2016, factored into DCAQ work</p>	<p>Initial output end Jan 2016.</p> <p>Programme of further work around performance monitoring –quarterly review process in place</p>	<p>Improved performance against agreed efficiency targets, example reduced DNA rate.</p>		<p>Phase two currently being developed.</p> <p>Ongoing</p>
<p>In line with the National Towards Our Vision for 2020 Delivering Outpatient Integration Together Programme. Aim of the programme is manage flow through consistently and sustainably delivering a suite of changes.</p> <p>Progress following work streams;</p> <ul style="list-style-type: none"> Advice Only – Allows clinician to provide advice as an alternative to an outpatient appointment where appropriate and safe to do so. Accommodation Matrix – 'At a glance' view of physical clinic space which is used by Outpatient Service Manager and Clinical Service Managers to identify available staffed clinic space and facilitate clinic reconfiguration without additional resource, thus increasing capacity for both new and review patients. Return Patient List – Demand for return patients will be captured. Allowing return patients to be seen at clinically appropriate times. Capacity can be planned in advance; rescheduled return appointment through cancellation will decrease, protecting new patient slots. Patient Initiated Follow-Up – Reduce the number of return appointments allowing patients to re-engage when they are unwell and require secondary care intervention. Appointments will be released which can be transferred to new patients. Early planning stages within Dermatology, Rheumatology and Gynaecology. 	<p>Specific work streams have various local target dates but overall programme delivering by 2020.</p>	<p>Decrease in number of new outpatient appointments (better demand management).</p> <p>Achieve upper quartile for the return: new ratio.</p> <p>Decrease DNAs.</p>		<p>Progressing each of these work streams</p>

Comments

Reasons for Current Performance

Demand greater than capacity.

Overall increase in demand of 2% but significant rises seen in General Surgery, Dermatology, Ophthalmology and Gastroenterology.

Return demand in some key specialties impacting on additional capacity- i.e. additional in house clinics required to manage return demand rather than new.

Cessation of independent sector capacity

DCAQ exercise to identify any mismatch in outpatient demand and capacity and take actions to address this.

Ensuring specialties are achieving the agreed efficiency targets.

Implementing actions in line with National Programme of Outpatient Redesign.

Psychological Therapies

Healthcare Quality Domain: Timely

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]: Joint Director, West Lothian

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Worse	90% (min)	72%	Apr 2016	No	Yes	JF

Summary for Committee to Note or Agree

The overall position including the data from Clinical Health Psychology, Neuropsychology and GSH services in 3rd Sector:

- Overall, 72% of patients who were seen for a 1st treatment appt were seen within 18 weeks
- At the end of April 1,066 patients were waiting over 18 weeks (compared to 1,013 at end of March)

Clinical Health Psychology & Neuropsychology

- No patients breached 18 weeks in Clinical Health Psychology services
- No patients breached 18 weeks in Neuropsychology services
- There were 471 patients waiting with the CHP and Neuropsychology services at the end of April of which, 7 had waited over 18 weeks.

Guided Self help services

- Of the 38 patients seen by GSH services, 1 patient breached 18 weeks
- There were 50 patients waiting for GSH at the end of April with no patients waiting over 18 weeks

Psychological Therapies delivered by the mental health services only:

- 44% of patients were seen within 18 weeks
- Number of people seen for a 1st treatment in April decreased by 68 patients from March (216 compared to 284)
- The total number of people waiting increased by 148 (3,186 compared to 3,038)
- The number of people waiting over 18 weeks in April increased by 56 (1,066 compared to 1,010 in March)
- The number of people reported as waiting over 1 year at the end of April was 126 (compared to 122 in March)

A comparison of direct clinical contact hours for the General Adult teams delivering Psychological Therapies showed that across teams staff were delivering 78% of expected activity. **In January 2016 this figure was 91%.**

The average number of patients starting treatment from Aug 14 to May 15 was 177. From June 15 to December 15 the average number has **increased to 279.**

Recent Performance – Percentages against Standard

Table 1: Psychological Therapies Performance Trend - Revised October 2015 (including CHP, NeuroPsychology & Guided Self Help (low intensity psychological intervention - GSH) [3rd sector])

	Feb-15	Mar-15	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
Percentage seen within 18 weeks	34%	41%	39%	44%	40%	45%	46%	47%	68%	69%	73%	66%	70%	72%	72%
Trajectory for seen within 18 weeks*															
Total waiting at end of month	3,105	3,176	3,190	3,341	3,261	3,219	3,150	3,015	3,457	3,540	3,697	3,426	3,480	3,548	3,707
Those waiting more than 18 weeks	1,167	1,237	1,254	1,257	1,173	1,146	1,108	1,085	1,069	985	1,041	902	892	1,013	1,073

*Revised Trajectory to be agreed by end of June 2016 in line with agreed investment plan.

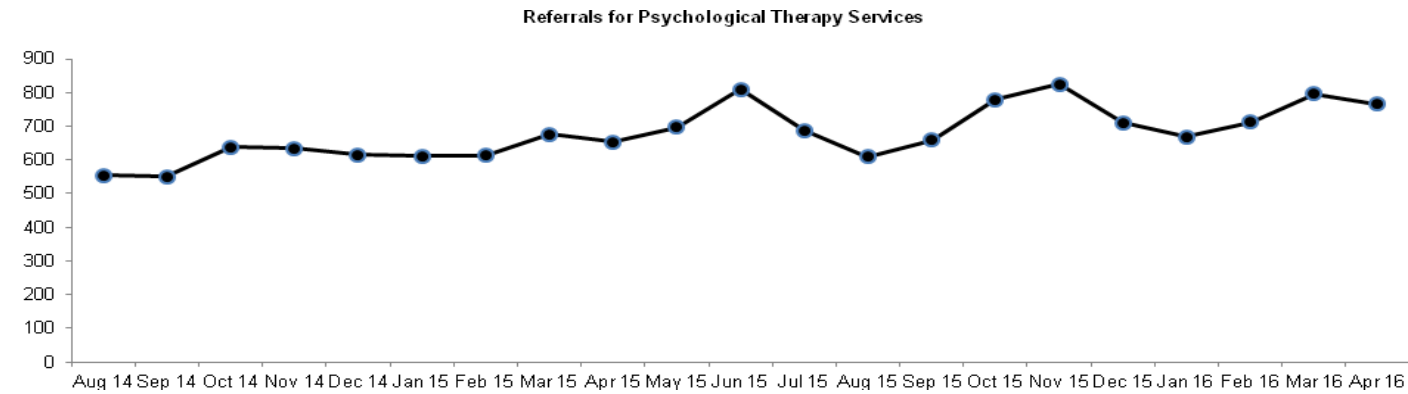
Table 2: Patients seen for 1st Treatment

Service	Patients seen for 1st treatment				
	Number seen	within 18wks	over 18wks	% within 18 wks	% over 18wks
Psychological Therapies (Mental Health)	216	95	121	44.0%	56.0%
Clinical Health Psychology	117	117	0	100.0%	0.0%
Neuropsychology	62	62	0	100.0%	0.0%
GSH (3rd Sector)	38	37	1	97.4%	2.6%
Overall Position	433	311	122	71.8%	28.2%

Table 3: Patients Waiting at Month End

Service	Patients waiting at month end				
	Number waiting	within 18wks	over 18 wks	% within 18 wks	% over 18 wks
Psychological Therapies (Mental Health)	3,186	2,120	1,066	66.5%	33.5%
Clinical Health Psychology	365	359	6	98.4%	1.6%
Neuropsychology	106	105	1	99.1%	0.9%
GSH (3rd Sector)	50	50	0	100.0%	0.0%
Overall Position	3,707	2,634	1,073	71.1%	28.9%

Figure 1: Referrals for Psychological Therapy Services



Timescale for Improvement

Demand Capacity Activity Queue (DCAQ) has been re-run. A revised trajectory is to be agreed in June by the newly convened Psychological Therapies A12 Board now chaired by Jim Forrest. Each service / team will use standard PRINCE2 project management reporting which will enable systematic review and escalation of issues to the Project Board. Each partnership area, hospital division and professional group involved in the delivery of this target is represented by a Director or their nominated lead. The trajectory will reflect the new “Building Capacity” funding allocation.

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.	Amber
A single prioritised amendments / additions work-plan for TRAK with named analytical, data and system support staff from clinical services, e-health and planning.	Completed and being monitored via A12 Project Board.	Transparency of progress; alignment of TRAK work; reporting of progress formally to the Project Board enabling escalation and resolution of issues.	As per planned benefit.	Amber
Development of a single implementation plan for the introduction of Patient Focused Booking across all service delivering psychological therapies.	Original date was May 2016. Due to configuration issues now anticipated July 2016.	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.		Amber
Development of a single implementation plan for the introduction of Text Reminder system across all service delivering psychological therapies.	Expected implementation: June 2015	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments.		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
Use of the Meridian work allocation tool to increase direct clinical contact within Edinburgh teams.				
Further development of the Meridian work allocation tool to streamline completion whilst retaining benefits of the tool.	1 st March 2016	Continue to maximise clinical capacity through forward planning of workload and ensuring appointments slots utilised.	Tool has been revised	Green
Completion of updated DCAQ for all general adult services.	Completed	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.		Green

Comments

Reasons for Current Performance

Incomplete data

A small number of specialist services 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

Reduction in capacity due to contracts ending which were funded on non-recurring basis.

Revised DCAQ continues to highlight capacity issues for adult mental health services. .DCAQ has consistently demonstrated a capacity gap in *General Adult Psychology Services* as being 13.1 WTE. An additional 12 WTE are required to clear the queue of patients waiting.

Increased demand

Increase in demand due to the increasing efficacy and awareness of the positive contribution of psychological therapies to improving patients' outcomes.

To mitigate –

Updated DCAQ for all services / teams.

Reviewing the range of psychological therapies available and ensuring delivery of those with the most robust evidence bases are prioritised and matched to those who will most benefit.

Building Capacity funding will be target at those who have waited longest - recruitment commences mid June 2016 to 10.5WTE clinical staff.

18 Weeks Referral to Treatment

Healthcare Quality Domain: Timely

Target/Standard: 90% of planned/elective patients to commence treatment within 18 weeks of referral.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Worse	90% (min)	83%	Apr 2016	No	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 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

Table 1: Trend in 18 Week Performance and Measurement

	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Patient Journeys within 18 weeks (%)	86.1	87.3	85.9	86.3	85.1	85.6	88.0	86.1	87.0	85.9	87.3	85.2	84.9	84.0	82.5	82.8	83.0	82.4	82.4	83.0
Number of patient journeys within 18 weeks	13,415	13,877	13,042	11,811	12,044	11,838	13,626	12,446	12,417	13,795	13,297	12,631	13,820	13,642	13,000	13,133	11,931	12,396	12,791	13,157
Number of patient journeys over 18 weeks	2,163	2,014	2,137	1,873	2,103	1,996	1,861	2,001	1,849	2,265	1,941	2,201	2,449	2,604	2,749	2,720	2,443	2,647	2,736	2,688
Patient journeys that could be fully measured (%)	86.3	85.9	86.0	83.4	85.5	85.6	85.8	85.1	85.7	86.0	84.8	84.9	86.7	87.4	86.3	86.1	86.8	87.0	87.1	87.0

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 Efficiency Programme; Demand and Capacity Programme, and Outpatient Redesign Programme.	DCAQ Phase1 - end of January 2016. Phase to monitoring of performance against key indicators started April 2016. Theatre programme- December 2016. Outpatient programme – 2020.	Improved performance against agreed efficiency targets, example improved Day Case rate. Improved demand management.		Progressing individual work-streams
Ensuring clinic outcome data is completed - achieve target of 80% clinic outcome completeness for all specialities.	End of June 2016	Clocks stop appropriately in line with clinical pathway.		

Comments

Reasons for Current Performance
Challenges within specific specialties as highlighted on the Outpatient and TTG proformas.

Stroke Bundle

Target/Standard: This is a **New Standard**, implemented from 1st April 2016:-

80% of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle.

Additional information

The key elements of the stroke care bundle are:-

1. Admission **to the stroke unit on the day of admission, or the day following presentation** at hospital;
2. Screening by a standardised assessment method to identify any difficulty swallowing safely due to low conscious level and/ or the presence of signs of dysphagia **within 4 hours of arrival at hospital**;
3. CT/ MRI imaging **within 24 hours** of admission; and
4. Aspirin is given **on the day of admission or the following day where** haemorrhagic stroke has been excluded, or other contraindication, as specified in the national audit.

Responsible Director[s]: Executive Director: Chief Officer

Performance:

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Not Available	80%	56.3%	April 2016	Yes	Yes	JC

Summary for Committee to note or agree

Stroke care is part of the Clinical Quality Programme during 2016, and part of it is focussed on the bundle of care. Four participants on the Leadership Course reported out their projects on 3rd June reflecting the various stages of completion relating to improving access to the stroke unit by 7 day working, TIA pathway and prioritisation; improved use of patient-focussed goals and efficiency of the stroke rehabilitation pathway; and improving time to carotid interventions for patients presenting with TIA and stroke. The projects are ongoing and support from NHS Lothian Quality Improvement leaders is continuing.

The single most common reason for failing the stroke bundle is the swallow screen, now within four hours of admission. Performance had improved month on month since November, but dipped again in April due to the updated standard. The nursing teams in the stroke units and at front doors are making focussed efforts to improving performance against this challenging target, but with patients often not getting their first assessment until close to four hours, they are then not identified as stroke until after this time.

There are increasing numbers of patients being seen and receiving initial diagnoses of stroke and this has meant performance against stroke unit admission remains challenging and unmet. Bed pressures across all sites and boarding patients in stroke beds have also impacted on admissions to new stroke patients. Performance for imaging remains steady and meets the updated national standard, and performance for aspirin treatment remains steady but hasn't met the national target of 95%.

Performances in this report are against the amended national standards for swallow screen and brain scan, and new national target for stroke bundle - from April 2016.

Recent Performance – Numbers achieved towards standard

Table 1: Stroke Bundle Performance
(provisional data for management, and liable to change)

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	Target
Stroke Bundle Performance	66.3%	79%	65.1%	65%	71.3%	66.1%	67.7%	56.3%	80%
1. Access to stroke unit by day after admission	71.1%	83%	75.8%	69%	77%	67.5%	75%	71.6%	85% ¹⁶
2. Swallow screen within 4 hours of admission	90.4%	89.1%	82.9%	83.5%	86.9%	84.7%	87.9%	77%	100% ¹⁷
3. Imaging undertaken within 24 hours	96.2%	97.5%	98.4%	97.1%	97.5%	98.3%	98%	97.6%	95% ¹⁸
4. Aspirin by the day following admission	92.1%	95.5%	93.8%	88.7%	94.5%	93.5%	88.9%	91.5%	95%

Timescale for Improvement

¹⁶ 85% is Local Trajectory; 90% is National Target.

¹⁷ From April 2016 standard has changed from 90% on day of admission, to 100% within 4 hours of admission.

¹⁸ From April 2016 standard has changed from 90% within 24 hours, to 95% within 24 hours of admission.

A trajectory has been agreed with SGHD and set out below (Local trajectory agreed at 70% for 2015/16. National target of 80% to be enforced from April 2016):-												
Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sep 2016	Oct 2016
70%	70%	70%	70%	70%	70%	80%	80%	80%	80%	80%	80%	80%

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
Appoint to vacant Outreach post at WGH to enable full outreach service to be offered.	15 th Feb, but delayed.	Increased capacity to identify and take care of more patients, at an early stage.	To be determined. Audit of calls from ARU to Outreach underway.	Delays in recruitment, but ongoing rota in place to deliver outreach service.
Full complement of band 6 nurses in stroke and MoE wards (101, 201, 104, 202 and 203) at RIE to enable stroke nurse to attend front door for sweeps throughout the night.	End of April 2016, but delayed.	Senior cover for 24/7 stroke outreach service at RIE.		Awaiting agreement from partnership on internal rotation.
Late evening telephone and in-person sweeps to front door to identify late admissions for swallow screens. Meeting arranged with RIE Front Door staff as there is inconsistency with swallow screening now, particularly with new 4 hour target.	In progress	Early identification of stroke pts and target met.	Decrease in performance in April due to amended target of 100% within 4 hours.	Daily activity. Meeting arranged for 21 st June 2016 (RIE).
Single point of contact to optimise use of stroke capacity. Daily 9.30am teleconference call discuss bed availability and potential for transfer(s) from RIE to WGH depending on other demands for beds, eg from ITU, ARAU and DCN. Potential boarders, non-stroke patients, transfers and discharges identified to create capacity for new strokes to be admitted to stroke units.	In progress	North zone patients to be transferred to WGH if beds are available and clinically safe. Acute stroke beds are used appropriately pan-Lothian.		In place and in testing phase
Stroke team identified to undertake the improvement work across four areas and are undertaking training courses in Quality Improvement. E.g. auditing patients who do not need to be admitted to stroke unit, but receive stroke care and discharged from AMU; patient destination once rehabilitation is no longer required.	In progress	Currently staff from both WGH and RIE are part Cohort 1 of QI Leadership and QI Improvements Skills Training		QI Leadership course report out – June 3 rd 2016 QI Clinical Skills course Report Out - Sept 2016
Rehabilitation triage to identify 'fast track' patients for increased intensity of treatment and earlier sign-posting to Intermediate Care Services (ICS).	In progress	Decrease LOS, more patients going home quicker	Free up beds earlier in ISU and improve bundle performance.	Commenced discharging patients on fast track to ICS. Awaiting data to confirm reduced LOS.

Comments
<p>Reasons for Current Performance</p> <p><u>Access to stroke unit breaches:</u> High demands on stroke unit beds across all sites.</p> <p>RIE: There were capacity issues at RIE with 12 breaches: seven patients were either discharged or admitted to the Stroke Unit by day 3; two required palliative care or MoE bed for co-morbidities; two were transferred to WGH (one for thrombectomy which necessitated ITU care).</p> <p>SJH: Five patients at SJH failed the access standard as the ward was closed due to norovirus.</p> <p>WGH: Two of the breaches at WGH were admitted to DCN for neurosurgery or required ICU care, so were clinical exceptions, and another required palliative care.</p> <p><u>Swallow screen:</u> The majority of the fails across all sites were due to the delays in identifying them as stroke patients, and 30% then received a screen within 8 hours. Other patients were missed by the stroke unit sweep to the front door and for two patients there were no record of it documented. Three in-hospital stroke patients also failed as they're 'last seen well' outwith the four hour window.</p>

Surveillance Endoscopy

Healthcare Quality Domain: Timely

Target/Standard: No patient should wait past their planned review date for a surveillance endoscopy.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Not Available	0 (max)	2,715	Apr 2016	No	Yes	JC

Summary for Committee to note or agree

- Surveillance scopes have continued to prove challenging;
- Activity in independent sector ceased 1 April 2016;
- Booking of the Regional Endoscopy Unit (REU) has transferred to External Provider Office;
- As well as reviewing options to increase capacity, the service is working to implement a 'pre-assessment' initiative aimed at reducing demand started mid May 2016.

Recent Performance – Numbers Against Standard

Table 1: Surveillance and Review Patients Overdue Appointment

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	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
Colonoscopy	191	301	447	487	570	614	621	611	627	686	741	869	1,017	1,142	1,265	1,347	1,456	1,596
Upper Endoscopy	99	125	206	279	299	320	326	307	340	369	404	436	497	546	597	605	602	637
Flexible Sigmoidoscopy	18	35	58	80	99	109	119	126	135	155	165	153	168	182	187	186	197	206
Flexible Cystoscopy	324	282	263	259	285	196	164	200	235	290	327	342	355	374	273	120	73	114
Other	34	62	105	93	98	93	104	100	105	98	106	111	127	138	142	133	139	162
Total	666	805	1,079	1,198	1,351	1,332	1,334	1,344	1,442	1,598	1,743	1,911	2,164	2,382	2,464	2,391	2,467	2,715

Timescale for Improvement

Based on recent DCAQ work a trajectory has been developed until Sept 2016. Timelines for various actions outlined below.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Completion of DCAQ for Endoscopy to confirm overall gap in list capacity	Quarterly monitoring process throughout 2016	Accurate measure of available capacity vs demand for both surveillance and new diagnostics		Next round of review meetings in July.
Transfer of booking of surveillance scopes to EPO, providing a dedicated resource.	May 2016	Improved use of capacity at REU, reduced length of wait, reduce DNAs	Early data suggest uptake has improved and lower DNA rate at REU.	Transfer occurred in May.
Plan for additional flexi cystoscopy activity to clear surveillance and planned repeat backlog.	Continuous evaluation of demand new and backlog demand against capacity; clear focus on reducing longest waits.	Reducing backlog and longest waits.		Continuing to evaluate.
Introduction of 'pre-assessment' service for surveillance patients to support demand management.	May 2016	Clinical triage of patients to improve appropriateness of procedures and compliance with BSG guidelines – delivering best possible standard of care to patients.		Process has just started; impact not yet demonstrable.

Comments

Reasons for Current Performance

Underlying capacity gap for endoscopy with additional demand pressures evident through bowel screening programme. 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. Poor utilisation of REU with high DNA's

Mitigating actions

New Consultant Urologist appointments to commence in May 2016 providing additional flexible cystoscopy capacity. Continued focus on booking process for surveillance patients appointed to the Regional Endoscopy Unit to maximise uptake of capacity and reduce DNA's and cancellations. Plans in progress to introduce model for 'pre-assessment' service for all surveillance patients and potentially reduce number of patients requiring a procedure.

Delayed Discharges – East Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	0 (max)	60	May 2016	No	Yes	DS

Summary for Committee to note or agree

- East Lothian performance has been steadily improving from a peak of 43 in 2014. But has recently plateaued at between 15 to 25 at each monthly census. In order to achieve the two week target and reduce the total number a further step change is needed. East Lothian routinely has c 1,000 hours of unmet care at home demand each week due to capacity problems with providers. C 400 hours of this relates to delayed discharges. The HSCP is implementing fair work and living wage in order to improve recruitment and retention. Funds have been set aside from the Social Care Fund to cover the increased costs of meeting the capacity gap once providers can provide the hours. The HSCP is also retendering the contracts in 2016/17 and will use this process to improve capacity and logistics.

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16
1. All Delays Recorded	403	403	382	392	394	364	358	355	318	319	280	302
2. All ISD Reportable Delays	238	248	237	253	258	257	244	249	231	206	182	203
3. ISD Reportable Delays excluding X codes (All Time Bands)	177	188	180	199	201	188	173	161	154	134	112	134
a. Those over 2 weeks	99	104	108	126	122	117	90	76	69	54	51	60
b. Those over 4 weeks	63	69	75	73	77	75	46	47	43	34	37	32

Table 2: ISD Delays excluding X Codes by Health & Social Care Partnership at census point

Health and Social Care - IJB	3. All Time Bands						a. >2 weeks					b. >4 weeks						
	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Edinburgh	121	122	95	82	67	85	67	61	54	38	32	43	36	36	32	23	25	23
East Lothian	22	19	15	25	15	20	10	7	8	7	8	7	4	5	6	5	6	3
Midlothian	11	3	12	10	11	11	3	0	0	1	2	2	0	0	0	0	1	1
West Lothian	15	14	29	13	17	13	8	3	6	6	7	5	3	3	3	4	3	3
All (inc. other)	173	161	154	134	112	134	90	76	69	54	51	60	46	47	43	34	37	32

Timescale for Improvement – East Lothian IJB

A trajectory has been agreed with SGHD and set out below (or please provide alternative information, if a trajectory has not been agreed):-

June 16	July 16	August 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17	Date	Date	Date
20	18	16	14	12	10	10	15	15	10	Figure	Figure	Figure

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.	To be determined	Being planned
East Lothian planning to invest some of social care fund in purchasing additional capacity in care at home following introduction of living wage	October 2016	Increase capacity of care at home	To be determined	Being planned
Investment in ELSIE through Integrated Care Fund to provide 24/7 cover to prevent hospital admission.	tbc	Avoid admission and support rapid discharge	To be determined	Being planned
Retendering of current care at home framework	April 2017	Improve capacity of providers in tandem with Living Wage implementation.	To be determined	Project underway and specification under development

Comments – East Lothian IJB

Reasons for Current Performance

East Lothian has seen sustained improvement over the last two years and currently sits between 15 and 20 delays each month, having fallen from a peak of 43. The key issue is capacity of care at home providers to meet demand. The actions above are mostly aimed at addressing this factor. However the care home market is vulnerable in East Lothian and the recent temporary cessation of admissions to one large care home has increased the number of delays waiting for care homes.

Delayed Discharges – Edinburgh Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	0 (max)	60	May 2016	No	Yes	RMG

Summary for Committee to note or agree

- Targets for the reduction of delayed discharge levels up to May 2016 were proposed based on scheduled investments and anticipated benefits. These targets were approved by the Scottish Government. Additional funding from the Scottish Government was linked to achieving the target of 100 for the total number of people delayed by February 2016 in the Edinburgh Partnership, and 50 by May 2016 compared with 121 in December, again for the Edinburgh Partnership.
- A comprehensive programme of actions to address delayed discharge for Edinburgh residents is being overseen by the Patient Flow Programme Board which is scheduled to meet on a fortnightly basis.
- Targets for June 2016 onwards have still to be determined.

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
1. All Delays Recorded	403	403	382	392	394	364	358	355	318	319	280	302
2. All ISD Reportable Delays	238	248	237	253	258	257	244	249	231	206	182	203
3. ISD Reportable Delays excluding X codes (All Time Bands)	177	188	180	199	201	188	173	161	154	134	112	134
a. Those over 2 weeks	99	104	108	126	122	117	90	76	69	54	51	60
b. Those over 4 weeks	63	69	75	73	77	75	46	47	43	34	37	32

Table 2: ISD Delays excluding X Codes by Health & Social Care Partnership at census point

Health and Social Care - IJB	3. All Time Bands						a. >2 weeks					b. >4 weeks						
	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Edinburgh	121	122	95	82	67	85	67	61	54	38	32	43	36	36	32	23	25	23
East Lothian	22	19	15	25	15	20	10	7	8	7	8	7	4	5	6	5	6	3
Midlothian	11	3	12	10	11	11	3	0	0	1	2	2	0	0	0	0	1	1
West Lothian	15	14	29	13	17	13	8	3	6	6	7	5	3	3	3	4	3	3
All (inc. other)	173	161	154	134	112	134	90	76	69	54	51	60	46	47	43	34	37	32

Timescale for Improvement – Edinburgh IJB

A trajectory has been 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)				
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
118	100	80	55	50	64	46	26	1	0	36	33	15	0	0

Actions Planned and Outcome – Edinburgh IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Following the Key Stakeholder Event on 8 March 2016, a work programme has been finalised and comprises two main work streams: a) addressing delays within the pathway b) admission avoidance.	8 March 2016	Reductions in delayed discharge.		Leads have been identified for the two main work streams. Progress will be overseen by the Patient Flow Programme Board which is scheduled to meet fortnightly. A Programme Group has been set up and will meet weekly to ensure that any emerging issues are identified and addressed.
Additional capacity at Gylemuir (interim care home) – 30 additional beds bringing the total capacity to 60. The phasing of the additional capacity was 15 in September 2015, 5 in December 2015 and 10 in January 2016.	Completed January 2016	Increase speed of discharge pathway for those awaiting care home	The latest figures show improved turnover within Gylemuir, showing that a higher number of hospital discharges are being supported.	All additional beds on stream. In the 12 weeks after the capacity was increased to 60 beds, the average number of admissions per week increased to 5.5 compared with 3.8 in the previous 12 weeks, indicating increased turnover and better use of capacity. However, the outbreak of norovirus in April has led to a temporary reduction in turnover.
Locality Hub development – employment of additional clinical support workers	Ongoing	Support people to leave hospital and avoid readmission	To be determined –monitoring and evaluation is being developed.	The model, originally piloted in South East, is now being tested across the four localities.
Review reablement provision to ensure effective use of the resource. This is part of the demand management work stream, being led by EY.	June 2016	With more effective targeting of the reablement service to people who are likely to benefit, it is anticipated that there will be a greater reduction in the level of support needed.		New selection criteria for the service and the referral and service pathways have been agreed. Monitoring of performance is underway.

Comments – Edinburgh IJB

The number of reportable delays in Edinburgh increased in May. Compared with April 2016, there was an increase in the number of people who had waited more than two weeks, but a reduction in the number waiting for more than four. However, the targets for both the headline figure (67 delays against a target of 55) and the target for those waiting for two weeks or longer (32 against a target of 0) were missed.

Reasons for Current Performance

Waiting for domiciliary care was the largest waiting reason at census. The demand management work stream noted in the table above is intended to address this.

Delayed Discharges – Midlothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	0 (max)	60	May 2016	No	Yes	EM

Summary for Committee to note or agree

- There continues to be a slight dip in performance within Midlothian, partly driven by difficulties being experienced by care at home providers within certain areas of Midlothian and work is now underway to establish a Health & Social Care Academy to support improved recruitment within key areas of the county.

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16
1. All Delays Recorded	403	403	382	392	394	364	358	355	318	319	280	302
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a. Those over 2 weeks	99	104	108	126	122	117	90	76	69	54	51	60
b. Those over 4 weeks	63	69	75	73	77	75	46	47	43	34	37	32

Table 2: ISD Delays excluding X Codes by Health & Social Care Partnership at census point

Health and Social Care - IJB	All Standard Delays						>2 weeks						>4 weeks					
	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
Edinburgh	121	122	95	82	67	85	67	61	54	38	32	43	36	36	32	23	25	23
East Lothian	22	19	15	25	15	20	10	7	8	7	8	7	4	5	6	5	6	3
Midlothian	11	3	12	10	11	11	3	0	0	1	2	2	0	0	0	0	1	1
West Lothian	15	14	29	13	17	13	8	3	6	6	7	5	3	3	3	4	3	3
All (inc. other)	173	161	154	134	112	134	90	76	69	54	51	60	46	47	43	34	37	32

Timescale for Improvement – Midlothian IJB

A trajectory has been agreed with SGHD and set out below (or please provide alternative information, if a trajectory has not been agreed):- The target for Midlothian in the number of patients waiting over 2 weeks is set out below though, as previously noted, work has begun in planning for delivery against the 72 hour target and a trajectory is in development **which will be included in future updates.**

May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	April 2017	May 2017
0	0	0	0	0	0	0	0	0	0	0	0	0

Actions Planned and Outcome – Midlothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Discussion and agreement with other home care providers to consider options for delivering home care support.	31 May 2016	Increased hours ad capacity for packages of care	To be determined and will be monitored on a weekly basis	Further negotiation with local providers and Council Procurement
Care Home that was previously closed to admissions now accepting new residents	30 June 2016	Increased capacity within Care Homes	Number of residents increasing but slowly as working through a phased approached to new admissions	Plan now in place to increase the number of weekly admissions

Comments – Midlothian IJB**Reasons for Current Performance**

The continued performance below target is a reflection on the ongoing issues in relation to Packages of Care at Home, particularly in the West of the County as a result of difficulties being experienced by local providers. The proposal for another provider taking on this work is yet to reach a conclusion, which has contributed to the 2 delays in May.

Delayed Discharges – West Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	0 (max)	60	May 2016	No	Yes	JF

Summary for Committee to note or agree

- Target to reduce delayed discharge level to 0 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.
- A new Care at Home Contract has been fully implemented in April 2016 and it is anticipated that this will contribute to achievement of 0 delays

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16
1. All Delays Recorded	403	403	382	392	394	364	358	355	318	319	280	302
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All (inc. other)	173	161	154	134	112	134	90	76	69	54	51	60	46	47	43	34	37	32

Timescale for Improvement – West Lothian IJB

An official trajectory for West Lothian has not been agreed with the SGHD.
Local improvement targets would aim to achieve compliance by end of 2016.

Actions Planned and Outcome – West Lothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Established Frailty Programme with following aims <ul style="list-style-type: none"> To design a whole system model of care for frail elderly adults that meet overall IJB strategic priorities To reduce hospital admission and re-admission and minimise delayed discharge To contribute to the financial efficiencies of the IJB To identify areas of skills development to support the new model of care 	March 2017	Reduction in emergency admission Reduction in delayed discharge.	Delays over 2 weeks average 6 per month Frailty programme work streams being reviewed and priorities identified	Amber
Embedding of new Care at Home contract	April 2016	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	Green
Further development and expansion of REACT	Sept 2016	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	Amber
Comprehensive needs assessment is in progress which will inform the IJB Commissioning Plan for Older People	Sept 2016	Clear identification of needs for older population	Outcome awaited of Needs Assessment to be completed end of June Priorities agreed within Strategic Plan	Green

Comments – West Lothian IJB

Reasons for Current Performance

Performance maintained across first quarter of 2016. Transition to the new Care at Home contract contributing to some delays in this period with home care packages the main reason for delay. It is anticipated this will improve as new contract is embedded

Staff Sickness Absence

Healthcare Quality Domain: Person Centred

Target/Standard: 4% Staff Hours or Less Lost to Sickness

Responsible Director[s]: Director of Human Resources and Organisational Development

Performance:-

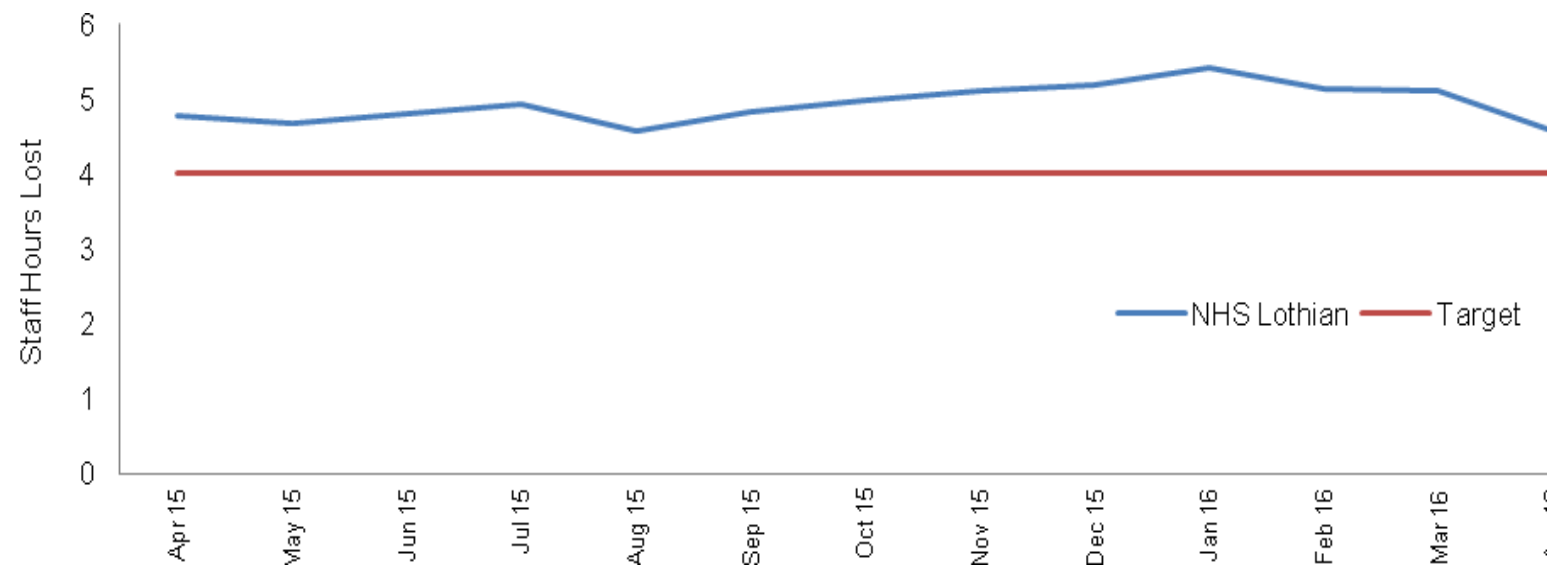
Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Better	4% (max)	4.57%	Apr 2016	Yes	No	AB

Summary for Committee to note or agree

- Performance remains below standard but an improvement seen from the previous month

Recent Performance – % against Standard

Figure 1: NHS Lothian Staff Sickness Absence (% Staff Hours Lost)



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 is being set up to facilitate effective performance monitoring.	-			Completed
As part of the Sustainable Workforce Programme Board a sickness absence project has been set up to focus on what support needs to be provided to managers to assist them with their management of absence.	Ongoing			

Comments

Reasons for Current Performance

Whilst NHS Lothian continues to perform better than the NHS Scotland average it has to be noted that the overall NHS Scotland performance in relation to sickness absence has deteriorated. 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, 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 we are currently taking to support managers with this task.

Smoking Cessation

Healthcare Quality Domain: Equitable

Target/Standard: 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).

Responsible Director[s]: Director of Public Health and Health Policy

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated Since Last Cycle?	Narrative Updated Since Last Cycle?	Lead Director
Not Met	↑	Better	293 (min) – 147 (50%) to be achieved by PCR-Pharmacy; & 'All Others' respectively:-	282 (rolling 3 month total)	Dec - Feb 2016	Yes	Yes	AKM
			a. PCR Pharmacy – 147 (50% of overall target)	110				
			b. 'All Others' – 147 (50% of overall target)	172				

Summary for Committee to note or agree

- The target for Q4 2015-16 will be **291** (146 for PCR Pharmacy and 'All Others' respectively). The target for Q1 2016-17 will be **368** (184 for PCR Pharmacy and 'All Others' respectively).

Recent Performance – Numbers Achieved towards Standard

Figure1: Successful Quits in 40% most deprived areas for NHS Lothian for financial year 2015-16 (For Quit Dates per Rolling 3 Months)

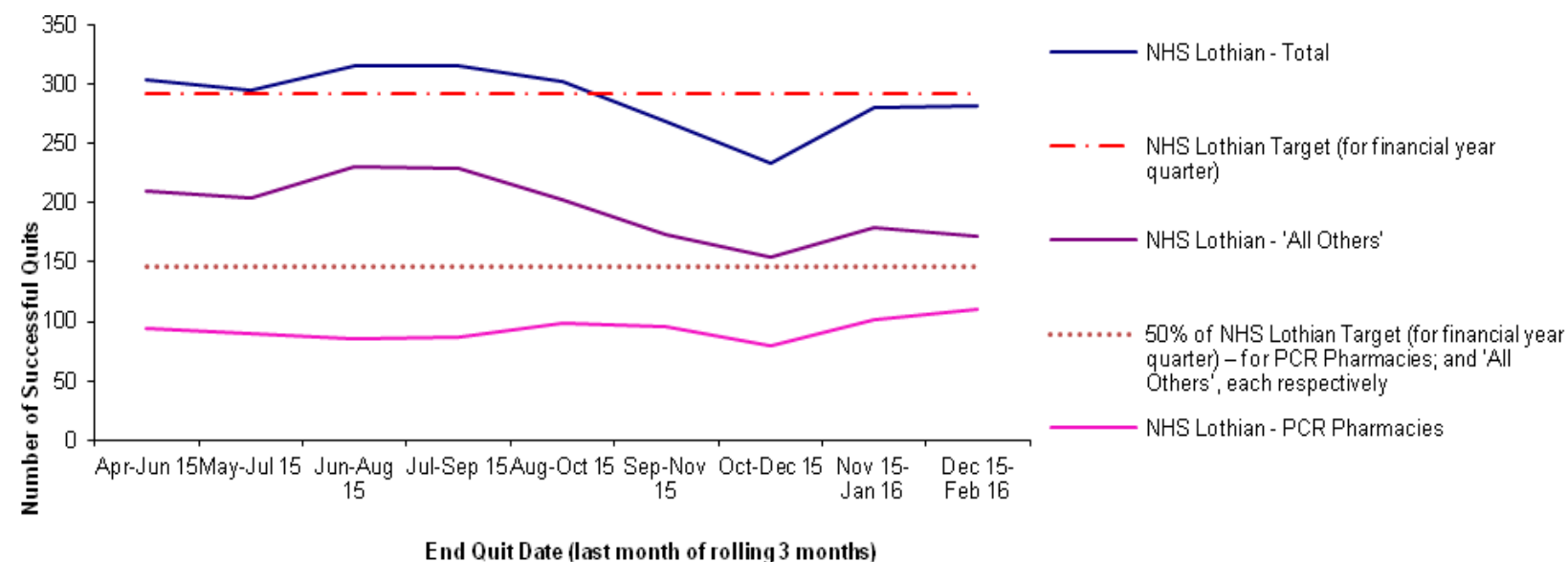


Table 1: Successful Quits in 40% most deprived areas for NHS Lothian for financial year 2015-16 (For Quit Dates per Rolling 3 Months)

Quit Dates	Apr - Jun 15	May - Jul 15	Jun - Aug 15	Jul - Sep 15	Aug - Oct 15	Sep - Nov 15	Oct - Dec 15	Nov 15 - Jan 16	Dec 15 – Feb 16
NHS Lothian Target (for financial year quarter)	293	293	293	293	293	293	293	293	293
NHS Lothian Total - incl. PCR Pharmacies	304	295	316	316	302	269	234	280	282
50% of NHS Lothian Target (for financial year quarter) – for PCR Pharmacies; and 'All Others', each respectively	147	147	147	147	147	147	147	147	147
NHS Lothian Total – PCR Pharmacies only	94	90	86	87	99	95	79	101	110
NHS Lothian Total – 'All Others'	210	205	230	229	203	174	155	179	

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 service is in the process of redesign to meet reductions in budget from LRP and the Scottish Government allocation and has therefore had some disruption to staffing levels. A new service manager will be appointed soon to take forward further improvements in the way the service operates.				

Comments

Reasons for Current Performance

Mitigating Actions

Complaints: 3-Day & 20-Day Acknowledgement/Response Rate

Healthcare Quality Domain: Person Centred

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 3 days.

Responsible Director[s]: Executive Director: Interim Nurse Director

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
1. Not Met	↑	Worse	100%	82%	Mar 2016	No	No	AMcM
2. Not Met	↑	Worse	80%	52%	Mar 2016	No	No	AMcM

Summary for Committee to note or agree

- There is no nationally agreed target for complaints and we are required to submit data quarterly to Information Statistics Division that is published annually on their website.
- NHS Lothian have set a local stretch target of 80% response rate for 20 days;
- 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;
- The denominator (number of complaints received) will change every month.

Recent Performance – Numbers against Standard

Figure 1: NHS Lothian 3-Day Formal Complaints Acknowledgment Rate

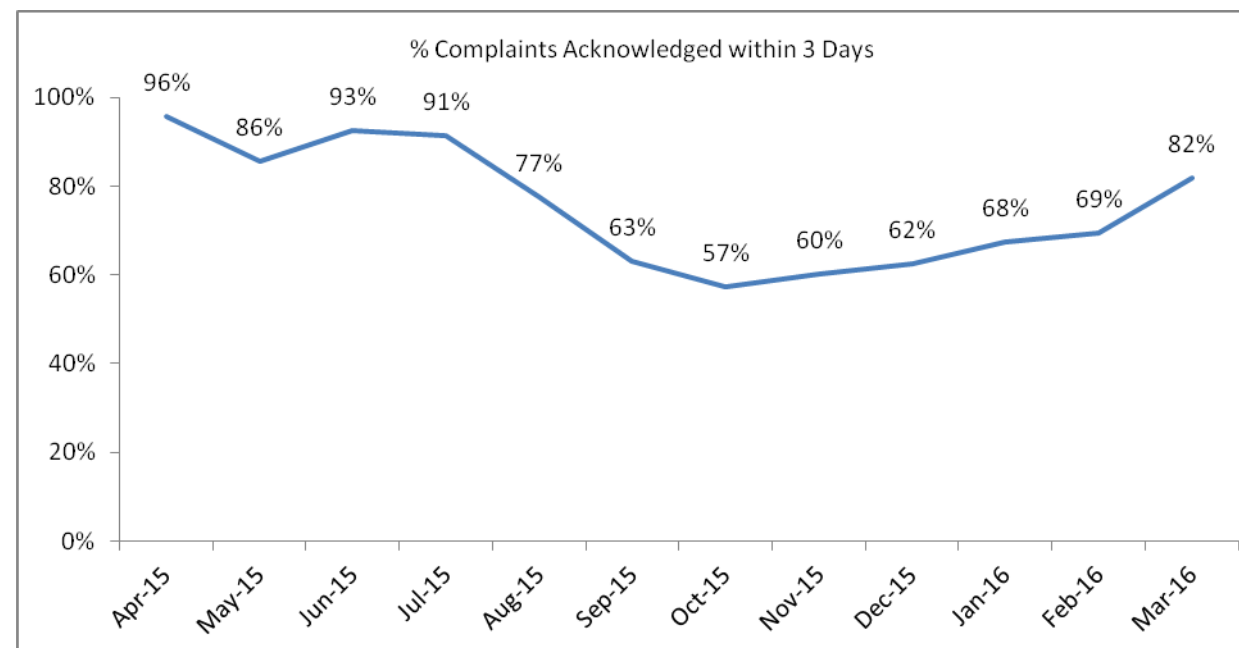
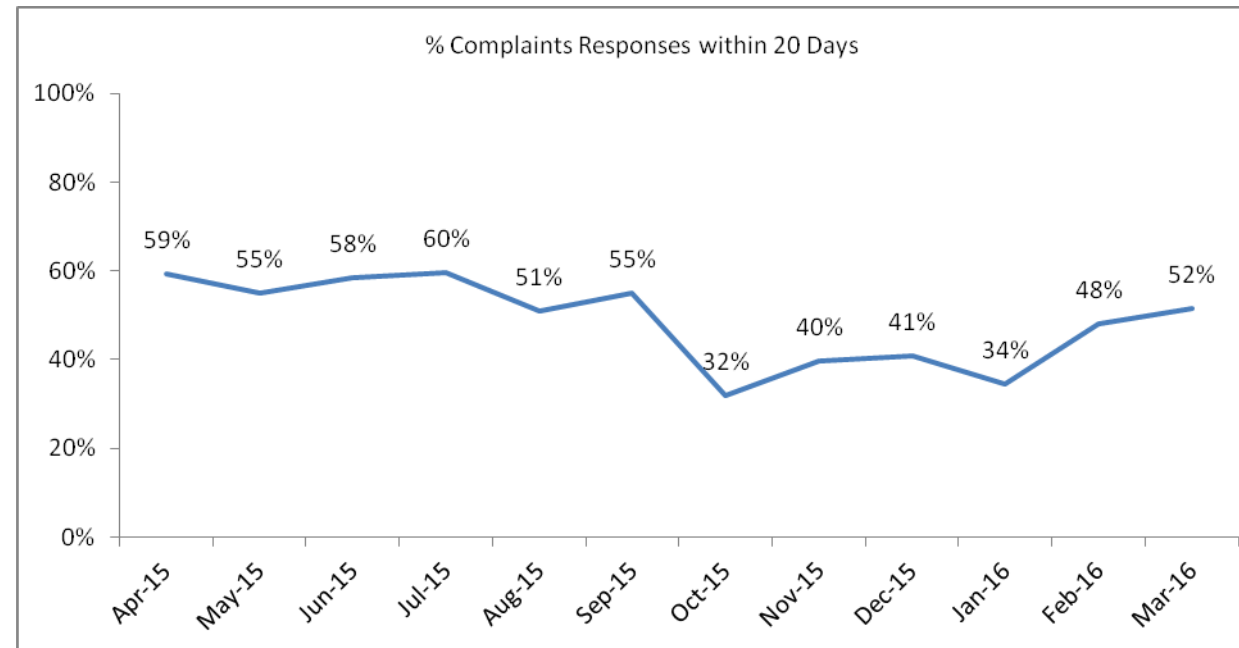


Figure 2: NHS Lothian 20-Day Complaints Response Rate



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
Patient Feedback paper went to April 2016 Board meeting included enhanced complaints information including themes.	Completed			
Reviewed targets with Executive Director in absence of nationally agreed targets and have set a target of 80% of complaints to be acknowledged which was agreed with Lothian Professional Nurses Forum at their April meeting.	April 2016	Agree trajectory with LPNF		
Appoint to vacant posts	June 2016	Improved performance for targets		
Non-Executive appointed as Board Champion for complaints & feedback				
Quality Assurance Committee being set up with first meeting planned in August				

Comments

Reasons for Current Performance

Improvements have been seen in both 3-day and 20-day response rates
Sickness within the team during April is 5% but there remains vacant posts as 2 WTE have been withdrawn.

Detecting Cancer Early (DCE)

Healthcare Quality Domain: Person Centred

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

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Better	29% (min)	26.2%	2013 & 2014	No	No	AKM

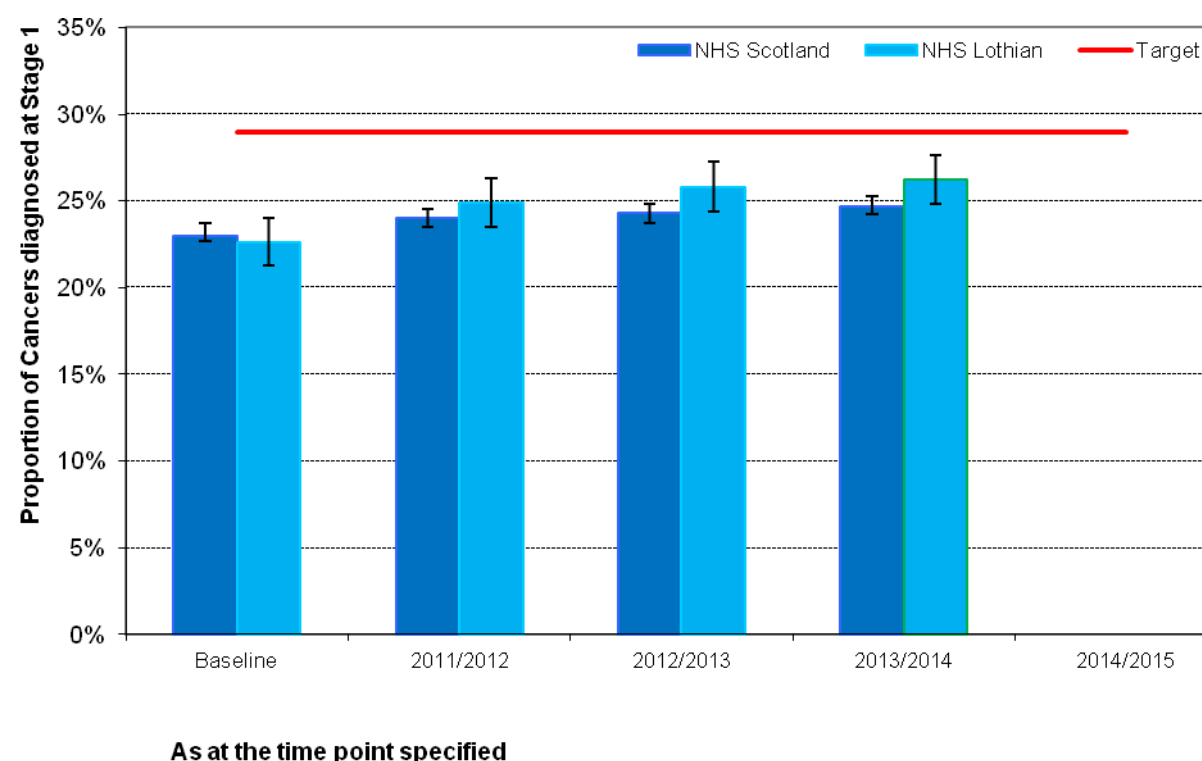
Summary for Committee to note or agree

NHS Lothian’s performance over time against this target has consistently been over the All Scotland position, and has met or exceeded our agreed performance trajectory for previous years, as shown in the chart below. NHS Lothian delivered the greatest percentage improvement of all Boards in the last reported performance period (2014-2015 combined). However we are not yet at the final targeted performance level of 29% to be reached by the end of 2015. The NHS Lothian DCE programme has continued to invest in the symptomatic cancer pathways and the cancer screening programmes throughout 2015 to support further improvement from our current performance of 26.2%.

The DCE target is reported on annually by ISD. The last published report was for 2013 & 2014 combined, as depicted in the chart below. The report for the period 2014 & 2015 combined will not be published until the autumn of 2016. Considering the trends in Lothian performance over time, we can observe an average of a 1.3% improvement each year. If this performance improvement is maintained we would estimate a final 2014/2015 combined year position for the Lothian DCE programme of 27.5% (for reference our performance for the single calendar year of 2014 was 27.4%). This would represent significant improvement and overall good performance from the Lothian programme, however would fall short of the full target of 29% by 1.5%. It is expected that NHS Lothian’s performance will continue to exceed the all Scotland level of performance.

Recent Performance – Numbers Against LDP Target

Figure 1: Current Performance for NHS Scotland and NHS Lothian



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 2015/16	31/3/16	Stage 1 detection performance improvement, particularly via the breast and bowel screening programmes.		Ongoing

Comments

The cancer pathways in 2015 are now complete and therefore the DCE investment and targeted schemes taken forward throughout the service have delivered their outputs. The final performance metric for 2014 – 2015 combined will not be known until the data is provided by ISD in the autumn of 2016. Because of ongoing data upload to ISD from NHS Lothian it is not possible to reliably estimate 2015 performance from our local management data.

Reasons for Current Performance

Mitigating Actions: As above. The actions undertaken, and increased capacity to address barriers to access and bottlenecks in the system, have been embedded in routine practice. An ongoing programme of investment in surveillance, identifying areas for improvement/addressing inequalities and implementing improvements continues across the patient pathway with significant engagement of general practice.

Dementia

Healthcare Quality Domain: Person Centred

Target/Standard: People newly diagnosed with dementia will have a minimum of 1 year of post-diagnostic support (PDS).

Responsible Director[s]: Executive Director: Chief Officer, Acute Services

Performance:-

Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
TBC ¹	N/A	Not Applicable	100% (1 Year (Min))	5.3	Apr 2016	Yes	Yes	JC

Summary for Committee to note or agree

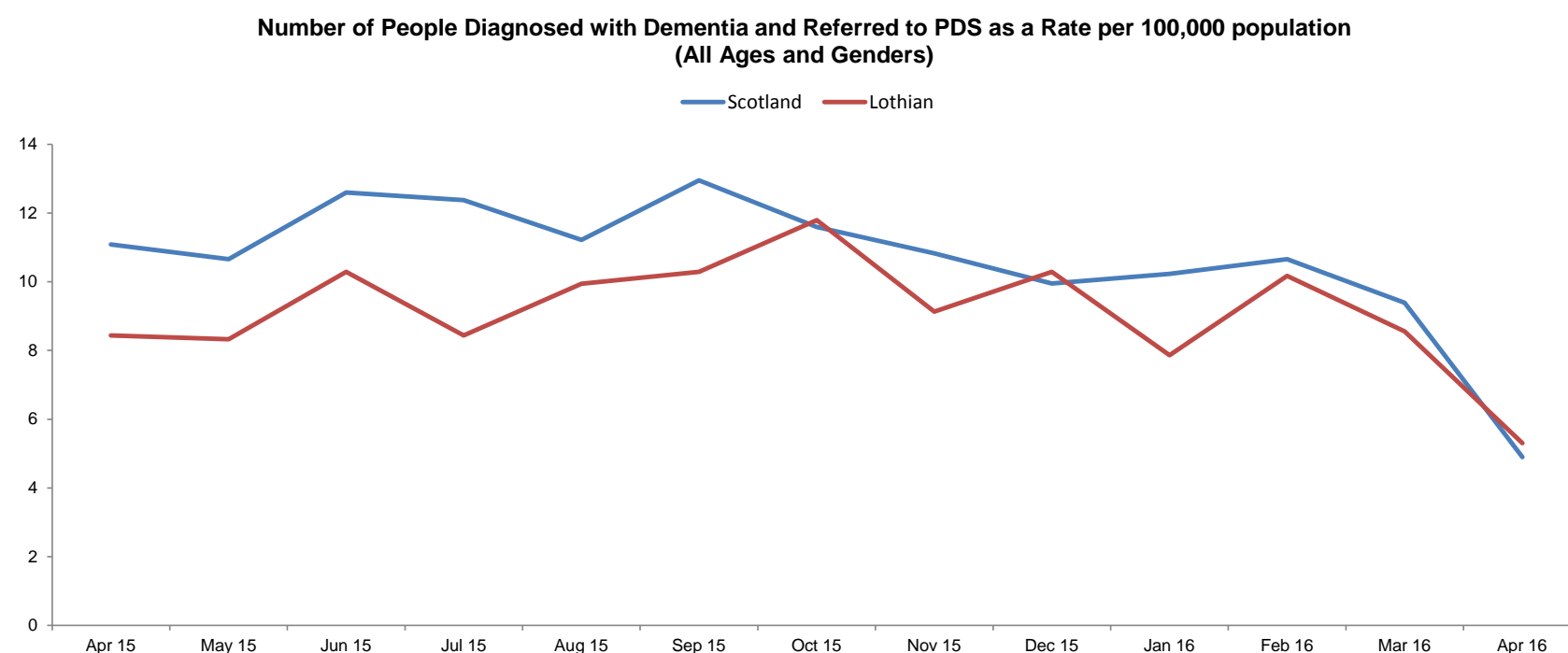
- ¹The data published by ISD on the dementia standard reports the rate of referral for post diagnostic support based on 100,000 per population. We are currently awaiting confirmation from ISD regarding what the expected rate would be in order to evaluate performance against the standard;
- The numerator is based on month of diagnosis rather than month of referral so there is 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 for referral for Post diagnostic support is currently in line with the overall national rate;
- The rate is only currently published at Health Board level not by IJB/ locality level. This has been requested from ISD.

Recent Performance – % against Standard

Table 1: Rate of Referral to PDS in each month for those Diagnosed with Dementia

	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
Scotland	11.1	10.7	12.6	12.4	11.2	13.0	11.6	10.8	10.0	10.2	10.7	9.4	4.9
Lothian	8.4	8.3	10.3	8.4	9.9	10.3	11.8	9.1	10.3	7.9	10.2	8.6	5.3

Chart 1: Rates of Referral to PDS in each month for Scotland and NHS Lothian, for those Diagnosed with Dementia - Source: ISD



Timescale for Improvement

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

Action	Due By	Planned Benefit	Actual Benefit	Status
Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.	Completed	Increase reported rate of referral for PDS.	The reported rate has increased. For example our rate for August 15 was 0.7, following capture of additional data it is now 9.3 and our rate is comparable with the Scottish average across most months.	Completed
Improve recording of diagnosis in TRAK. <ul style="list-style-type: none"> Procedures agreed and implemented with local teams Routine reports to feedback performance to teams in place 	Ongoing	Increased recording of all diagnosis to allow comparison of actual versus expected rates for diagnosis of dementia.	Initial Position for % of patients on older adult services caseloads (with at least 1 attended appointment with a consultant) who had a diagnosis of dementia recorded in TRAK in May 2015 was 21%. Position reported in January 16 was 75%.	Will continue to monitor recording
Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area.	July 2016	<ul style="list-style-type: none"> Enable reporting of performance by IJB; Increase local ownership of performance and improvement planning. 		Awaiting ISD guidance
Awaiting ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia.	TBC (ISD)	<ul style="list-style-type: none"> Allow more accurate evaluation of performance against the standard at Board and partnership level. 		

Comments

NHS Lothian's rate for referral for Post diagnostic support is currently in line with the overall national rate;

Reasons for Current Performance

Improving recording of diagnosis remains a priority.

Patient Experience – Tell us Ten Things (TTT) Inpatient Survey (Question 10 – Overall Experience)

Healthcare Quality Domain: Person Centred

Target/Standard: 9.0 out of 10

Responsible Director[s]: Executive Director: Interim Nurse Director

Performance:-

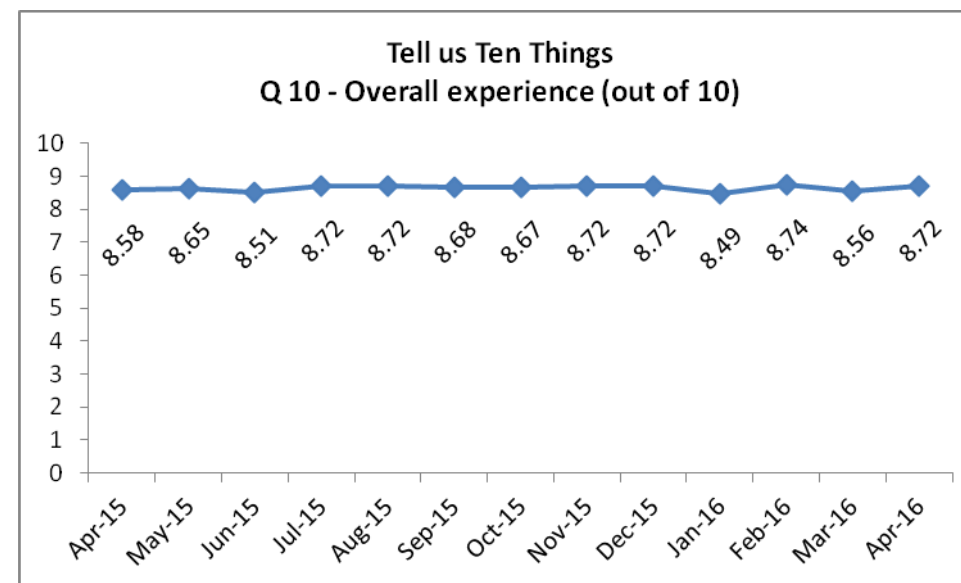
Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Not Applicable	9.5/10	8.72	April 2016	Yes	Yes	AMcM

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



Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:- **N/A**

Measure	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure

Actions Planned and Outcome				
Action	Due By	Planned Benefit	Actual Benefit	Status
Agreed with Director's of Nursing Group an initial stretch target of 10% return rate				
Improved circulation of TTT site and local reports to ensure ANDs receive these				
Reviewing return rates to highlight areas where there is a very poor return rate				
Midlothian to test TTT survey in community hospital setting and will test the use of an electronic data-capture system.				
Comments				
Reasons for Current Performance				
Patient Experience staff have been asked to prioritise complaints and feedback activity				

5 Risk Register

5.1 Not applicable.

6 Impact on Inequality, including Health Inequalities

6.1 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.

7 Involving People

7.1 As the paper summarises trends in performance and identifies remedial action, no impact assessment or consultation is expected.

8 Resource Implications

8.1 The resource implications are directly related to the actions required specified in the proforma.

Katy Dimmock
Analytical Services
17 June 2016

katy.dimmock@nhslothian.scot.nhs.uk

Andrew Jackson
Analytical Services

andrew.c.jackson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Technical Document

Appendix 2: HAI Scottish Government Reporting Template

Measure	Target/Standard	Source for Current Data
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).	Smoking Cessation Database
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.	Discovery
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.	Management Information
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.	Management Information
Delayed Discharges (over 2 weeks)	No patient should wait more than 14 days in hospital once they are ready for discharge.	EDISON
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.	NHS Lothian Infection Prevention and Control Team
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.	NHS Lothian Infection Prevention and Control Team
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%.	Management Information
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.	Management Information
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).	Management Information
Stroke Bundle (% receiving)	The stroke bundle covers four targets: 1. Percentage admitted to a Stroke Unit within 1 day of admission – 90%; 2. Percentage with swallow screen on day of admission – 90%; 3. Percentage with brain scan within 24 hours of admission – 90%; 4. And percentage of ischaemic stroke patients given aspirin within 1 day of admission – 95%.	Management Information
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.	Management Information
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.	Management Information
Referral to Treatment (18 Weeks)	90% of planned/elective patients to commence treatment within 18 weeks of referral.	Management Information
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.	Management Information
Surveillance Endoscopy (past due date)	No patient should wait past their planned review date for a surveillance endoscopy.	Management Information
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.	Management Information
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%).	ISD Scotland
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%.	ISD Scotland
Staff Sickness Absence Levels (<=4%)	4% Staff Hours or Less Lost to Sickness	Management Information (SWISS)
Cardiac Arrest	50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2015 from February 2013 (1.9 per 1,000), baseline. "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.	Management Information (Local Audits (Resuscitation Officer Database))
Falls with Harm	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.	Management Information (Datix)
Hospital Standardised Mortality Ratios (HSMR) (20% reduction)	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.	ISD Scotland
48 Hour GP Access - access to healthcare profession; or GP appointment.	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	Scottish Government
Alcohol Brief Interventions (ABIs)	This is the emergency readmissions to a surgical speciality within 7 days of discharge as a rate per 1000 total admissions to a surgical speciality. This measure has been standardised by age, sex and deprivation (SIMD 2009).	Management Information
Hospital Scorecard - Standardised Surgical Readmission rate within 7 days	As for 7 day readmissions.	ISD Scotland
Hospital Scorecard - Standardised Surgical Readmission rate within 28 days	This is the emergency readmissions to a medical speciality within 7 days as a rate per 1000 total admissions to a medical speciality. This measure has been standardised by age, sex and deprivation (SIMD 2009).	ISD Scotland
Hospital Scorecard - Standardised Medical Readmission rate within 7 days	As for 7 day readmissions.	ISD Scotland
Hospital Scorecard - Standardised Medical Readmission rate within 28 days	Ratio of 'observed' length of stay over 'expected' length of stay. This indicator is case mix adjusted by HRG* and speciality. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each speciality and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).	ISD Scotland
Hospital Scorecard - Average Surgical Length of Stay - Adjusted		

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).	ISD Scotland
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.	Management Information (Datix)
Dementia	People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support	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

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	1	3	2	1	2	1	2	0	2	3	4	1
MSSA	21	20	15	15	16	7	14	20	18	20	21	12
Total	22	23	17	16	18	8	16	20	20	23	25	13

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	7	7	10	12	18	12	11	6	8	8	9	8
Age 65 plus	15	17	16	24	22	18	13	23	9	19	12	13
Total	22	24	26	36	40	30	24	29	17	27	21	21

Hand Hygiene Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
AHP	98.11	94.58	96.35	96.10	95.73	97.08	93.07	96.85	97.17	92.11	96.86	95.11
Ancillary	90.37	95.03	93.82	90.79	93.28	94.35	93.58	92.78	95.35	91.30	92.38	91.43
Medical	94.48	92.07	92.92	92.27	91.58	92.59	92.60	94.13	93.35	93.61	93.79	92.78
Nurse	98.67	98.25	97.66	97.11	97.62	98.02	97.50	97.28	98.16	98.59	98.43	98.27
Board Total	97.23	96.45	96.35	95.63	95.88	96.53	95.79	96.30	96.96	96.46	97.06	96.55

Cleaning Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	95.55	95.25	95.50	95.45	97.40	95.60	95.70	96.00	95.80	95.55	95.45	95.75

Estates Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	96.40	96.15	95.70	95.35	94.90	94.85	95.65	95.70	95.95	95.45	95.80	95.30

ROYAL INFIRMARY OF EDINBURGH

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	1	0	1	0	1	0	2	0	1	2	3	0
MSSA	10	9	10	7	7	3	5	8	8	10	14	5
Total	11	9	11	7	8	3	7	8	9	12	17	5

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	1	2	3	2	5	3	6	2	2	1	2	2
Age 65 plus	2	4	5	8	6	6	2	3	0	5	4	2
Total	3	6	8	10	11	9	8	5	2	6	6	4

Cleaning Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	96.61	96.53	97.26	97.12	96.52	96.96	97.02	97.43	97.26	97.11	97.62	97.08

Estates Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	95.87	95.94	97.24	94.42	95.23	96.86	98.47	98.79	97.80	97.70	98.87	98.39

WESTERN GENERAL HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	0	0	0	1	1	0	0	0	1	0	1	0
MSSA	7	7	4	8	6	4	5	6	4	5	5	4
Total	7	7	4	9	7	4	5	6	5	5	6	4

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	2	3	1	7	4	2	4	2	1	3	3	1
Age 65 plus	2	5	5	9	7	2	9	9	1	5	4	3
Total	4	8	6	16	11	4	13	11	2	8	7	4

Cleaning Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	94.65	94.17	94.01	94.02	93.74	93.94	95.73	95.58	95.16	95.12	94.84	95.31

Estates Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	96.07	95.33	94.84	94.87	93.24	92.55	93.33	92.74	93.03	93.04	93.65	92.62

ST JOHNS HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	0	3	1	0	0	0	0	0	0	1	0	0
MSSA	3	4	0	0	1	0	2	3	2	4	0	2
Total	3	7	1	0	1	0	2	3	2	5	0	2

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	0	0	2	1	2	0	0	0	1	1	0	2
Age 65 plus	1	4	2	1	4	4	1	2	2	3	1	4
Total	1	4	4	2	6	4	1	2	3	4	1	6

Cleaning Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	95.79	94.75	94.92	95.65	95.14	95.65	95.34	95.66	94.97	94.89	95.45	95.21

Estates Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	95.45	95.16	93.97	94.56	94.24	94.73	93.85	94.05	95.23	93.87	94.36	95.01

LIBERTON HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	0	0	0	0	0	1	0	0	0	0	0	1
MSSA	0	0	0	0	0	0	0	2	1	0	0	0
Total	0	0	0	0	0	1	0	2	1	0	0	1

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	0	0	0	1	1	0	0	0	0	1	0	0
Total	0	0	0	1	1	0	0	0	0	1	0	0

Cleaning Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	97.87	96.63	97.39	97.92	96.41	97.77	97.69	97.19	98.50	97.91	97.90	98.70

Estates Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	97.52	97.84	97.73	98.06	98.40	97.49	99.59	98.92	97.14	97.23	97.71	97.05

ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	0	0	0	2	0	2	0	1	1	2	1
Total	1	0	0	0	2	0	2	0	1	1	2	1

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	1	1	0	0	0	1	0	0	0	0	0	0
Age 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	1	0	0	0	1	0	0	0	0	0	0

Cleaning Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	94.22	93.47	94.11	94.90	93.93	94.42	94.54	94.02	94.51	94.72	95.16	94.37

Estates Monitoring Compliance (%)

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Board Total	97.77	95.83	93.99	95.73	93.27	93.54	94.25	95.16	96.08	94.90	95.63	94.12

COMMUNITY HOSPITALS

Community Hospitals include the following hospitals and care facilities

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

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	1	0	0	0	0	1	2	0	0	0
Total	0	0	1	0	0	0	0	1	2	0	0	0

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	1	1	0	0	0	1	0	0	1	1	0	0
Total	1	1	0	0	0	1	0	0	1	1	0	0

OUT OF HOSPITAL INFECTIONS

Clostridium difficile Infection Monthly Case Numbers

	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Age 15-64	3	1	3	2	7	6	1	2	4	3	4	3
Age 65 plus	8	3	4	5	4	5	1	9	5	4	3	4
Total	11	4	7	7	11	11	2	11	9	7	7	7

REVIEW OF MEDICAL PAEDIATRIC INPATIENT SERVICES IN Lothian**1 Purpose of the Report**

- 1.1 The purpose of this report is to inform the Board about the Royal College of Paediatrics and Child Health's Review of Medical Paediatric inpatient services in Lothian and its recommendations, and seek approval to implement these as set out in this paper.

Any member wishing additional information should contact the Chief Officer, University Hospitals and Support Services, in advance of the meeting.

2 Recommendations

- 2.1 To note the comprehensive review undertaken by the Royal College of Paediatrics and Child Health (RCPCH) which NHS Lothian Board commissioned in October 2015
- 2.2 To note that this review makes a series of important recommendations in respect of services and staffing arrangements at both the Royal Hospital for Sick Children (RHSC) and St John's Hospital (SJH) and recommends a 'one Lothian' approach to workforce and operational planning
- 2.3 To approve the RCPCH's recommendation for securing a safe and sustainable medical workforce model for SJH by establishing a resident consultant model of care for the paediatric inpatient service with additional investment (Option 1)
- 2.4 To approve that while the staffing infrastructure for Option 1 is being developed, the RCPCH's interim option, Option 2, or a variation of this option agreed with the SJH consultant team, is implemented. Whichever interim model is agreed, there will continue to be a 24 hour inpatient paediatric service at SJH but this must demonstrate a reduced risk of an unplanned service collapse, stop the reliance on staff having to work excess hours to cover locum shifts and end treble time payments to staff for this work. This interim option should be put in place from the end of August 2016.
- 2.5 To approve the RCPCH's recommendation for immediate additional investment in consultant staffing for the Medical Paediatric / Acute Receiving unit service at RHSC
- 2.6 To approve proposals for a Lothian wide strategy for the further development of advanced practice nursing roles for both Paediatric and Neonatal services
- 2.7 To approve the proposal to appoint a non Executive Board lead to chair a Paediatric Programme Board which will take forward the Report's wider recommendations about strategy, workforce, patient focus, infrastructure, safeguarding and governance.

3 Discussion of Key Issues

Background to Review

- 3.1 In October 2015, the Board agreed to commission an independent, external expert review of Medical Paediatric inpatient services across Lothian. This followed long standing challenges in sustaining the paediatric medical workforce at St John's Hospital, resulting in the temporary closure of the inpatient ward on two occasions, in July 2012 and again in July/August 2015. At the same time, the steady rise year on year in the number of admissions to the Acute Medical Receiving unit at RHSC has been putting increasing pressure on the medical workforce there which has needed to be addressed.

Terms of Reference

- 3.2 The Terms of Reference for this pan-Lothian review were: to review the patient pathways, workforce and services across the sites; to recommend what the most reliable, sustainable and affordable model for the future would be, with timescales; to advise on developing associated ambulatory care and medical assessment services; to advise on outcome measures to evidence the effectiveness of services.

Review process

- 3.3 The RCPCH agreed to undertake this review and their Review team spent 3 days in January 2016 visiting services and meeting staff and stakeholders. They also ran an online survey from December 2015 to mid March 2016 and held a series of focus groups in February 2016 in different parts of Lothian. NHS Lothian itself held a series of public meetings in March, two in each local authority area and the feedback from these was also taken into account in the Review.
- 3.4 The RCPCH's draft Report was received and circulated to Board members on 6 May 2016 and discussed at a Board members workshop on 11 May, with members of the Review Team present. The final Report is now attached and contains 31 separate recommendations.

Key Recommendations

- 3.5 This paper addresses the specific recommendations made by the RCPCH for the SJH medical workforce and the RHSC medical workforce as these are the most pressing issues.
- 3.6 The other important recommendations which include developing the Advanced Practice nursing workforce, the recommendations for the involvement of children, young people and their families in service planning, developing agreed criteria for Short Stay Paediatric Assessment on both sites, closer working with Primary Care, recommendations for the Neonatal services, more pan-Lothian workforce and operational planning and strengthening governance arrangements across all sites, will be taken forward by a Paediatric Programme Board to be chaired by a Non Executive Director of the NHS Lothian Board and will be the subject of separate future reports.
- 3.7 It is proposed that this Paediatric Programme Board will include clinical and leadership representatives from across the whole system including Primary Care

and it will be supported by a Programme Manager. A formal Project Plan will be developed and approved through the Acute Hospitals Committee.

St John's Hospital

- 3.8 The RCPCH's recommendation for SJH is that paediatric inpatient services there should be retained, in view of the population and activity in West Lothian and the need for a full obstetric service at SJH. They have provided 2 options to deliver this and a 3rd option which would deliver a short stay paediatric assessment service and would require alternative cover for the neonatal service.
- 3.9 The key principles which the College recommends should be agreed before modelling takes place are: that the SJH neonatal service should be designated as a Special Care unit under British Association of Perinatal Medicine (BAPM) 2010 Standards, with all infants under 32 weeks gestation transferred out; compliance with the RCPCH 'Facing the Future' standards in terms of presence and assessment of children and young people; compliance with the European Working Time Directive (EWTD); maximum 12 PA on rota; minimising cross-site cover.
- 3.10 The implications of formally designating the SJH neonatal service as a Special Care unit are that a very small number of mothers and babies may need to be cared for at the RIE Maternity and Neonatal Unit in future instead of SJH but this can be accommodated within existing resources.

Option 1

- 3.11 The College's recommended option, Option 1, is to establish a resident consultant model of service which all consultants at SJH (current and future appointments) should support in principle and in practice. This would require each consultant to do occasional overnights to provide onsite senior presence, supported by a non-resident consultant on call from home. The resident consultant model is in place in other hospitals around the UK to support paediatric inpatient services and the College estimates that it would take up to 2 years to implement in full. The current workforce could provide two nights per week and would be augmented by additional consultants including rotational posts with RHSC.
- 3.12 The College also recommends that the Deanery be asked to review the allocation of speciality Trainees to provide some daytime support for paediatric activity at SJH.
- 3.13 The College notes NHS Lothian's positive initiatives to develop Advanced Practice Paediatric and Neonatal nurses and recommends that this programme is enhanced and encouraged.

Option 2

- 3.14 Option 2 is presented by the College as either an interim option whilst progressing Option 1, or an alternative if Option 1 fails.
- 3.15 This option would see the SJH service providing overnight inpatient care as a 24 hour 'low acuity' unit which does not admit children overnight (8pm to 8 am) when consultants are not present. Paediatric patients could be accommodated overnight if their condition is sufficiently stable, as assessed by the evening consultant, but the emphasis would be to discharge home with 'safety netting' information or transfer to RHSC. Cover out of hours on site would be provided by mixture of Advanced Practice nurses/ other Tier 2 medical staff, with a non resident consultant on call

from home. The College estimates that this model could be put in place within 12 months with support from the wider Lothian staffing pool. It would require RHSC to have sufficient capacity to take the required admissions/ transfers.

Option 3

- 3.16 This option is a Short Stay Paediatric Assessment Unit (SSPAU) open from 8am to 10 pm, with no overnight accommodation for sick children and is in essence how the service operated during its two temporary closure periods. Consultant cover would be available during the daytime and until 10 pm but decisions to discharge or admit to RHSC would require to be made from 6pm, with no new attendances after 8pm.
- 3.17 The College points out that this option would require separate consideration of how neonatal support would be delivered when senior paediatric staffing was not available on site and suggests that this might require maternity provision at SJH to be reviewed and moved to a midwife-led / low risk model. We agree that separate provision for neonatal services would be required but this would not require NHS Lothian to review or reduce its maternity provision at SJH as contingency planning over the last 5+ years has allowed us to build up our neonatal workforce (both medical and nursing) so as not to be reliant on paediatric medical staff for this. This means that we could provide a high quality expert neonatal service for the Maternity service and Special Care Baby Unit at St John's as part of a networked staffing solution with the Neonatal service at the Royal Infirmary of Edinburgh.

Response to the options

- 3.18 It is recommended that NHS Lothian should accept the advice of the RCPCH as a UK expert body in this field and should therefore now vigorously pursue Option 1 as the recommended model for the SJH service.
- 3.19 The Board has previously tried to move towards a resident consultant model but only in respect of new appointments to the SJH service. 3 consultant posts were advertised and filled in 2012/13 but this approach resulted in a two tier consultant staff group and recruitment and retention has been an issue. One consultant left soon after appointment and the post has been repeatedly advertised but not filled.
- 3.20 The RCPCH's recommended approach is different as they are clearly advocating that all the consultants currently at SJH as well as any new appointments should sign up to this new model of care, to provide a cohesive, self sufficient workforce model. This is the cornerstone of Option 1. With enough consultants working to this model, the less frequently each will be required to provide this overnight cover.
- 3.21 Under the current national Consultant Contract, NHS Lothian cannot compel existing consultants to work to a resident consultant model and so the next stage in the process of pursuing the RCPCH's recommended option, Option 1, will be to initiate formal discussions with the SJH consultant group to determine what changes in support of a resident consultant model are mutually agreeable. The importance of securing the agreement of the current consultant workforce to provide routine out of hours cover to deliver Option 1 successfully cannot be underestimated.
- 3.22 If the consultant team at SJH all agree to this new model, the Board will proceed to implement it as soon as possible, with a commitment to appoint more consultants to the team as required, in order to stop the current reliance on existing staff doing locum shifts at treble time payment.

- 3.23 The Board will also have discussions with the Deanery about getting speciality Trainees allocated to SJH again for day time work as it is agreed this provides good training opportunities.
- 3.24 It is recognised that even if all the consultants currently working at SJH are able to agree to the resident consultant model there will still be a lag time until any additional consultants can be recruited and put in to post, as well as any additional Advanced Nurse Practitioners to support the wider service. The RCPCH Report estimates that this is likely to take up to 2 years.
- 3.25 Given that the full implementation of Option 1 will take time, the current model of care which relies on volunteers to cover the out of hours rota, working excess hours requiring EWTD waivers and treble time payment, must cease.
- 3.26 Instead, it is recommended that the Board should move *either* to implement Option 2, as an interim option, as proposed by the RCPCH *or* a variation of this model, as agreed with the SJH consultant team, while Option 1 is being progressed.
- 3.27 There will be further discussion about this with the SJH consultant team, who may be willing to agree changes to their working practices on an interim basis, whilst the Board works with them and the RHSC team to develop more pan- Lothian working, with the appointment of more consultants and the development of the Advanced Nurse Practitioner workforce. Whichever interim option is agreed, there will continue to be a 24 hour inpatient paediatric service at SJH but it must demonstrate a reduced risk of an acute patient service collapse, as well address the staff governance issues highlighted above.
- 3.28 The interim arrangements will also allow more time to pursue complimentary plans to enhance paediatric services at SJH such as increases in Day Surgery activity, more specialist outpatient clinics and more programmed investigation activity, to increase the care provided closer to home for West Lothian children. There is significant support across all the clinical teams to maximise services for children at SJH but the ongoing challenges of covering the out of hours service have distracted attention from this.

Royal Hospital for Sick Children

- 3.28 The RCPCH report highlights the growing pressure on the Medical Paediatricians at RHSC and specifically, the rising number of admissions through the Acute Receiving Unit (ARU) service which has insufficient consultant staff to meet this demand and to meet the College standards for acute paediatrics set out in 'Facing the Future' 2015.
- 3.29 The Report states that cover of the ARU by the core consultant team is not sustainable and an urgent solution is needed. It recommends that NHS Lothian expedites plans to increase Medical Paediatric consultant staff and this recommendation is accepted.
- 3.30 The Board should now proceed to recruit four more consultant paediatricians. This recruitment will need to comprise two as soon as possible, in order to have staff in place for the winter months, and two in 2017/18. As well as sustaining the ARU service, these additional posts will also allow the development of closer links with Primary Care, support the increasing pressures on High Dependency Care and support the increased age range of patients who will be cared for from 2017 in the new Children and Young People's Hospital.

- 3.31 The RCPCH also recommend that RHSC and SJH should each develop a formal Short Stay Paediatric Assessment Unit, which focuses on discharge and helps address the increasing activity through the Emergency Departments. Discharges can be nurse led and the Report recommends an active ongoing programme of recruitment/ training of Nurse Practitioners.

4 Key Risks

- 4.1 Ongoing potential for service collapse at SJH and risk to patient safety if plans to remodel the workforce cannot be quickly implemented.
- 4.2 Ongoing staff governance and health and safety risks if there is a continued reliance on staff working above EWTD maximum hours to support the SJH service in the interim.
- 4.3 Potential for internal competition between RHSC and St John's for applicants to consultant paediatrician posts.
- 4.4 Partly as a consequence of the risk in 4.3, an inability to recruit consultants to staff the recommended Option 1 model of service
- 4.5 The report did not consider in detail the specialist paediatric services delivered at RHSC and it is important that pressures due to activity, patient complexity and staffing are considered fully, along with those of general and acute paediatrics, by the proposed Paediatric Programme Board.

5 Risk Register

- 5.1 There are no new risks for the NHS Lothian Risk Register.

6 Impact on Inequality, Including Health Inequalities

- 6.1 A full Integrated Impact Assessment will require to be carried out if the Board agrees to move to Option 2, or a variation of this, as an interim option from end August

7 Involving People

- 7.1 The RCPCH committed from the start to involving and engaging with patients, families, staff, the public, voluntary sector and political stakeholders and the detail of this is set out in their Report
- 7.2 In addition, NHS Lothian organised two Public meetings in each of the 4 local Authority areas and the feedback from this was also submitted into the RCPCH review process.
- 7.3 All of the views gathered via the Review Team's visit, the online survey, the Focus Groups and the NHS Lothian Public meetings have informed the RCPCH's recommendations.

8 Resource Implications

- 8.1 Significant investment in new consultant posts will be required to implement Option 1 for the St John's service and to address the urgent consultant staffing pressures at RHSC.

- 8.2 In addition to medical posts, the Board will need to invest in a strategy for developing/ recruiting more Advanced Nurse Practitioners.
- 8.3 There are further resource implications highlighted in the Report, including the need to invest in a new Neonatal patient activity system (Badgernet) for both SJH and the RIE Neonatal unit.
- 8.4 These costs will be quantified as more detailed workforce plans are developed over the next few months.

Jim Crombie
Chief Officer
15 June 2016
j.crombie@nhs.net

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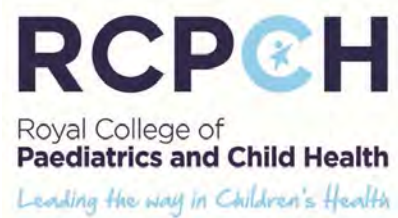
- Appendix 1: RCPCH Design Review of Paediatric Services in Lothian Health Board
- Appendix 2: 'You said, we heard' - Contributions to the RCPCH Design Review for Lothian Health Board

RCPCH Invited Reviews Programme

Design Review

Paediatric Services in Lothian Health Board

June 2016



RCPCH Invited Reviews Programme
June 2016

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5-11 Theobalds Road
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Tel: 0207 092 6000
Email: invited.reviews@rcpch.ac.uk
Web: www.rcpch.ac.uk/invitedreviews

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Executive Summary

Paediatric services in Lothian have faced staffing challenges for several years, particularly at the St John's Hospital site in West Lothian, but now increasingly for the Royal Hospital for Sick Children (RHSC) in central Edinburgh. At St John's there are public and political fears over the potential loss of inpatient paediatric services, and at RHSC the rapidly increasing activity is putting strain on the general paediatric service. Next year the RHSC wards and departments will relocate to purpose built accommodation alongside the Simpson maternity and neonatal intensive care units at the Royal Infirmary in Edinburgh.

The Royal College of Paediatrics and Child Health (RCPCH) was invited to review the paediatric service and recommend options with timescales for development of sustainable workforce model that meets professional service standards. The Review team was also asked to consider ambulatory (urgent) care and advise on outcome measures which would provide transparent evidence of the effectiveness of service distribution.

The Review team comprised two experienced consultant paediatricians, a children's nursing consultant and a lay reviewer, who visited the area three times, meeting staff, patients/parents and other stakeholders. The team was also provided with extensive data and information by NHS Lothian.

The Review team's overarching view is that the population, activity and demand for a full obstetric service in West Lothian merits the retention of inpatient paediatrics at St John's. The significant challenges to medical recruitment are due in part to 'custom and practice' amongst the medical team, the lack of senior trainees experiencing and enjoying busy general paediatrics at St John's and consequently choosing it for their first consultant post, and the history of uncertainty about the unit's future. We have provided staffing models based on the current establishment and also included alternative models making greater use of nurse practitioners. The challenge for NHS Lothian will be to implement this as a rolling improvement model.

Turning to the RHSC; the significant increase in activity through the Acute Receiving Unit (ARU) and consequent demand on specialist consultants to assist on the general 'take' is affecting the achievement of national targets. These include quality indicators such as waiting times, requiring expensive 'waiting list initiatives' or long delays for patients. The business case to recruit further consultant general paediatricians should be expedited to supplement the current team.

Finally the paediatric medical team at the Simpson, despite an impressive range of quality initiatives appears to be relatively unconnected from the wider neonatal network. Whilst consultants will provide rota cover for St John's there did not appear to be a truly shared responsibility for the infants born in West Lothian. The provision of internal 'locum'

neonatal consultant cover at St John's is expensive for a Special Care Unit (SCU) for which a general paediatrician should be competent. The absence of networked comparative data for benchmarking and to stimulate improvement is disappointing and the team is working towards achievements of the British Association of Perinatal Medicine 2010 document.

Nurse staffing across children's services in NHS Lothian is planned using specific Scotland-wide tools and is comparatively stable with nurses reporting high levels of satisfaction. There continue to be some posts which are difficult to fill but the Health Board has previously invested in development of specialist and Advanced Nurse Practitioners. This should be encouraged in order to 'grow' an appropriately skilled workforce in future which can contribute to the Tier 2 paediatric /neonatal rota. These skilled staff can often work across paediatrics and neonates but can take up to three years to train once an appropriate course is identified.

The operation of the paediatric assessment facilities at St John's and the RHSC should be tightened with much clearer protocols around referrals and discharge. Closer working with primary care, including the out of hours service and stronger links with the community children's nursing team should improve compliance with the RCPCH's 'Facing the Future Together for Child Health' standards, reducing demand for acute review and admission.

In terms of outcome measures to monitor progress of the service, there are a range of process indicators available but few that truly consider 'outcomes' objectively. We make several recommendations in the report around strengthening governance processes and would suggest that appropriate indicators should be developed by the clinicians themselves in conjunction with patients and families. These should be monitored as a monthly 'dashboard', including a programme of training if required to identify the impact of service changes. The chosen indicators may vary by site or by progress along the journey of improvement.

Overall the Review team found an enthusiastic and committed team of clinical and managerial staff, who are proud of their service, but needing strong and committed leadership to define and then deliver a positive vision for the service. It has been a pleasure to work alongside NHS Lothian, its staff, patients and stakeholders in this review and the RCPCH would be very happy to provide further information to the Health Board if clarification is required.

Recommendations

The recommendations below include all the issues that the Review team identified during the visits and through study of the documentation provided by the Health Board. We have grouped them into strategic and operational but the timescales and urgency require discussion with the Board and clinical teams in order to ensure sustainability and buy-in.

Strategic focus

- a) Commit to development of a clear 3-5 year strategic plan for the future of St John's inpatient paediatric service and the workforce that meets the needs of patients and includes investment in new ways of working. (10.3)
- b) Commit to a `one Lothian` approach to workforce and operational planning in paediatrics with staff rotation, and consistent governance which is clinically and confidently led. (10.4)
- c) Identify a Board- level Champion to chair a `Children's Board` which oversees all issues relating to children's services in Lothian. (10.5)
- d) Clearly communicate the vision through engagement with staff, patients, public, stakeholders and the future workforce. (10.4)

Workforce and Staffing

- e) Urgently address the emergency department/ARU medical staffing rotas at RHSC with the Deanery; consider relocation of some of the daytime trainee capacity to ARU, ED or St John's or other service pressures. (5.1.16), (5.2.13)
- f) Work with the Deanery towards increasing general paediatric experience earlier in the training schedule to increase numbers wanting to become general paediatricians. (6.1.8)
- g) Recruitment of general consultants to the RHSC ARU against the NHS Lothian Plan should proceed swiftly. (5.2.10)
- h) A robust and equitable approach to job planning and staff rotation across Lothian is required with clarity about expectations and a focus on the patients' and service needs as well as an appropriate work-life balance for the doctors. RCPCH Job planning guidance is available to assist. (6.3.2)
- i) Review all nursing establishments against Scottish guidance and the acuity tool to determine whether there is a significant shortage of nurses during winter periods. (5.2.23)

- j) Develop a funded nursing strategy to include nurse staffing guidance, education and future direction of nursing including the continued development of advanced practice roles. (5.2.23)
- k) Establish the Nurse Consultant roles in PICU and at St John's to lead the development of advanced practice across the hospitals. (6.4.12)
- l) Develop a funded Lothian-wide strategy for advanced nursing practice, with a five year plan for introduction of roles to address gaps in medical rotas and required service developments. (6.4.4)
- m) Review the overall policy for recruitment and retention of ANPs to include career progression and mechanisms for support. (6.4.4)
- n) Continue to support the development of in-house ANNP training and consequent strengthening of the Tier 2 rotas across the Lothian neonatal service. (6.4.9)
- o) Benchmark regularly linking with other units in order to clarify the gap in neonatal nursing and gain support and ideas. (5.5.10)
- p) Establish a rotation of nurses between the RIE and St John's neonatal units to build the team and ensure knowledge and skills are consistent across the service. (5.5.10)

Patient Focus

- q) Review protocols for assessment and transfer of young people under 16 years of age to adult wards to ensure that appropriate safeguarding and emotional support is in place. (5.1.9)
- r) Develop, with the involvement of young people/young adults, a Lothian-wide policy for transition of young people to adult services which is followed and audited across all hospitals in the Board area. (5.1.9)
- s) Overhaul the information available online for children, young people and carers at RHSC including advice on coming to hospital and (perhaps) details of management of common conditions, and links to useful websites. Involve CYP in website and information design. (9.5.9)
- t) Ensure that adequate information on RHSC is readily available to children, young people and families who are being transferred from St John's. (9.5.9)
- u) Ensure that there is a clear mechanism for incorporating patient and family feedback into decision making and that where there are gaps, further feedback/information is proactively sought. (9.5.13)

Infrastructure and Sustainability

- v) Establish a network approach to neonatal care with regular governance meetings and strategy. (5.7.2)
- w) Develop a plan for engaging more closely with local GPs in order to implement the recommendations from Facing the Future Together for Child Health. (7.2.4)
- x) Agree and implement criteria for the use of the short stay facility at each site which focusses on discharge and does not require full admission paperwork to be completed. (7.2.4)

Safeguarding and Governance

- y) Establish a programme of alignment of policies and procedures across the three children's and neonatal units ready for the move to the new accommodation. (9.3.4)
- z) Strengthen governance arrangements to include formal reporting and actions on quality and governance issues such as risk management, incidents and complaints, clinical audit. (9.3.8)
- aa) Actively seek experiential data from patients and families to inform decision making, by understanding the population and any possible health and/or social inequities that may arise. (9.3.8)
- bb) Re-emphasise the processes for reporting incidents and safety concerns to ensure risks are owned and appropriate action taken. (9.3.4)
- cc) Devise and implement an urgent plan to record and mandate safeguarding training across the medical staff at RHSC. (9.2.4)
- dd) Expedite the business case for Badgernet to enable national benchmarking. (5.6.2)
- ee) Consider an annual event for doctors to celebrate achievement across Lothian, with presentations and posters of audit and research projects and updates regarding educational developments. (9.3.16)

1 Introduction

- 1.1. In September 2015 the RCPCH was approached by the Medical Director at NHS Lothian, to conduct an invited review of paediatric services to help shape the future provision of safe, high quality and sustainable care for children and young people across Lothian.
- 1.2. This RCPCH review is an independent assessment of the service against agreed terms of reference (see section 2). The Review team consisted of two consultant paediatricians, a children's nurse, a lay reviewer with expertise in public engagement, and a member of RCPCH staff (see Appendix 1).
- 1.3. This report belongs to NHS Lothian through its Medical Director. The RCPCH encourages dissemination of this report, especially amongst those involved in the service. But this decision is the responsibility of the report owners and the RCPCH will not publish without the express permission of NHS Lothian.

2 Terms of reference

- 2.1 The RCPCH was invited to review the paediatric services across Lothian following the process set out in the '[RCPCH Guide to Invited Reviews \(April 2014\)](#)', The terms of reference, agreed by NHS Lothian's Acute Hospital Committee are:
 - a) **To review** NHS Lothian's Acute Medical Paediatric service and pathways of care at RHSC and at St John`s in terms of current and projected demand, expected quality & standards of care and current workforce arrangements;
 - b) Given NHS Lothian's current and realistically projected clinical workforce, **to recommend** what the most reliable, sustainable and affordable model of service for the foreseeable future would be;
 - c) If there are options about the best model, **to advise** NHS Lothian of the timescales within which each model could reasonably be implemented;
 - d) **To advise** NHS Lothian on how associated Acute Medical Paediatric services such as ambulatory care and medical assessment could be enhanced to improve care and maximise local access;
 - e) **To advise** NHS Lothian on outcome measures to provide transparent evidence of the effectiveness of service distribution;
 - f) All five objectives should be with clear reference to RCPCH's published standards within its [Facing the Future](#) work stream.

3 Background and context

3.1 NHS Lothian

3.1.1 NHS Lothian is an integrated NHS Board providing primary, community, acute and mental health services to the population of Edinburgh and the Lothians (total population approximately 870,000). It is a Teaching Board and also provides tertiary services across a range of specialities, including paediatrics, for patients from all other parts of Scotland.

3.1.2 Hospital based paediatric services and most community children's services are managed as part of NHS Lothian's University Hospitals Acute Division, within the Women's and Children's Services Directorate. Paediatric allied health professional services, child and adolescent mental health services (CAMHS), imaging and pharmacy are managed separately.

3.1.3 The Board includes a Child Health Commissioner whose remit for child and maternal health strategy spans the whole of Lothian.

3.1.4 The Children's Clinical Management Team is responsible for:

- The Royal Hospital for Sick Children, Edinburgh
- Paediatric acute services at St John's Hospital in Livingston, West Lothian
- Community child health services, across Lothian
- Community children's nursing services across Lothian
- Children's respite/residential houses
- Health visiting services, Edinburgh
- School nursing services, Edinburgh
- Family nurse partnership services across Lothian

3.2 Acute paediatrics - Service provision and challenges

3.2.1 Acute paediatric and neonatal services in Lothian are currently provided at three main hospital sites. The Royal Hospital for Sick Children (RHSC) near Edinburgh city centre provides secondary and tertiary medical and surgical care for children. The services will move in summer 2017 to a new hospital on the Royal Infirmary (RIE) site alongside the Simpson maternity hospital and its co-located neonatal intensive care unit (NICU).

3.2.2 St John's Hospital in Livingston opened in 1989, around 17 miles from the RHSC and provides a full range of acute 'DGH' paediatric services including an emergency department/receiving unit, a 14-bed paediatric inpatient ward seeing around 3,000 children a year, GP Assessment Bay, outpatient services and a recently refurbished neonatal unit supporting a consultant led obstetric service with approximately 2,600 deliveries annually.

Figure 1 – map of the three main hospital sites within NHS Lothian¹



3.2.3 St John's has struggled to attract skilled paediatric medical and nursing staff to cover the medical rota despite national and international recruitment drives. There was a period of closure of the inpatient ward in 2012, as overnight medical cover could not be secured. Two reviews of training arrangements attempted to find a workable and sustainable solution. In June 2013 an expert panel commissioned by the Scottish Government Health Department (the Tailored Workforce Support Team) reviewed the St John's situation along with the paediatric staffing position at RHSC and RIE. While outlining a number of potential service and workforce options for St John's, the panel did not recommend a preferred option.

3.2.4 The staffing problems of 2012 recurred resulting in a six-week closure of overnight beds between 3rd July and 17th August 2015. NHS Lothian approached the RCPCH to conduct an external review of the service and provide objective independent recommendations as to the best model for long-term, sustainable provision of paediatric care to the people of Lothian. The matter was discussed at a meeting of the Acute Hospitals Committee on 1 September 2015 and following this the RCPCH was approached to conduct the review.

3.3 Demography and population growth

3.3.1 This review considers the whole paediatric population of NHS Lothian. However the trigger was the concern that staffing issues at St John's Hospital may result in its overnight service becoming unsustainable, and the impact this might have on local families. According to NHS Lothian's Children and Young People's Strategy 2014-20, the population of West Lothian served by St John's in 2012 included an estimated 41,767 children under 18, with projections indicating that the Lothian population (including the child population) will continue to grow until 2030. National Records of Scotland are not however predicting any increase in the

¹ Source: Google Maps (captured 14:55, 15/04/16)

under 16 years population in West Lothian from 2012-2025. The numbers of babies being born at St John`s has been dropping over recent years (from 3003 births in 2009 to 2703 in 2015) although numbers may have been artificially inflated by an increase in the number of women from Edinburgh being diverted there for election caesarean sections.

3.3.2 Whilst there are clearly pockets of deprivation in West Lothian, some stakeholders perceive the entire area to be very deprived and infer that families would struggle to travel into Edinburgh to access children`s healthcare.

3.3.3 Examples of issues relating to deprivation include low levels of breastfeeding in areas such as Armadale and Whitburn, problems with substance misuse and high levels of teenage pregnancy with a lack of extended family support for some mothers. The 2011 Scottish census² reported 75.6% of households in West Lothian had access to at least one car or van (Scottish average: 69.5%). In 2013 the Scottish Parliament Information Centre briefing on Teenage Pregnancy indicated that West Lothian had lower teenage pregnancy rates than the Scottish average³ and the area has seen a progressive reduction in pregnancy rates in both under 16s and 18s over the last decade⁴.

3.3.4 In October 2015 the West Lothian Local Development Plan outlined proposals to build 18,010 new houses in the West Lothian area⁵ between 2009 and 2024, but the impact on demand for the acute services is difficult to assess.

3.4 Local voices

3.4.1 Although St John`s opened relatively recently with the development of the `new town` of Livingston, it has forged a firm place in the community`s infrastructure. A high proportion of staff live locally and regard Edinburgh as a distant and expensive place to visit. There is a strong and longstanding public campaign, backed and encouraged by local politicians and media, to support the unit against any proposed reconfiguration.

3.4.2 The RCPCH`s Review team was keen to hear the views of patients and their families, staff and their representatives. Recognising that access to public and stakeholder meetings could be difficult, an online survey and focus groups ran alongside the review, which were publicised widely through the media, campaign groups and NHS Lothian itself. The survey received over 1900 responses, and the Review team was also provided with other relevant materials received by NHS Lothian. A thematic analysis of the submissions is provided in Appendix 8.

² <http://www.scotlandscensus.gov.uk/documents/censusresults/release2a/rel2asbfigure22.pdf>

³ Scottish Parliament Information Centre (2013) SPICe Briefing, Teenage Pregnancy

⁴ Sexual and Reproductive Health Statistics, NHS Lothian, February 2014

⁵ West Lothian Council (2015) West Lothian Local Development Plan: *Proposed plan*

4 The review process

4.1 The review was conducted by the RCPCH using established processes ([Guide to Invited Reviews April 2014](#)), led by the RCPCH. The project had four main phases:

4.2 **Phase 1: Setup** (September - December 2015)

- Initial meeting between the Lead Reviewer and RCPCH staff, and NHS Lothian and representatives and senior staff from the units
- Set up of the Review team and confirmation of visit date
- Planning and setup of the main visit
- Study of background documents, activity data and policies etc. relating to the services and making contact with stakeholders
- Launch of the patient, staff and public survey seeking the views of people who work in or use the services
- Creation of a webpage to explain the review process
- Contacting political representatives and other stakeholders

4.3 **Phase 2: Fact-finding** (December 2015 - March 2016)

- Meetings / calls with staff across the three sites, individuals who work with the services, political representatives and other stakeholders
- Whole-team tour of the services at all three sites
- Driving the journey between the sites
- Focus groups to hear the views of patients, parents and carers and other stakeholders

4.4 **Phase 3: Drafting and delivering the report** (March - May 2016)

- Fact checking and alignment with standards
- Seeking clarification on areas of inconsistency
- Thematic analysis of survey findings, focus group discussions and other correspondence
- Drafting the report with full team involvement
- Quality assurance and critical challenge (internal) of the report
- Draft report presented to client for accuracy checking
- Full report presented to Health Board meeting

4.5 **Phase 4: Follow up** (May - June 2016)

- Explanation and communications as required to summarise the report
- Assistance as needed towards implementation

5 Acute pathways of care

A. Royal Hospital for Sick Children (RHSC), Edinburgh

5.1 Service Design and Demand

5.1.1 The Royal Hospital for Sick Children has 141 beds which provide secondary and tertiary medical and surgical care, day care and critical care for around 100,000 children a year up to age 13. Its outpatient department currently sees more than 34,000 patients a year. The services are planned to relocate in summer 2017 to a new hospital on the Royal Infirmary (RIE) site in Little France (approximately 1.2 miles South East of RHSC). The new site will comprise 154 paediatric beds, a redesigned children's emergency department, six paediatric operating theatres, and twelve CAMHS beds. There will also be 67 adult beds in a new Department of Clinical Neuroscience. This will be on the same site as the Simpson maternity hospital and the neonatal intensive care unit.

5.1.2 There are two paediatric medical wards at RHSC with 38 beds in total where most medical patients are admitted. Ward 6 is the Acute Receiving Unit (ARU) with 14 staffed beds rising to 20 at peak winter times.

Ward	Beds	Details
Ward 6 Acute Receiving Unit (ARU)	14 (20)	Takes acute medical paediatric admissions
Ward 1 Specialist Medical Services	18	GI, Renal, Rheumatology, Respiratory etc. Provides a Regional / Lothian service, acute and planned admissions
Ward 2 Haematology/ Oncology	8	Provides a Regional Specialist Service
Ward 3 Surgical Services	16	Mixture of general surgical and specialist regional/national services e.g. Cleft Lip & Palate
Ward 4 Surgical Services	14	Mixture of regional, national and local services including orthopaedics and spinal.
Paediatric Critical Care Unit	19	Provides services on a local, regional and national level 10 Intensive care, 6 high dependency, 3 neonatal surgery
Ward 7 Neurosciences	12	Provides both Neurology specialist care and Neurosurgery

Table 1 - Details of current wards at RHSC

5.1.3 All urgent and emergency paediatric patients are assessed by ED and those requiring medical admission are seen by the ARU paediatricians except a few who are admitted during the daytime directly to medical specialty beds. Across the

hospital there were reports of insufficient beds to accommodate peaks of activity and the Review team was told that patient numbers overall had increased by 15%.

Acute Receiving unit

- 5.1.4 The ARU is increasingly busy and struggling to cope within its bed capacity. Admissions have risen by 16% since 2010 totalling around 3400 in 2015. Most are acute medical admissions from ED with a small number being ‘step-down’ patients from critical care. There were only nine days in 10 months when there were no ‘outliers from the ARU’ and this peaked at 22 outliers in November 2015. The unit managed between 21-28 attendances per day in summer 2015 with the winter increase peaking at 55 one day in November. Weekly admissions ranged between 54 and 102 in 2015, peaking at 24 in one day during November 2015, with 69% of patients staying longer than 48 hours.
- 5.1.5 At peak times medical or HDU admissions are occasionally held in the ED longer than clinically necessary until a bed becomes available. This provides a poor experience for some patients and families and leads to breaches of the four hour standard. The business case for the new hospital has modelled beds and activity based on 2012/3 population figures and activity projections which have been updated regularly. It did not include any assumptions about potential changes to the St John’s inpatient service.

	0900-1700	1700-2100	2100 -0900
Admissions	30%	24%	45%

Table 2 Time of day of admissions

Length of stay	<24 hours	24-48 hours	>48 hours
2014 (n=222)	36%	26%	31%
2009 (n=419)	34%	30%	36%

Table 3 Length of stay

Outpatients

- 5.1.6 Outpatient clinics are provided in four discrete areas within the hospital, but the main clinics are adjacent to ED. Around 730 general outpatient clinics are scheduled each year. There are also additional consultations by telephone and ward attenders on the inpatient unit who are not recorded. There were around 2650 new GP referrals to general paediatric clinics in 2015 and 400 from the ARU. However annual capacity for scheduled clinics provides for only 2600 patients. Routine outpatient referrals are usually seen within twelve weeks, but urgent referrals such as cancer are seen within 24 hours. Increasing pressure on consultants to cover ARU is resulting in the cancellation of outpatient clinics and consequent increases in waiting times and unplanned attendance at ARU. ‘Waiting list initiative’ clinics have been added to meet the 12 week target and these

provided for 288 patients in 2015. GP referrals to general paediatric outpatient clinics rose 10% between 2010 and 2014. However there was a 19% rise in the six months between January and July 2015 compared with attendances in 2010.

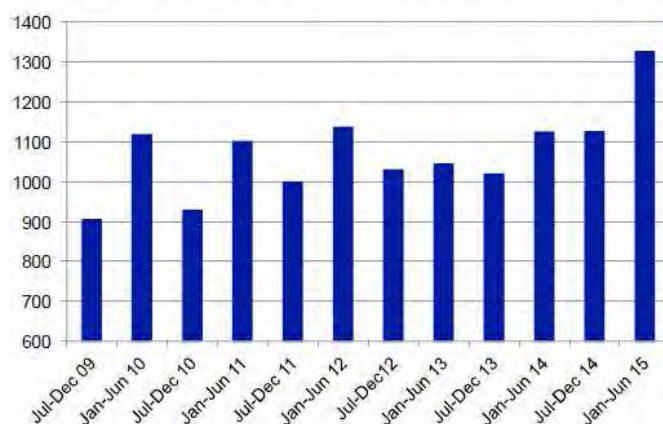


Table 4 – GP referrals to general paediatric outpatients (RHSC)

High dependency care

5.1.7 Some nurses were anxious about pressure on critical care beds (due to a high number of long term patients) resulting in patients with high dependency needs occasionally being cared for on general wards. More experienced / senior staff will usually be assigned to care for such patients but this adds pressure to nurse staffing levels. There are plans in the new hospital to develop a four-bed transitional care unit for those children with long term conditions who are waiting for packages of care to be established prior to discharge. These are often children with respiratory, neurological or gastroenterology problems, who require a team of carers to be trained prior to discharge. These carers are often Band 3 staff who can be recruited and trained in around 4 months, but this can be considerably longer for non-Lothian patients.

Age range and transition

5.1.8 The Review team was advised that the hospital will usually only admit children for medicine or surgery up to 14 years of age unless they are known to the service. This varies by speciality, and is dependent upon assessment by the admitting clinician, taking into account physical factors and capacity to consent to treatment (Gillick competence). This results in around 200 children under 16 years old being accommodated every year in adult wards (e.g. at the Western General, around 3 miles away) but it was not clear to the Review team what safeguarding protocols were in place to ensure these children received appropriate care by children-trained staff. There is also no formal protocol for acceptance or otherwise of young people over 13. In contrast, the outpatient department at RHSC continues to see children until they transition to adult care. The new hospital is designed to

accommodate children and young people up to 16 years old with modelling anticipating 300 additional ARU admissions per year.

- 5.1.9 Several services such as gastroenterology, diabetes and cystic fibrosis have well developed arrangements for transition of patients to adult services. Others have yet to fully develop transition arrangements. The NHS Lothian CYP Strategy (2014-2020) does not highlight transition arrangements as a priority but for children and young people with chronic or long term conditions, and their families, moving from children's to adult services can have significant impact on their lives and confidence in managing their condition.

Recommendation: Review protocols for assessment and transfer of young people under 16 years of age to adult wards to ensure that appropriate safeguarding and emotional support is in place.

Recommendation: Develop, with the involvement of young people/young adults, a Lothian-wide policy for transition of young people to adult services which is followed and audited across all hospitals in the Board area.

Emergency Department

- 5.1.10 The unit on floor 1a, comprises one resuscitation room, six cubicles and a three-bed bay, plus a stitch and plaster room. The outpatients department is adjacent and is equipped with oxygen, which enables the ED to 'overflow'. There is a focus on minimising admissions so triage and tests occur swiftly to reduce the numbers breaching the four hour target and requiring admission. Despite these endeavours this target features on the Clinical Management Team's risk register.
- 5.1.11 The ED saw 47,263 children and young people in 2015, an increase of 25% over five years. This is a high level of attendance and the unit should be monitoring compliance with the Intercollegiate Standards⁶ including identification of a lead consultant and lead nurse for children.
- 5.1.12 There is consultant 'shop floor' presence from 08.30-22.00 weekdays, nine hours each day at weekends and on-call cover at all other times. These consultants may also do shifts at other sites and/or deliver specialist care.
- 5.1.13 Specialty doctors at Tier 2 are present from 08:00 to 24:00 each day supported by two LAS doctors and a LTFT Paediatrics EM trainee. A six-slot junior doctor rota staffed by four ED trainees and two GPSTs (all of whom are ALS providers) provides cover from 10:00 - 08:00 seven days a week.

⁶ RCPCH (2012) Standards for Children and Young People in Emergency Care Settings

5.1.14 One general paediatric FY1/2 trainee is present from 09:00 to 21:00 Monday to Friday, and from 14:00 to 21:00 at weekends. Out with these hours they also cover the in-patient areas as part of the on-call team.

5.1.15 There are usually two paediatric Emergency Nurse Practitioners (ENP) from 07:30 or 09:30 until midnight.

Grade	0800	1000	1200	1400	1600	1800	2000	2200	2400	0200	0400	0600
Tier 3 consultant								On call				
Tier 2 SAS												
Tier 1 ED/GPST												
Tier 1 paed FY2												

Table 5 – ED staffing cover – weekdays

5.1.16 This arrangement results in a high level of medical staffing during the day, but insufficient cover at night time. Increasing the consultant presence in the evenings, to include some teaching etc. would provide a smoother management of activity.

Recommendation: Urgently address the emergency department/ARU medical staffing rotas at RHSC with the Deanery; consider relocation of some of the trainees to ARU, ED or St John`s for daytime shifts. Consider redeploying some of the daytime capacity to cover other service pressures. (see also 5.2.10)

5.2 Workforce

5.2.1 Consultant staffing includes eight general paediatricians as well as a range of specialists who provide tertiary cover across south east Scotland as well as contributing to the general paediatric rota and ARU. Only neurology and oncology have dedicated out of hours on call rota, and many of the other specialists reported they are often called out of hours even when not on call - a situation that has existed for over 15 years. The Review team heard that a significant proportion of the specialist doctors feel demotivated and that ‘the only time anyone pays attention is if they miss the Health Improvement Scotland targets’.

5.2.2 There should be a minimum of two consultants on the general paediatrics / ARU rota on a Consultant of the Week (COTW) system. The first covers 08:00 – 18:00 and second 09:00 – 17:00. At weekends the oncall consultant is present from 9am to 2pm and often for longer. Evening cover is provided between 16:30 – 21:30 three days a week. The consultant on-call covers from 16:30pm to 09:00 Monday to Friday and 17:00 Friday to 09:00am Monday. Facing the Future standard 1 requires consultant presence 12 hours per day, seven days per week, with extended on site working to 22:00 so the unit is not yet compliant.

5.2.3 Handovers are scheduled three times a day although consultants are not always present at the evening handovers. Facing the Future standard 4 recommends at least two consultant led handovers per day so the unit is compliant. The first consultant also covers HDU and ward 6 and the second consultant visits the outlying wards and carries out duties such as arranging complex discharge planning, child protection meetings, teaching and supervision.

5.2.4 There are consultant rota vacancies at present, and during summer of 2015 there were nine weeks with just one consultant available. There are 7 permanent consultant level posts and one locum post assigned to the ARU`s core team. Three of the consultants have other commitments (e.g. specialty rotas or educational roles), and the wider team covers both inpatient and outpatient general paediatric activity.

Location/interest	No consultant + SAS/academic	WTE
ARU and General Paediatrics	7+1	8
Infections disease / immunology	1	1
Diabetes / endocrinology	3+1	3.8
Respiratory	3+1	4.0
Gastroenterology	3+1	3.5
Metabolic Medicine	1	1
Neurology	5+1	5.5
Nephrology	1+1	1
Rheumatology	2	1.2
Haematology / oncology	6+3	8.5
Cardiology	1+1	1.6

Table 6– Specialist Consultant medical staffing (RHSC 2016)

5.2.5 This core team contributed 64/100 weeks' consultant cover for ARU, with remaining weeks covered by subspecialty consultants from Respiratory, Endocrinology, Gastroenterology, Community paediatrics and ED. There is no further consultant capacity in the hospital and since the review visit the respiratory team has withdrawn its eight weeks of cover because of respiratory workload. There will be a consultant going on maternity leave from mid-August, and a locum post has been advertised. Another maternity leave locum has had their employment extended for six months from August over the winter period.

5.2.6 Recent diary exercises to inform the annual job planning round indicate that significant amounts of work in addition to agreed job plans are being done to cover the general and specialist service.

5.2.7 The RCPCH has reviewed consultant numbers against similar tertiary paediatric units in the UK, using data submitted to the RCPCH from the workforce census returns of 2013 and 2015. NHS Lothian has submitted data for the 2015 census which uses a snapshot date of 30th September 2015, but for the other units, some

of which have not completed the 2015 returns the census date of 30th September 2013 has been used.. Table 7 shows the number of consultant subspecialists at Edinburgh in each subspecialty, the 2013 national mean and median plus the number of units those medians and means are derived from. Given that in the two years there will probably have been some expansion and recruitment to posts in other units, the data does not indicate that the unit is relatively understaffed for subspecialties

5.2.8 For the 2nd set of columns we have removed data where there was only one subspecialist (except for palliative) to see if that made a difference – the reasoning being that single-handed subspecialists do not make a ‘service’ - but that does not indicate relative understaffing either. GOSH is not included in the analysis as they are “quaternary” and the high numbers skew the data.

Sub specialty	NHS Lothian 2015				Single handed specialties removed			
	NHS Lothian 2015	Mean consultants	Median consultants	No of comparative tertiary centres 2013	NHS Lothian 2015	Mean consultants	Median consultants	No of comparative tertiary centres 2013
Diabetes and endocrinology	2	3.05	2.5	22	2	3.14	3	21
Emergency medicine	4	3.71	4	17	4	4.54	4	13
Gastroenterology, hepatology and nutrition	4*	3.32	3	22	4	3.68	3	19
Immunology, infectious disease and allergy	1	3.53	2	17				
Inherited metabolic medicine	1	2.11	1	9				
Intensive care	3	6.14	6	22	3	6.14	6	22
Neurodisability	2	1.86	1	7	2	3.00	2	3
Neurology	5	4.04	3.5	24	5	4.48	4	21
Oncology	6	4.91	4.5	22	6	5.53	5	19
Palliative medicine	1	1.00	1	6	1	1.00	1	6
Respiratory medicine	5*	3.50	3	24	5	3.86	4	21

*Noted for respiratory the return included a semi-retired consultant, no longer working
 *Noted for gastroenterology the return for 30th Sept included a half-time academic role

Table 7 - Tertiary paediatric comparisons (ref RCPCH Workforce census 2013 and 2015)

5.2.9 The Health Board subscribes to the `Civil-Eyes` benchmarking club which provided comprehensive comparative data at a workshop in November 2015. This data has been used previously to design the new hospital and has again been utilised recently to refresh the activity modelling. The data is also used for routine elective demand and capacity planning.

5.2.10 Cover of the ARU by the core team is not sustainable and an urgent solution is required. There is a four-stage plan and business case in place to appoint six more general paediatric consultants and two more specialty doctors over four-five years to contribute to the ARU / medical rotas, increase links with primary care and cover the new adolescent and HDU area after the move. As part of this, the ARU consultants wish to make substantive a fixed term consultant post put in place in October 2014

Recommendation: Recruitment of general consultants to the ARU against the NHS Lothian Plan should proceed swiftly.

Non-Consultant staff

5.2.11 There are 12 WTE trainees on the Tier 2 rota which includes specialties as well as general paediatrics, all of whom are ST5 and above. They work at least 60% daytime, plus evening shifts and resident cover. Senior trainees (1.6 WTE) are assigned to the admissions team on ARU. Although this is not guaranteed from August, the Training Programme Director does not anticipate significant changes to trainee allocations. There is a Tier 1 doctor based in the ARU and a Tier 2 registrar for 50% of the time.

5.2.12 The Tier 1 admissions team rota comprises ST1/2 trainees. Between 0900 and 1700 at least 4 trainees cover ED, PIU, Ward 6 and outliers on other wards. FY and GPST trainees are based in specialties during the day. Between 1700 and 2130 there are two senior paediatricians one ST1/2 and two FY/GPST covering ED and all medical inpatients. Overnight there are three trainees resident.

5.2.13 There are a high number of less than full time doctors on the training rotas which makes staffing and rostering very complex. Overall the trainees reported that they receive good training and experience and are well supported. However there is a better experience out of hours for Tier 1 trainees as there are a lot of trainees rostered during the daytime.

Recommendation: Urgently address the emergency department / ARU medical staffing rotas at RHSC with the Deanery; consider relocation of some of the trainees to ARU, ED or St John`s for daytime shifts. Consider redeploying some of the daytime capacity to cover other service pressures. (See also 5.1.16)

Nursing - staffing

- 5.2.14 The Review team were informed there was no funded strategy for the current staffing model. Nurse staffing is based on the mandated National Workforce Planning tools which inform safe staffing, rather than the RCN's 2013 standards⁷. Education and career development in Scotland is based on the NHS Education Scotland (NES) career framework and this is used to develop and inform posts within RHSC Directorate. For critical care, staffing is based on PICS standards⁸ for intensive care beds and local guidance for HDU/NUU.
- 5.2.15 All clinical areas use the Scottish Children's Acuity Tool (SCAMP) twice daily to assess staffing levels in relation to patient acuity and run the Professional Judgement Tool for two weeks per year. These are triangulated with the Clinical Quality Indicator measurements for each area, collected monthly and collated nationally as well as at Board and ward level. Staff reported that the number of nurses is satisfactory in summer, but not in winter when the number of patients increases along with staff sickness, patient acuity and turnover.
- 5.2.16 There have been some increases in nursing establishments, but this is constrained by financial resources. Managers have to work within their budgets, although there is some additional funding for the winter period. A particular concern was that clinical areas such as ARU are reliant on nurses with only two years' experience to take charge of the area, although the Review team also heard that there were a stable group of senior nurses.
- 5.2.17 Twenty-four hour senior nursing support is provided by the Clinical Co-ordinators who cover the site for clinical issues and work within the 'Hospital at Night' team. These nurses have undertaken the Masters level 'clinical decision making' module and are supported to complete the Masters Level Non-Medical Prescribing Module. The aim is that all nurses will have a minimum skill set. The establishment is 8.0WTEs, although there is one vacancy which was proving difficult to fill.
- 5.2.18 Whilst the hospital is perceived as a 'net exporter' of nurses, many of the nurses return having gained experience elsewhere. The hospital operates a rolling programme of nurse recruitment. At the time of the visit, there were vacancies across the hospital including five vacancies in critical care. Access to temporary staffing is limited, as the local bank does not have many children's nurses available within it, but staff are flexible and change shifts depending on demand. Staff can work overtime or extra shifts as bank and critical care are able to employ

⁷ RCN (2013) Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers, London: RCN

⁸ PICS (2010) Standards for the care of critically ill children (4th edition), London: PICS

agency nurses. The Review team were informed that there is daily movement of staff between clinical areas to ensure that wards are covered.

5.2.19 The critical care team have conducted a skill mix review and are developing the Band 4 Assistant Practitioner role. Job descriptions and competencies are in place, with two support workers appointed and plans to increase by two per year converting the unfilled Band 5 vacant posts.

5.2.20 Nurse staffing is currently under review with plans for a new nursing model at the new hospital, where children will be accepted up to 16 years of age. The new model includes increasing the number of Band 6s, especially in the ED and ARU with the aim of having a senior nurse on every shift.

5.2.21 The ED has an ENP covering 09:30 – 24:00 on two overlapping shifts. ENPs review, treat and discharge independently and are nurse prescribers. However, at the time of the visit some were on maternity leave. Since there are not a large number of nurses with these skills, it is difficult to cover this leave. In addition, there are Specialist Nurse Practitioners in medicine (2.61WTE), surgery (5 WTE) and oncology.

5.2.22 Over the last 18 years, the RHSC has developed the nurse specialist role at Bands 6 and 7 and is keen to further develop the ANP role in order to provide input to Tier 2 medical rotas. Specialist Nurse Practitioners work across all services, in clinics, the community, in children's homes and schools. They also provide specialist support and teaching to nurses on wards and families.

5.2.23 Mandatory and PILS training for nurses at RHSC and St John's is undertaken in the on-site training centre at RHSC, with additional educational support provided at St John's.

Recommendation: Review all nursing establishments against Scottish guidance and the acuity tool to determine whether there is a significant shortage of nurses during winter periods. See also section 6.

Recommendation: Develop a funded nursing strategy to include nurse staffing guidance, education and future direction of nursing including the continued development of advanced practice roles. See also section 6.

5.3 Compliance with standards

5.3.1 The unit is subject to the RCPCH's acute paediatric standards 'Facing the Future' published in April 2015, although NHS Lothian did not participate in the RCPCH audit in 2012-3. Table 8 shows the Review team's understanding of current compliance.

No	Detail (abbreviated)	Compliant?
1	A consultant paediatrician* available during peak activity 7/7.	No, not weekends
2	Every child seen by tier two (middle grade) paediatric rota within four hours of admission.	Possibly
3	Every child seen by a consultant paediatrician* within 14 hours of admission,	Not weekends
4	At least two medical handovers every 24 hours are led by a consultant paediatrician*.	Yes
5	Every child referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged.	Yes
6	Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.	Yes - assessment is medically led
7	Attending consultant* system, most often in the form of the 'consultant of the week' system.	Yes
8	All training rotas are made up of at least ten whole time equivalent posts,	No
9	Specialist paediatricians are available for immediate telephone advice	Yes
10	Access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies)	Yes

Table 8 – Compliance against 'Facing the Future (2015)'

B. The Royal Infirmary of Edinburgh (RIE)

5.4 Service Design and activity

5.4.1 The RIE hosts the Neonatal Intensive Care Unit (NICU) which provides tertiary level care for neonates across the south east Scotland catchment. There are around 6800 births annually at the Simpson, including in-utero transfers in from outlying units (including St John's) of women with high risk pregnancies. A single clinical director oversees maternity services at both St John's and the Simpson ensuring good communications between both units. There are no plans to amalgamate the two maternity units.

5.4.2 The Simpson unit is the largest in Scotland⁹, and comprises:

- 9 Intensive Care cots
- 8 High Dependency cots
- 22 Special care cots
- A seminar room for meetings / teaching

5.4.3 Data for the RIE NICU activity are as follows

Measure	2013	2014	2015
Average occupancy	83.32%	84.10%	75.48%
Days of respiratory support	3142	4112	3832
Intensive Care days	1861	2264	1979
Infants with birthweight,1500g	91	132	96
CPAP/BiPAP/HFNC days			2818

Table 9 – RIE NICU activity data (2013-15)

5.4.4 Facilities for parents with infants in the unit include two twin en-suite parents' rooms and two further rooms on another floor. Outside the unit is a waiting area with a desk with a computer and access to the internet. There are no kitchen or drinks facilities so parents need to leave the unit for meals. They are provided with visitors access passes to gain prompt authorised access to the unit.

5.4.5 A neonatal outreach team, comprising three neonatal nurses provides support for parents so that infants can be discharged home early. Each member of the team spends two days a week on the unit to teach and prepare families before discharge. They then spend a further two days in the community providing support at home. The team aims to have one nurse on the unit throughout the week, Monday to Friday.

⁹ South East and Tayside Regional Planning Group. *Neonatal Care in Scotland: A Quality Framework Progress Report*. October 2015.

5.5 Workforce

Consultants

- 5.5.1 The neonatal service at the RIE presently has ten (8.5WTE) consultant neonatologists including one Reader and one Senior Lecturer. There are always three consultants available weekdays (08:00 – 18:00) covering ICU, HDU/SCU and the antenatal and postnatal areas. There is one consultant present by day at weekends with the availability of a second on call consultant for 12 hours on Sundays. Shifts are supported by resident consultants with 12.5 hours additional cover for three months a year either at St John's (without a Tier 2) or at RIE with resident Tier 2 doctor or ANNP.
- 5.5.2 There is presently a full time vacancy with sessions at both RIE and St John's and some resident on call sessions but this post is proving difficult to recruit. Out of hours the consultant is on call with immediate availability and will usually attend for 21:00 handover and ward round to manage problems overnight. Three of the consultants (plus the vacant post) include a job-plan commitment to cover the neonatal units on both sites (currently 2 in 9). This includes resident shifts at St John's when required.
- 5.5.3 There are two higher specialist trainee posts approved but one is on maternity leave and one on a clinical secondment at present.

Tier 1 and 2 Neonatal rota

- 5.5.4 The non-consultant Tier 2 rota comprises 15 staff including 1 ST3, 5 ST4, 2 ST5, 1 staff grade, plus 2 clinical fellows and 4 ANNPs who work across the RIE and St John's; a specialty doctor based at St John's who only covers out of hours at RIE and works in paediatrics at St John's during the daytime.
- 5.5.5 Three consultant neonatologists provide resident on call/acting down cover on whichever site the need is greatest which at the time of the Review team's visit was at the RIE.
- 5.5.6 Tier 1 cover of approximately 9 WTE comprises 3 FY2, 4 ST1, 3 ST2, and 1 clinical fellow and 2 ANNPs. It is EWTD, New Deal and BAPM 2010 compliant.
- 5.5.7 Medical workforce requirements are set out under the BPAM guidance of 2010 as follows and compared with the national picture from the RCPCH Census 2013: Comparing with similar units in the UK is difficult as there are not many single rotas in neonatal units in tertiary centres.

BAPM Requirements for a Neonatal Intensive Care Unit (NICU) 2010:	Status at RIE	National picture
5.4.1 All staffing roles should be limited to neonatal care at all levels	Compliant	
5.4.2 Recommended numbers of staff for a Neonatal Intensive Care Unit:		
• Tier 1: Separate neonatal rotas with a minimum of 8 staff. from paediatric ST1-3, ENNPs or ANNPs, specialty doctors.	12 individuals - 8 WTE 3FY2 , 4 ST1, 1 fellow, 2 ANNPs , 3 ST2).	7.8 WTE
• Tier 2: Separate neonatal rota with a minimum of 8 staff. from paediatric ST4-8, specialty doctors, other non training grade doctors, ANNPs (with appropriate additional skills and training), resident neonatal consultants	15 individual s - 9 WTE 1 staff grade, 4 ANNPs(1 shadowed), 2 clinical fellows, 1 ST3, 5 ST4, 2 ST5,	7.8 WTE
• Tier 3: A minimum of 7 neonatology consultants on the 24/7 on call rota with resident consultants on the tier 2 rota additional to this number.	7 consultants	9.12 WTE
5.4.3 For larger NICUs special consideration should be given to the number of staff required at each tier throughout the 24 hours and giving due consideration to the time required at each handover.	Not applicable	

Table 10 BAPM compliance

Neonatal Nursing

5.5.8 NHS Lothian recruits neonatal nurses on a site basis, but with contracts that enable flexibility to occasionally work at other units as service demand requires. The nursing establishment in both units has been determined using the BAPM standards¹⁰ and the Scottish Neonatal Quality Framework based on the cot numbers above. Activity and occupancy is collated but not retrospectively measured. The staff based at RIE would be the first call for rota gaps at St John's. More detail about nursing workforce planning is in section 6.

¹⁰ British Association of Perinatal Medicine.2010 Service Standards for Hospitals Providing Neonatal Care.

5.5.9 Recruitment to these levels, especially in specialist neonatal nursing roles, is a continuing challenge. Although there is no shortage of applicants, the work is highly specialised and appropriate support and training is needed to ensure staff develop the specialist knowledge and skills.

5.5.10 Sickness and maternity leave levels are high and a number of nurses are nearing retirement age. Many nurses return to part time hours following maternity leave, which leaves gaps in the rota, particularly if these are qualified neonatal nurses. The uplift for annual leave, study leave and sick leave of 22% is insufficient to maintain a fully staffed rota and falls below the RCN recommendation of 25%¹¹.

5.5.11 A recent review of establishment resulted in increased numbers, and whilst staffing and activity data are collected daily this is not benchmarked against equivalent units. There are occasions when RIE send staff to St John's to fill staffing gaps.

Recommendation: Benchmark regularly linking with other units in order to clarify the gap in neonatal nursing and gain support and ideas

Recommendation: Establish a rotation of nurses between the RIE and St John's neonatal units to build the team and ensure knowledge and skills are consistent across the service.

5.6 Quality and Outcomes

5.6.1 The Newborn Care Collaborative has been established under the Scottish Patient Safety Programme to improve the quality of neonatal services, and safety and outcomes for patients. These include guideline and audit programmes alongside research within the RIE neonatal unit. The group includes three parent representatives and 45 staff are involved in delivering the 66 projects in the 2014-16 pan Lothian action plan.

5.6.2 Over the last 10 years, neonatal units across the UK have subscribed to the Badgernet patient activity system from software developer Clevermed. This enables national benchmarking alongside local activity monitoring. The RIE and St John's are the two remaining neonatal units that do not connect into the national network and is thus unable to benchmark within UK systems or report on the National Neonatal Audit project indicators. The clinical teams on both sites are keen to progress the introduction of the Badgernet Electronic Patient record on both sites and the Business case for this is in development.

¹¹ RCN (2013) Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers, London: RCN

Recommendation: Expedite the business case for Badgernet to enable national benchmarking

5.6.3 The IT system is increasingly posing a clinical risk as there were reports of loss of records half-way through writing them and the system does also not interface with the St John’s IT package so information on infants transferred cannot be reconciled even within the Health Board.

5.7 Compliance with standards

5.7.1 Scottish units need to be compliant with ‘Neonatal care in Scotland - a Quality framework’ (2013)¹² which builds on the BAPM 2010 Standards for Neonatal Care. In addition, guidance for NICUs published in 2014 makes some overarching recommendations as follows:

Recommendation	Compliance
Neonatal Intensive Care Units (NICUs) in the UK should admit at least 100 very low birth weight (VLBW) babies per year	The unit average over 3 years is 106
NICUs in the UK should undertake at least 2000 days of respiratory support per year	Currently around 4000 days
All UK NICUs should comply to existing standards of nurse to baby ratios and cot occupancy as well as those related to family and parent quality of experience	Nurse staffing = BAPM, good engagement reported under the Newborn Care Collaborative
Units with more than 7000 deliveries should augment their tier 1 medical support *	6800 deliveries – should be considering.
NICUs undertaking more than 2500 Intensive care (IC) days per annum should augment their tier 2 medical cover and provide two consultant led teams during normal hours*	Currently around 2000 days per year. Two consultant led teams and 15 Tier 2 doctors already in place.
Neonatal consultant staff should be available on site in all NICUs for at least 12 hours a day	Three on site weekdays one daytime weekends. Not 12 hours per day

Table 11– Compliance with BAPM (2014) guidance for NICUs

5.7.2 Overall the team at the Simpson was focussed specifically on their own unit and the Review team did not see evidence of a truly networked approach to resolving the issues at St John’s in an equitable and fully ‘networked’ way.

Recommendation: Establish a network approach to neonatal care with regular governance meetings and strategy.

¹² Neonatal Care | Scotland - a Quality Framework Scottish Government 2013

C. St John's Hospital, Livingston

5.8 Service Design and Demand

5.8.1 The paediatric service at St John's comprises:

- A 14-bed children's ward, including:
 - a 6 bed bay used for day surgery
 - a 4 bed bay
 - 4 cubicles - 1 for HDU, 1 for adolescent care
- A 6-bay assessment area, used for ambulatory patients
- A treatment room
- An investigation unit
- A dedicated play room staffed Monday-Friday
- Parents' and carers' waiting area
- A training room at the end of the ward

5.8.2 The ward is primarily a medical paediatric service, providing both emergency and planned care. It also provides ENT, General and Maxillo-facial day surgery on Mondays, Tuesdays and Fridays, with between six and eight children per list. The numbers are flexed up in the summer and reduced in the winter to accommodate fluctuating activity levels. Paediatric outpatient services are provided by a mixture of St John's paediatric consultants, and specialists from RHSC. There are three consultant – led handovers per day, and all children are discussed by/with a consultant prior to discharge.

5.8.3 Pathways of care in the Lothian catchment area are not formalised, although children from West Lothian are generally seen at St John's, whilst all other children attend the RHSC. Referrals to St John's assessment area are taken from the ED, West Lothian GPs or the primary care out of hours (OOH) service. One of West Lothian's three GP OOH clinics is located on-site and was reported to have a relatively low threshold for referral, with many children consequently bypassing ED and attending the ward despite the nurses and doctors in OOH services being trained in paediatric minor illness and injuries.

5.8.4 There were 3,546 non elective admissions to the St John's children's ward in 2015.

- 78% of these admissions (2,461) had a length of stay of less than 24 hours
- 22% (764) had a length of stay of over 24 hours
- Staff reported 2-3 re-admissions each month, although this can increase during the bronchiolitis season.

5.8.5 There is no facility for the provision of paediatric intensive care. When the need arises children are transferred with a paediatric nurse to the adult Intensive Care Unit (ICU) for stabilisation until transport to a PICU bed is arranged.

- 5.8.6 The Review team were told the children's ward can come very close to capacity, particularly during the winter months, although no occupancy data was provided. The assessment area aims to work towards admission or discharge within the national 4 hour target, but the team will keep patients longer under defined circumstances.
- 5.8.7 The ward generally accepts children up to the age of 16years (up to 18 years for those with long-term or chronic conditions and/or frequent attenders), and staff aim to keep adolescents separate and have an 'ad hoc' room for this purpose.
- 5.8.8 The local risk register has a number of issues relating to paediatrics including: staffing, the 4 hour ED target and the ED layout. There are concerns that the service at St John's may not be safe at times, as it is not always possible to ensure safe staffing levels, with regular gaps in the Tier 2 rota.

Neonatal care

- 5.8.9 The consultant-led obstetric service at St John's delivers around 2600 infants per year. The 10-cot neonatal unit (described variously as a level 1 and a level 2 unit) has been recently refurbished and provides special and high dependency care and short term intensive care to approximately 290 infants annually with an occupancy of 60-70%. The babies are usually over 32 completed weeks' gestation although some at 30-31 weeks remain on the unit. Women in labour up to 31+6 weeks are transferred out and infants requiring ongoing intensive care are transferred to the neonatal unit at the RIE.
- 5.8.10 The Neonatal Nurse Manager works across both sites. The ANNP based at St John's is a Newborn Life Support (NLS) Instructor and newborn examination trainer. The nursing establishment has been determined using the BAPM recommended staffing levels for 2 high dependency and 8 special care cots. Nurse staffing is provided by three nurses per shift; one qualified in specialty (QIS), one registered nurse and one nursery nurse. Occasionally they may have two QIS nurses on shift.

Emergency Department

- 5.8.11 The Emergency Department (ED) at St John's saw 10,133 attendances by children under 16 years of age in 2015, a rise of 8% over the last five years, and approximately 10% of these are referred to the children's ward. It is thought these figures are artificially low as a result of GP OOH services bypassing ED and referring children directly to the ward.

- 5.8.12 The ED at St John's is staffed by ED consultants (who rotate across the other units in Lothian SJH/RHSC/RIE), ENPs and Tier 1 doctors. There is one children's nurse working in the ED, who will attend the daily safety huddle if on duty.
- 5.8.13 The ED was perceived to have its own pressures, such as the lack of children's waiting and treatment area which led to a tendency to move children quickly to the ward when ED was busy. Out of hours referrals to the ward at night had also increased, partly attributed to a lack of experience and confidence in staff working in ED and OOH services.
- 5.8.14 The OOHs activity generates a significant amount of work in terms of children who are sent home but requiring review the following day on the ward or via an urgent out-patient appointment. This can add to the workload of the clinical team, in particular the Consultant of the Week when there is no tier 2 doctor and on Mondays and Fridays when the ward is busy. In April 2016 a number of strategies were proposed at the consultant business meeting to manage this and improve communication.
- 5.8.15 During the closure of overnight beds in the children's ward in 2015, a number of ED nurses from RHSC rotated to St John's, to provide a children's nurse at the 'front door' of the hospital. This was apparently a popular opportunity for nurses, and was welcomed by ED doctors as it enhanced their paediatric provision. The children's ward provided the majority of paediatric nurse cover both overnight and at weekends.

5.9 Workforce

- 5.9.1 The service has been under continuing pressure since 2008 due to staffing shortages, long term recruitment difficulties and the removal of training posts in August 2013 due to low activity levels, particularly out of hours. Despite extensive recruitment initiatives going back to 2010 (see appendix) the unit has relied upon a small core of staff, a number of whom work over and above their job plans, to keep the unit functioning. However, there remain continued concerns about the OOH rota, low activity levels and the ability of consultants, in particular, to maintain core skills. Rest periods are actively monitored and reported to be 'highly compliant', but some staff have signed out of the European Working Time Directive (EWTD) and the team heard of two or three staff who 'consistently over work'.
- 5.9.2 The consultant equivalent medical establishment on the unit comprises eleven individuals as set out below. There are currently one resident consultant, one speciality doctor and two clinical fellow posts vacant and the unit has struggled to recruit to this site. One of the consultants in post applied for a fixed term post of

eight months (January-August 2016) to fit in with her career plans and after August there will be a further consultant vacancy in this group of resident consultants.

6 consultants	5.7 WTE	44 weeks ARU	ward/SCU
3 consultants with resident out of hours middle grade shifts in job plans	3 WTE		
1 associate specialist	1.0 WTE	6 weeks ARU	ward/SCU
1 specialty doctor with resident out of hours middle grade shifts in job plans	1.0 WTE	9 weeks ARU	ward/SCU

Table 12 - consultant staffing at St John's

5.9.3 Neonatal medical cover is provided by the consultant paediatricians, three of whom have neonatal experience and some specialty doctors, one of whom has significant neonatology experience. There was reported to 'always be a senior doctor around during the day for neonates', and at least two of the RIE neonatologists cover shifts at St John's.

Non-consultant grades

5.9.4 Prior to 2013 the two or three trainees allocated to the department contributed to the out of hours rota within the limits of adequate day time training and WTD compliance. Since the removal of trainees in 2013 the out of hours Tier 2 rota is one in 9, covered by a mixture of

- job planned out of hours middle grade shifts for the specialty doctor and three of the consultants
- local doctors in training based in other hospitals doing occasional locum shifts
- the associate specialist agreeing to work resident middle grade night shifts on a time limited basis
- a combination of an ANNP and an APNP filling a slot to cover neonates and paediatrics
- consultants in the department agreeing to work resident out of hours middle grade shifts on a voluntary basis remunerated at £149/hour for a 12.5 hour shift
- consultants based in other hospitals doing occasion locum shifts for £149/hr

Only five out of the nine positions were regularly filled. This situation was compounded in 2015 by a period of maternity leave and inability to recruit a locum.

5.9.5 There is no capacity at middle grade for sickness or absence and staff risk breaching EWTD if they provide additional short-notice cover which can result in cancelled clinics/shifts the following day. There is no rotation at Tier 2 with RHSC which reduces flexibility.

5.9.6 Locum cover is provided internally as agency paediatricians are not available. Attempts to initiate a physician's associates' programme a few years ago was not successful, and it has proved difficult to recruit APNPs locally.

- 5.9.7 It was not clear why it has not been possible for a more flexible arrangement to be negotiated with the Deanery possibly with juniors staffing the unit during the (busier) daytime. At the time of the review, RHSC appeared to have plenty of Tier 2 doctors on daytime shifts. Rotation through St John's would provide a variety of experience, increase resilience and flexibility for rota cover and potentially increase the attractiveness of consultant jobs for trainees who knew the site.
- 5.9.8 Tier 1 staffing comprises a single rota comprising 4 FY doctors and, 2 GP trainees¹³ covering both paediatrics and the neonatal unit. One ANNP works permanently at St John's and three rotate through St John's and the RIE on a monthly basis to cover Monday to Friday 8am to 8.30 pm.

Anaesthetics

- 5.9.9 There is no resident paediatric anaesthetic cover at St John's overnight although a consultant anaesthetist (not necessarily paediatric) is available within 30 minutes. There are at least four consultant anaesthetists with some paediatric training covering daytime work but overnight anaesthetic cover is provided from the adult ICU, where children requiring intubation would be managed prior to retrieval. ICU is informed of any children in the HDU cubicle. Resuscitation of infants is performed by the consultant paediatricians.

Nursing – staffing

- 5.9.10 The children's nursing team of 21.21 WTEs consists of 1 Band 7, 0.92 Band 6, 13.89 Band 5, and 1.64 Band 4, 1.71 Band 3s and 2.05 Band 2s. This team covers the ward, assessment area and investigation unit, with three children's nurses, the ward manager and one support worker or three nurses and two support workers on during the day and 3 registered nurses or 2 nurses and a support worker at night.
- 5.9.11 During each shift there will be one nurse with HDU skills and one nurse responsible for reviews in the investigation unit. Senior Nursing support is provided from the St John's site team for emergencies or from the RHSC Clinical Coordinators for other issues. Operational Nursing management is provided by one of the Clinical Nurse Managers at RHSC, who visits the ward weekly.
- 5.9.12 The support workers generally take blood specimens, as there is no paediatric phlebotomy service on site. The Review team were told that staffing became unsafe if one person went off sick and they were unable to replace them. There is no longer rotation of staff between the neonatal unit and the ward, so it is not possible to borrow staff from the neonatal unit. Staff will be borrowed from the

¹³ 2015 census return

RHSC as required. Fortunately, a nurse is not required to escort children who need transfer to Edinburgh, as ambulance staff have the skills to accompany a sick child.

5.9.13 An Advanced Paediatric Nurse Practitioner (APNP) covers the Assessment Unit during the day. The APNP bridges the gap between medicine and nursing, provides the lead for the HDU service, is an advanced paediatric life support (APLS) instructor and leads on audit of the service. The service has advertised for a second APNP, but did not receive suitable qualified applications. Therefore, a training post was advertised to develop a nurse into the post with little interest. Nursing staff value this post, as the APNP provides good training and support.

5.9.14 The Ward Manager reported reviewing staffing needs if changes were required to the service. She has never been refused requests for additional staff and does not have difficulties recruiting to vacant posts; turnover is low although there are limited career opportunities above Band 7.

5.10 Compliance with Standards

5.10.1 The Review team has considered the unit's compliance with the Facing the Future Standards 2015 as follows:

No.	Detail (abbreviated)	Compliant?
1	A consultant paediatrician* available during peak activity 7/7.	No
2	Every child seen by tier two (middle grade) paediatric rota within four hours of admission.	Unusual rota
3	Every child seen by a consultant paediatrician* within 14 hours of admission,	Not weekends
4	At least two medical handovers every 24 hours are led by a consultant paediatrician*.	Yes
5	Every child referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged..	Yes
6	Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.	Yes - assessment is medically led
7	Attending consultant* system, most often in the form of the 'consultant of the week' system.	Yes
8	All training rotas are made up of at least ten whole time equivalent posts,	T2 No trainees. T1 not compliant
9	Specialist paediatricians are available for immediate telephone advice	Yes
10	Access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies)	Yes

Table 13 - Compliance against 'Facing the Future (2015)'

6 Workforce Planning

6.1 Narrative - Medical rotas

- 6.1.1 The situation regarding medical staffing across the two main Lothian hospitals is serious with significant shortages at consultant and middle grade level and a lack of reserve capacity to provide cover. Attendances have increased in recent years without commensurate expansion in staffing since 2013 on either site, and St John's has developed a reputation of being a difficult place to work which is constraining the Board's ability to recruit.
- 6.1.2 Senior paediatric (Tier 2) staffing levels at St John's are inadequate although the consultants themselves consider that they are delivering a safe service. At RHSC there are significant gaps in evening and weekend rotas, a lack of double cover during the summer and gaps are already predicted for summer 2016. The consultants in both units are working extra hours to fill the gaps which impacts on work-life balance and overall morale.
- 6.1.3 All staff are employed by NHS Lothian on pan-Lothian contracts. However whilst specialties such as emergency medicine and critical care had been able to re-deploy staff across sites, the Review team was told that consultant paediatricians were generally disinclined to rotate between units to support St John's. There is a reluctance to implement new ways of working such as resident consultant models in order to provide an appropriate service to meet demand, and differing cultures and residual tensions across the three sites appear to be preventing medical staff from working cohesively across Lothian.
- 6.1.4 Across the UK there is an increasing move towards resident consultant models to tackle the gaps in Tier 2 workforce and national policy initiatives towards seven-day working in other specialties. This was predicted by the RCPCH in 2009¹⁴ and across the UK over 30% of units responding to the 2015 Workforce census run with resident consultant cover for at least a part of the week, reducing the demand on Tier 2 rotas and providing enhanced support and training for Tier 1 doctors. Anecdotal evidence from teams working in such a way indicates a number of benefits for consultant staff, particularly in smaller, quieter units; with contractual commitment completed in fewer working days, and reported improvement to work-life balance for those with caring responsibilities.
- 6.1.5 In April 2012 the College published its report Consultant Delivered Care – an evaluation of new ways of working in paediatrics. The report concludes that children would receive better care if they had 24/7 access to a consultant or equivalent senior doctor.

¹⁴ RCPCH. RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital, May 2009

- 6.1.6 There is an increasing need for overnight consultant cover with recognition nationally that 24hr consultant led service is important to improve outcomes, but also that a phased arrangement is needed for consultant careers, moving off the on call rota as they approach retirement. There is wide policy evidence that jobs will change over time and there is a lack of leadership and strategic planning to shape the medical workforce to meet the needs of the future service and maintain morale and organisational loyalty.
- 6.1.7 An analysis of medical and nursing workforce by SEAT (Deanery) published in November 2015 confirmed staff perceptions around training posts, indicating that:
- Trainees do not receive DGH experience until ST3, which may be resulting in fewer trainees aspiring to be general paediatricians.
 - There appeared to be an abundance of junior staff at RHSC in the daytime whilst there were shortages at St John's; the Deanery considered moving trainees to SJH during the day, but had been thwarted by high levels of maternity / parental leave. Overnight cover by trainees at St John's was not feasible as there was insufficient activity.
 - Trainees were not applying for consultant posts at St John's - a possible reason was their absence of experience there but the Review team considered that there may be other factors.
 - The 65 paediatric trainees in region were requesting a high level of parental leave and around 10% spend time out of the programme (OOP) conducting research.
- 6.1.8 It is important that the Deanery and Health Board work closely together to resolve the staffing issues. Doctors in training could benefit more from experience in general paediatrics at St John's during the daytime and support new ways of working.

Recommendation: Work with the Deanery towards increasing general paediatric experience earlier in the training schedule to increase numbers wanting to become general paediatricians.

6.2 Workforce Standards and guidance

- 6.2.1 In 2010 the RPCPH published 'Facing the Future' standards for acute paediatric care, supported in April 2011 by national modelling demonstrating the implications of the standards on workforce design and planning for the next 10 years. An audit of these standards, published by the RPCPH in 2013¹⁵ indicated reasonable compliance nationally but NHS Lothian did not participate. The standards were revised and reordered in April 2015 and compliance is shown under each of the unit sections above.

¹⁵ RPCPH. *Back to facing the Future: An audit of acute paediatric service standards in the UK*. April 2013

Facing the Future - Service Standards for Paediatric Units (April 2015)

1. A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.
2. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.
3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.
4. At least two medical handovers every 24 hours are led by a consultant paediatrician*.
5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.
6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.
7. All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.
8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report.

* or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota

6.3 Job planning

6.3.1 There is no formal approach to job planning, which is conducted by various senior staff, despite clear guidance being available from a number of sources including the RCPCH¹⁶ and the BMA¹⁷. The Health Board is reviewing all contracts exceeding 10PA, yet the Review team was told that the electronic management system indicates that most consultants are working considerably in excess of their job plans covering the service through goodwill. There is a feeling amongst the consultants that the service needs to ‘fail’ before extra resources are made available but they are very motivated to keep the service working and safe.

6.3.2 Most new posts currently are designed with just 1 SPA compared with the College recommendation of 2.5 and minimum of 1.5 to enable sufficient time for revalidation activities. Consultants reported having to do training in their own time or whilst on leave but the Review team was told that there are plans for all new and substantive posts to be designed with 2 SPA.

Recommendation: A robust and equitable approach to job planning and staff rotation across Lothian is required with clarity about expectations and a focus on the patients’ and service needs as well as an appropriate work-life balance for the doctors. RCPCH Job planning guidance is available to assist.

6.3.3 A 10 PA contract should include a maximum of 4 PAs for resident on-call duties (12 PA contracts should include a maximum of 6 PAs resident on-call) – as out-of-hours PAs are 3 hours duration this is equivalent to 12 – 18 hours while resident. The remaining Direct Clinical Care (DCC) PAs will be spent on the clinical activities determined by the job plan.

6.3.4 While the 10 PA contract is the norm, consideration should be given to increasing this (up to the 48 hour limit), particularly when resident duties are required to support the acute service 4.5 DCC PAs (in addition to any resident PAs) is sufficient to enable a consultant to fulfil an appropriate consultant role and to maintain and develop their clinical skills .

6.3.5 The number of Supporting Professional Activities (SPAs) should be linked to expected output, and this should be explicit in the job description. There should be a minimum of 1.5 SPAs for personal supporting professional activities: (Appraisal, Governance, Training, Continuing Professional Development (CPD) and activities supporting recertification and revalidation).

¹⁶ Paediatrician’s Handbook - available to RCPCH members

¹⁷ BMA Job Planning guidance <http://www.bma.org.uk>

6.3.6 The job plan should also contain SPAs directed at service quality, development and leadership,(eg College roles, research, management, service developments, lead clinician roles, project management, teaching).

6.3.7 There may be a need for further external duty or additional responsibility PAs. SPAs should not be undertaken during the time that a consultant resident duties (although there would be opportunities for informal teaching and training).

6.4 Nursing Strategy and Advanced Practice

6.4.1 Development of Advanced Nursing Practitioners (ANPs) for paediatrics and for neonatal care is a recognised way of addressing the increasing gaps in the middle grade (Tier 2) rota, resulting from changes to training and immigration arrangements. The projected decline in Tier 2 staff is widely documented and, although Clinical Fellows and non-career grade doctors are available, their numbers are also declining with increasing reliance on locum staff who may not provide the same level of teaching, local expertise or continuity of care.

6.4.2 Developing ANPs can be challenging as there is no formal national training curriculum. However, the RCN does outline the functions of advanced practice roles and key requirements of educational programmes¹⁸, as well as the competences required in neonatal practice¹⁹. Often courses are commissioned on a regional basis with local assurance or competencies frameworks overseen by the supervising consultants or expert advanced nurse practitioners. The ANNP course at Napier University has now been linked with the APNP course at University of West of Scotland in Glasgow to make these courses more viable. It is important that all are engaged and clear about the purpose and expectations of advanced practice and more formalised and consistent ANP training would be beneficial.

6.4.3 Training can take 3-5 years to be fully competent and may require backfill during college attendance, all funded by the unit. The shortage of ANNPs and APNPs means that there is a risk of losing trained staff to other units²⁰, but many places report considerable loyalty from nurses who have been recruited and trained locally. Three-year funding cycles for training programmes make longer term planning difficult for the Health Board and course providers and RHSC can only release 6-7 nurses (and St John`s only one) at a time for advanced study despite high numbers of applicants.

¹⁸ RCN (2014) Specialist and advanced children's and young people's nursing practice in contemporary health care: guidance for nurses and commissioners

¹⁹ RCN (2015) Career, education and competence framework for neonatal nursing in the UK.

²⁰ Smith SL & Hall MA (2003), Developing a neonatal workforce: role evolution and retention of advanced neonatal nurse practitioners, Arch Dis Child Fetal Neonatal Ed 2003, 88: F 426-F429

6.4.4 There was some uncertainty whether there was complete support for the development of advanced practice roles across NHS Lothian, although there is support from Scottish parliament for the development of advanced practice nursing²¹ and a history of advanced nurse development at RHSC. Some of those undertaking the roles indicated that there was inconsistent medical support, difficulty in maintaining training and CPD and no clear pathway for progression to nurse consultant status. This is holding back development of the service and reducing nurse morale, particularly in sub-specialities (the single immunology nurse is funded through patient fundraising year on year).

Recommendation: Develop a funded Lothian-wide strategy for advanced nursing practice, with a five year plan for introduction of roles to address gaps in medical rotas and required service developments.

Recommendation: Review the overall policy for recruitment and retention of ANPs to include career progression and mechanisms for support.

Advanced Neonatal Nurse Practitioners

6.4.5 The Neonatal Unit Manager works across St John's and RIE and has been developing the neonatal service with the introduction of eight ANNPs (7.53WTE) of whom 3.77 WTE work on the Tier 2 rota, (Band 8a) and the remainder either work at Tier 1 or are undertaking the training programme. One is based at St John's.

6.4.6 The Band 8s are keen to extend their roles on the unit and rotate through the neonatal transport service (see section 9). Three of them rotate through St John's covering 08.00 - 20.30 Mondays to Fridays and one weekend in nine but do not cover nights there. They reported feeling more confident and supported working across both sites with the consultants doing the same.

6.4.7 Senior management are keen to develop the ANNP and specialist neonatal nursing roles with further rotational posts, and envisage the future neonatal service at St John's hospital supporting a 24/7 obstetric centre with 24/7 ANNPs and non-resident consultants. The Board agreed to recruitment of 14 WTE ANNPs within the Lothian neonatal services, to strengthen the Tier 2 rotas at St John's and the RIE but trained ANNPs are difficult to recruit from outside and the workforce is being developed by training new ANNPs over time. 6.5 WTE trained ANNPs are required to provide an ANNP-led service at St John's and support the RIE NICU in the longer term.

²¹ Ford S (2016) Scottish government pledges to keep bursary and boost ANPs, Nursing Times, 10022016 (<http://www.nursingtimes.net/news/education/pledge-to-keep-bursary-in-scotland-and-boost-anps/7002330.article>)

- 6.4.8 The ANNPs undertake roles with a high level of clinical responsibility, including resident out of hours neonatal unit cover supported by non-resident consultant supervision. National terms and conditions and clinical governance systems have not kept pace with this development. Pending the development of national governance systems, the Lothian Neonatal Service has introduced a framework in partnership with this staff group that involves appraisal, peer and patient feedback, competency assessment and continuing professional development in order that proper clinical governance of this workforce can be evidenced. There are still elements of the terms and conditions that need to be modified nationally for this staff group to consolidate the role and facilitate recruitment and retention of staff.
- 6.4.9 The development of ANNPs is positive and strategically important and the RCPCH encourages the development of these individuals. It is important however that these posts rotate between St John's and RHSC in order to maintain interest and skills, to share protocols and encourage good communication. It takes 3-5 years to fully train a registered neonatal nurse to ANNP level, but there has been a shortage of applicants to date.

Recommendation: Continue to support the development of in-house ANNP training and consequent strengthening of the Tier 2 rotas across the Lothian neonatal service

Advanced Paediatric Nurse Practitioners

- 6.4.10 There are APNPs working in PICU on the middle grade rota, and the Review team was told of plans to establish a Consultant Nurse role and for APNPs to cover HDU. The proposals for the PICU involve eight APNPs. Currently there are five in post, three of whom are trained.
- 6.4.11 There is just one Advanced Paediatric Nurse practitioner at St John's, and the Review team was told that recruitment to such posts had generated little interest. Development of a government-commissioned local course, to provide 'in-house' training for both APNPs and ANNPs, was proving difficult to recruit to. Possible reasons cited for this are the lack of certainty about the future of the services at St John's, the lack of support to use the advanced skills once these are developed and a lack of money to increase nurse establishments. Funding for these posts does not appear to come from the vacant medical posts.
- 6.4.12 The APNP at St John's would like to develop her role to become Nurse Consultant, which was supported by her medical colleagues. There is a Nurse Consultant in adult cardiology at St John's and in Children's Epilepsy at RHSC, providing a model for development of this role. Establishing a Nurse Consultant post might send positive messages to prospective APNPs and provide the

leadership and support for the development of advanced practice in children's and neonatal services at St John's.

Recommendation: Establish the Nurse Consultant roles in PICU and at St John's to lead the development of advanced practice across the hospitals.

Nursing - Training and support

- 6.4.13 Children's nurses and support staff reported a high level of satisfaction with the experience gained and the teamwork at St John's, with good support from medical colleagues. They like the mix of medical and surgical work, with HDU and the assessment unit, as it provides a varied job and good experience particularly for a first post after qualifying. However, some of them expressed anxiety about HDU at night, when consultants were less available. When workload is high, they stated that everyone 'stepped up' to support each other and it was a supportive culture.
- 6.4.14 Some nurses moved on to tertiary or specialist services, or to London but often returned with additional skills. Some staff could see the benefits of cross-site working or moving to other areas at St John's, such as the ED, but these opportunities were not currently available. The Review team were informed that nurses from St John's were generally reluctant to rotate to RHSC, although they worked there when the children's closed at overnight beds in summer 2015.
- 6.4.15 All nursing staff undertake mandatory training, much of which is provided through the e-learning system, LearnPro, although topics such as Paediatric Immediate Life Support (PILS) are undertaken face to face. Training is monitored by the ward manager. Support worker development opportunities are available, based on individual ability and progression. This enables individuals to develop skills such as phlebotomy. None of the nurses have completed CDM despite being offered the opportunity
- 6.4.16 There are some concerns regarding nurse training across Lothian. These include access to the neonatal course and loss of newly trained nurses to England, especially London. Nurses are better able to access additional training and move between jobs more easily in England and often return to Lothian once they have gained experience and jobs are available.
- 6.4.17 Nurses from both sites are supported to undertake the neonatal course with staff from St John's rotating to the RIE to undertake the Intensive Care module. Ongoing availability of a neonatal course is essential to ensure that babies who require intensive or high dependency care are cared for by QIS nurses as recommended by BAPM and the Scottish Neonatal Quality Framework. However the future of the neonatal course in Scotland is often uncertain, with contracts renegotiated every three years to ensure viability of the course. Work is currently

being undertaken with the Neonatal Managed Clinical Network, the Scottish Neonatal Nurses Group and NHS Education for Scotland to secure provision of the course for the next three years.

6.5 St John's Medical Staffing Model (see also Appendix 7)

6.5.1 The Review team considered the longer term viability of the St John's site in the light of national workforce standards but also in comparison with other units in the UK. The biennial RCPCH Workforce Census 2013 provides comparative information about similar sized units as follows:

- There are at least 44 inpatient units with fewer admissions than St John's (RCPCH 2012/3 data) out of a total of 272 units.
- St John's is 'medium sized' under the 'Facing the Future' criteria. There are in our selection of 203 units for which admission data was available 16 very small, 35 small, 77 medium sized. Very small units may be NICUs, women's hospitals, etc.
- Of the 112 small and medium units in our sample, only 32 did not have an SSPAU.

6.5.2 Given that there are no plans to reconfigure maternity cover, and obstetric led care will be available round the clock, it is essential that appropriate paediatric cover is retained at the St John's site. There are two options below to achieve this which will provide a safe and cost-effective service that reflects national policy direction and current challenges to the workforce. A third option is included to provide short term cover but this is less sustainable/cost effective if obstetric provision remains unchanged.

6.5.3 A number of principles should be agreed before modelling takes place as follows:

- The neonatal unit should be designated a Special Care Unit under BAPM 2010 Standards with all infants under 32 weeks gestation transferred out. The unit will therefore not require consultant cover from RIE as there is sufficient expertise onsite to manage infants in special care.
- Compliance with the RCPCH 'Facing the Future' standards in terms of presence and assessment of children and young people.
- Compliance with European working time directive
- Maximum 12PA on rota (although modelled for 10PA)
- Minimising cross-site cover

Option 1 – 24 hour consultant and Tier 2 rota, 12 hour Tier 1 rota (see App 7)

- 6.5.4 This is the recommended model and will take up to two years to implement. We have modelled consultant presence onsite for 12 hours and for 14.5 hours.
- 6.5.5 The local paediatric medical team will cover both neonates and paediatrics although rotation to maintain skills and build a cohesive cross-Lothian workforce should be encouraged.
- 6.5.6 We have modelled on the assumption that there is no availability of Tier 2 trainees – there is appropriate reluctance by the Deanery to support out of hours work with trainees but daytime activity and occasional overnight shifts may provide useful experience and we have suggested in preceding sections that this is reviewed.
- 6.5.7 A resident consultant model should be introduced which requires occasional overnight cover to provide senior onsite presence, supported by non-resident consultant on call from home. Such cover can be provided for two nights per week, reducing pressure on the Tier 2 rota. All consultants at St John`s should support the principle and practice of resident consultant working – unless the whole team is involved in designing and supporting the out of hours rota our experience is that they are difficult to establish and sustain. There is a recognition that those over 55 years may be permitted to opt out of overnights, but continue to cover evenings.
- 6.5.8 Our current modelling indicates that there should be sufficient staff in post to implement this rota arrangement but where there are gaps there should be a networked solution for staffing, including rotational posts with Edinburgh. Whilst this has not worked in the past the RCPCH can see no obvious reason why implementation would not be possible with appropriate clinical leadership and a clear strategy for recruitment.
- 6.5.9 The Tier 1 rota should comprise as at present a mixture of FY2 and GP trainees (doing more of the daytime hours recognising the training element of the job) plus APNPs with both children`s and neonatal training so they can cover basic resuscitation. There are already ANNP and APNPs providing dual-cover. There should be ongoing efforts to extend the Tier 1 competencies towards Tier 2 in order to strengthen out of hours cover, and increase the numbers to 10 to comply with the `Facing the Future` standards.
- 6.5.10 There are already positive initiatives to develop ANNPs and APNPs, and this programme must be enhanced and actively encouraged. It takes a minimum of two years to train an Advanced Nurse Practitioner and 36 months to become completely accomplished in the role so this model will become sustainable within

two years, and reduce the need for locum cover before that, depending upon the pace of negotiations over job plans with the consultant team.

Option 2 – either as an interim or if Option 1 fails - 14.5 hours consultant cover, 24/7 Tier 2 cover (see App 7)

- 6.5.11 The service would provide overnight inpatients as a 24-hour `low acuity` unit which does not admit children overnight (8pm to 8am) when consultants are not present. It could be achieved within 12 months if existing ANNPs from RHSC and those on the training programme are involved. Cover out of hours would be provided by APNPs /Tier 2 staff with neonatal and resuscitation experience and non-resident consultants on call from home within 30 minutes²² to support neonatal resuscitation.
- 6.5.12 Paediatric patients could be accommodated overnight if their condition is sufficiently stable (as assessed by the evening consultant) but the emphasis would be to discharge home with 'safety netting' information or transfer to RHSC.
- 6.5.13 This model would require sufficient capacity in a nearby children's unit (RHSC) to accept the children overnight. See section 7 covering activity management and ambulatory care for recommendations to achieve this.
- 6.5.14 To deliver these models would require an integrated consultant workforce across the three sites to ensure equity amongst the sites in terms of providing their share of the resident cover and on-call service. For consultants too distant to provide 30 minute presence the option of a local hotel for nights on call is suggested. This model is in place within the Yorkshire and Humber Transport service.

²² This was a requirement from CNST requiring appropriate resuscitation expertise present at birth and consultant within 30 minutes. CNST is no longer audited. Safer Childbirth states 30 minutes.

Option 3 - no overnight paediatric care and a 14 hour (8am-10pm) Short Stay Paediatric Assessment Unit (SSPAU) (see App 7)

- 6.5.15 This model is in effect the approach which was implemented in Sumer 2015, with no overnight accommodation for sick children. Consultant cover would be available during the daytime, but decisions to discharge or admit to RHSC would be made from 6pm and no new attendances from 8pm. The arrangement would require protocols for management of emergency attendances - ambulances can be diverted but ambulatory patients would require staff with sufficient competencies in ED to identify those in need of urgent paediatric care and arrange transfer.
- 6.5.16 This approach would require consideration of how neonatal support would be provided to the obstetric service when paediatric cover is not present. The service could be supported by ANNPs, or `upskilling` of midwives to ensure they are competent to resuscitate infants, or the provision of a medical rota just covering neonates which would be expensive and unusual. In the longer term a review of obstetric provision would be required, perhaps moving St John`s to a midwife led unit, attracting women with low-risk pregnancies or day case surgical procedures who would currently deliver at the Simpson. Changing the obstetric arrangement would require capacity at the Simpson and is likely to be unpopular with local people.
- 6.5.17 In terms of numbers requiring transfer under this model, during the closure in 2015 76 children transferred to RHSC and were admitted (excluding 8 who would have gone for specialist care anyway). Given this was the summertime, when attendances are lower, but also that staff are likely to be overcautious, we would anticipate numbers transferring to be around 2 per day under this model.
- 6.5.18 Such an approach will only work if there is capacity on general wards at RHSC (or elsewhere) to take children overnight and will require provision of additional transport services alongside clear communications and preparation of the public.

7 Options for associated acute medical paediatric services

7.1 Reducing activity and relieving pressure on the services

7.1.1 At both St John's and the RHSC there is increasing activity through the emergency department of children and young people requiring acute medical assessment.

This is a national picture driven by a range of factors which could include:

- Increased awareness from the media of the need for vigilance around young children's symptoms
- Limited training and experience in paediatrics by General Practitioners
- Increased mobility of the population making hospital access easier
- A good experience at RHSC ED (see survey)
- A sense at St John's of 'use it or lose it'

7.1.2 Currently all patients who arrive from ED are admitted to the ward/ARU as inpatients which was reported to be laborious. Plans to establish short stay (48hr) admission wards have stalled as many patients have complex medical needs and stay longer. The new hospital at RIE is planning for improved 'electronic assessment' area (based on the St John's model for adult observation ward) and a 72hour short stay ward as well as a 4-bed observation unit alongside ED and the paediatric ARU. There is a high number of potentially inappropriate admissions, where patients are referred to the hospital by their GPs through ED, but could instead be seen in a rapid access clinic/assessment unit or managed by the GP with consultant advice.

7.1.3 A number of strategies are available to address this activity and ensure that children receive the right care in the best place for them within an efficient and properly staffed service. Progress is being made with engaging GPs and offering rapid assessment and telephone consultations. We would suggest the following are considered and formatted into a clear plan for the next 2-4 years, and incorporated into the modelling for the new RHSC:

- a) Development of a formal Short Stay Paediatric Assessment Unit at each site
- b) Implementation of the 'Together for Child Health' standards
- c) Active programme of recruitment / training of Nurse Practitioners

7.2 Short Stay Assessment Units

7.2.1 The RCPCH set out the rationale and guidance for developing SSPAUs in 2009²³ and this is currently being refreshed given the sharp increase in prevalence of such units in the UK. The new guidance will launch during 2016-7.

²³ http://www.rcpch.ac.uk/sites/default/files/asset_library/Policy%20and%20Standards/SSPAU.pdf

7.2.2 'An SSPAU is a facility within which children with acute illnesses, injuries or other urgent referrals...can be assessed, investigated, observed and treated without recourse to inpatient areas' (RCPCH 2009).

In recent years, attendance by children in Emergency Departments (ED) has been increasing (2). Over the last ten years, children's emergency admissions have risen by 18 per cent (2) and over half of these are via the ED. At the same time, the overall length of stay for paediatric hospital admissions has fallen, with many children staying under 24 hours in hospital.

The contributory factors are complex. They include higher parental anxiety about minor illness, lower thresholds for admission amongst doctors in training, changes in 'out-of-hours' provision in England, and the necessity for EDs to take early decisions on admission as a consequence of the 4 hour waiting time target.

In the early stages of any illness it is difficult to distinguish minor conditions from more serious disorders without further assessment and observation. However, the time frame for assessment and observation tends to be much shorter in paediatric than in adult medicine.

RCPCH 2009 SSPAU guidance

7.2.3 This model overlaps with the ARU in taking patients from ED, GP referral and next-day returners, but operates by different principles²⁴:

- Senior clinical staff should be involved in gate-keeping and should be pivotal in decision making, providing effective training and delivery of services.
- Senior clinical staff should be available at times of peak demand, including during evenings and weekends.
- Bed numbers in the SSPAU should be sufficient for needs and should accommodate variable admission rates.
- There should be good access to diagnostics.
- The expectation should be discharge rather than later admission.
- Discharges can be nurse-led according to pre-set criteria with robust safety netting and clear re-attendance policies.
- Access to enhanced community care nursing teams is essential, and there should be close links with the acute unit to allow early discharge and home review (7 days / week).

7.2.4 There are a number of well-functioning SSPAUs around the UK²⁵ from which a 'partner unit' could be identified which could describe the journey undertaken and support the RHSC team with decision- making and transition to new ways of working. Key requirements are:

²⁴ RCPCH (2009) Short Stay Paediatric Assessment Units: Advice for Commissioners and Providers.

²⁵ The RCPCH can provide contacts

- A project plan and rationale, developed carefully with full clinical involvement, on how the service would work, the steps needed to achieve it, and indicators of progress.
- Agreed and realistic criteria for acceptance to and discharge from the unit.
- An escalation plan if there are too many attendees or discharge is not possible
- Full support and understanding by clinicians able to explain the rationale to patients families and each other without negative intonations or unresolved anxieties
- External communications, patient leaflets, media stories projecting the short-stay image and culture.

Recommendation: Agree and implement criteria for use of the short stay facility at each site which focusses on discharge and does not require full admission paperwork to be completed.

7.3 Improving out of hospital care

- 7.3.1 In 2015 the RCPCH launched guidance and 11 standards²⁶ for achieving better urgent care for children and young people in settings outside hospital, including GP practices and community nursing hubs. These standards aim to reduce unscheduled attendances at ED and assessment units and improve the experience for families receiving safe and appropriate care as close to home as possible.
- 7.3.2 A key component of these standards is renewing dialogue and support for local GPs and establishing community children’s nursing teams. Whilst there has been good work to date in engaging local GPs the consultants appeared to be keen to develop these pathways and work more with primary care but were hampered by staff shortages, lack of SPA time and such activity apparently not being prioritised by management. Whilst the standards do take additional resources to develop initially, in the long run implementation will provide more local care for patients and families, reducing their need to travel and relieving the pressure on the acute general wards.
- 7.3.3 The Review team was advised that there is a strong team of 42 clinical nurse specialists working with children and families across Lothian, together with 18 community specialist practitioners / community staff nurses in paediatrics equivalent to 12 WTE, plus nurse specialists in palliative care and discharge planning . An Outreach Nursing Team provides Care Packages at home for 18 children with exceptional health care needs.

²⁶ RCPCH. (2015) Facing the Future: Together for Child Health.

7.3.4 The RHSC ARU team are working towards implementation of the standards with a business case for increased ARU consultant cover, rapid access clinics, a dedicated GP line, development of web-based guidelines and advice on common paediatric conditions.

Standard

1. GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.
2. Each acute general children's service provides a consultant paediatrician-led rapid access service so that any child referred for this service can be seen within 24 hours of the referral being made.
3. There is a link consultant paediatrician for each local GP practice or group of practices.
4. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.
5. Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.
6. There is a link community children's nurse for each local GP practice or group of GP practices.
7. When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.
8. Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand
9. Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.
10. Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.
11. There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

8 Outcome measures

- 8.1 Defining outcome measures for children's health services is complex; there are many process measures based upon waiting times, but unlike surgery it is difficult to directly measure physical outcomes across the spectrum of paediatric care. The RCPCH is currently developing a suite of such measures but these are currently not published.
- 8.2 The paediatric service in NHS Lothian does however have great potential to improve the way that information is gathered and presented to staff and stakeholders in order to measure development of services and achievement of objectives. There is much to be learned from obstetric colleagues where the development and use of 'dashboards' within indicators agreed amongst clinical teams and regular monitoring is used to identify quality improvement and impact of change to the system.
- 8.3 A regular governance meeting is the forum for the development of such indicators. This will require participation and involvement of clinical and managerial staff, supported by swift and accurate data on activity and actions. Initial indicators / headings for such meetings can include RAG-rated
- Activity numbers, trends, referral sources, length of stay
 - Audit findings and forward plan for audit
 - Compliance with standards - Facing the Future, Emergency Care
 - Complaints, incidents (Datix) themes and actions arising
 - Critical Incidents and SUIs
 - Staffing - sickness, locum cover, non-compliant nursing levels
 - The development and monitoring of never events and trigger tools identified locally and monitored carefully
- 8.4 These indicators need to be 'owned' and developed by clinical leaders within the team, including nurses.
- 8.5 The RCPCH has a range of Quality Improvement models which can assist clinicians in reviewing services and developing new ways of working alongside the benefits of 'networking' amongst colleagues. Involvement in QI activities should be part of job plans and appraisal.

9 Cross Lothian Issues

9.1 Transport/retrieval

9.1.1 All patient transport in Scotland is managed by the Scottish ambulance service, including paediatric and neonatal emergency transfers through the separately funded and administered SCOTSTAR service. There are three neonatal transport teams within SCOTSTAR and one of these is based at the RIE providing regional services for south east Scotland and contributing to national services. Response times are reported to be good, with mobilisation usually within an hour, and back transfers are provided by the same team. Only rarely is a team unavailable due to attending another call. This team is staffed separately from the neonatal unit.

Table 14 – 2014 transfer data out of RIE after birth (2014)

Receiving unit		Despatching unit				Total
		RIE	St John's	RHSC Edinburgh	Outside Lothian	
	RIE		23	87	35	145
	St John's*	39		9	13	61
	RHSC Edinburgh**	121	18			139
	Ninewells		5			5
	Victoria Hospital		2			2
	Wishaw		1			1
	RHSC Glasgow***	7				7
	Outside Lothian	49				49
	Total	216	49	96	48	409

* Back transfers

** For investigations / surgical procedures

*** For specialist services

9.1.2 There is not a similar arrangement for Paediatric back transfers. Bed capacity issues can sometimes result in children and neonates potentially 'blocking' intensive or high dependency beds to others needing this level of care.

9.1.3 Paediatric intensive care retrieval is provided by a national service that has recently changed its structure from two teams based in Edinburgh and Glasgow to a single team based in Glasgow.

9.2 Safeguarding

9.2.1 The safeguarding team operates on a pan-Lothian basis and comprises a multi-disciplinary team available 24/7. This team deals with concerns and provides consultant-led emergency medical assessment of children and young people where abuse or assault is alleged and arrange emergency admission as a place of safety where this is required. The team comprises consultants, associate specialists and specialty doctors along with 7.8 WTE nursing staff with 0.4 WTE

administrative support, and is managed across three ‘patches’ – St John’s, RHSC and community services.

- 9.2.2 There are three child protection committees across Lothian which consider all cases with a risk of significant harm and manage initial and full case reviews. The Inter-Agency Child Protection Procedures (October 2015²⁷) set out how agencies will work together and these are supplemented by NHS Lothian’s Child Protection Procedures for health care professionals, which can be accessed from their intranet.
- 9.2.3 The NHS Lothian Child Protection Advisory & Training Team (CPAT) exists to ensure that every healthcare employee receives training in child protection. This is a rolling programme of training to meet the varying professional needs of staff.
- 9.2.4 Collated medical staffing information indicates that completion of formal safeguarding training amongst ED staff is inadequate. All staff have completed level 1 and most level 2 training but in a children’s hospital most should have level 3 to meet the requirements of the professional guidance²⁸. Although there are training pathways, induction cross-border training programmes, two national and various local peer review sessions and engagement with the RCPCH study days, the Review team did not see formal training records nor evidence that training was mandated to level 3 for all staff who see children frequently.

Recommendation: An urgent action plan is devised and implemented to record and mandate safeguarding training across the medical staff at RHSC.

9.3 Leadership and governance

Governance structure

- 9.3.1 The governance arrangements across NHS Lothian and within each hospital were not consistent and seemed to lack openness. This appeared to affect staff morale. The Clinical Management Group acts as the clinical governance committee for the acute sector and NHS Lothian’s healthcare governance group provides an overarching governance structure and assurance lead. Many staff, including senior hospital staff, were unable to tell the Review team who leads on governance in children’s and neonatal services at St John’s, and there was not a formalised approach to reviewing and developing learning from complaints, incidents, audit, safety alerts and patient engagement. The Review team has been advised that since their visit NHS Lothian has established a formal Children’s Services Clinical Governance and Risk Management Group, to meet quarterly, to review all incidents, complaints, audits, peer reviews etc., to ensure a clearer,

²⁷ http://www.edinburgh.gov.uk/download/downloads/id/287/child_protection_procedures

²⁸ RCPCH. (2014) Safeguarding children and young people: roles and competences for health care staff.

structured approach to this. The first meeting was held on 3 May 2016, and the Review team welcomes this initiative.

- 9.3.2 At RHSC there are monthly governance meetings involving the heads of specialty and service leads. A monthly Paediatric Services Group (PSG) covers business and operational topics. It is chaired by the Clinical Director at RHSC and all paediatricians in RHSC and St John's are invited together with community paediatricians. Senior staff from other departments such as pharmacy are invited to speak on a topic but there is no formalised agenda that covers governance reporting and no formal action plan. Morbidity and Mortality (M&M) meetings are held across RHSC at lunchtimes and there is a safety briefing every morning. Some longstanding issues (such as beds and staffing) have failed to be resolved, however, which undermines its impact.
- 9.3.3 At St John's there is a monthly paediatric business meeting, followed by a risk management meeting, but there did not appear to be a formalised agenda nor regular presentation of data. NHS Lothian management team expressed concern about 'outlier' status and a number of incidents relating to resuscitation in the weeks prior to the Review team's visit. These were reportedly attributed to inadequate training and maintenance of competencies compounded by overworked staff with minimal backup. The Review team heard that similar concerns had been raised by nursing staff. Fortnightly Datix meetings have been initiated by a SAS doctor. The discussion in April indicated that there was not an open culture of reporting with staff feeling 'guilty' to report and lack of clarity over which incidents required logging. Records of retrievals are recorded separately and raised at bi-monthly M&M meetings.
- 9.3.4 The Review team did not see shared, pan-Lothian guidelines, policies and procedures although the neonatal forum is developing shared guidelines between RIE and St John's. This is important poses a quality concern since the rotation of staff during periods of staff shortage is common. Considerable development of the RHSC policies for identification of sick children, escalation, retrieval and critical care management has been led by one paediatrician as part of a safety programme which has resulted in a reduction in unplanned admissions and reduced length of stay some years previously, but more is required to ensure consistent implementation.

Recommendation: Establish a programme of alignment of policies and procedures across the three children's and neonatal units ready for the move to the new accommodation.

Recommendation: Re-emphasise the processes for reporting incidents and safety concerns to ensure risks are owned and appropriate action taken.

- 9.3.5 Paediatric data was not reported at Board level beyond the ongoing staffing issues. The monthly Quality Report and Risk Register focuses on other priorities and are mainly narrative in nature; a small set of national targets, complaints (process), infection control, sickness and cardiac arrests. There are dashboards at site level but these are not tailored to be sensitive to specific areas such as paediatrics, and directorate indicators relate to maternity facts and figures.
- 9.3.6 There is a process for major adverse events and deaths to be reported weekly to the corporate team and board with fortnightly discussions. However, the Review team did not see any dashboards for safety metrics or systematic unit-level analysis of complaints, incidents and audit in terms of risk and resulting actions which is good practice in most acute settings.
- 9.3.7 There is little evidence of patient and public involvement to inform decision making within the governance structure (see section 9.5). Although information may be gathered at a ward/service level, the mechanisms for reporting this are not strong enough to enable senior leaders to use this data effectively.
- 9.3.8 Neonatal dashboard data is collected but the introduction of a networked BADGERNET system in Autumn 2015 meant that recent data was not available electronically for the review team. MBRRACE data published in autumn 2015 had raised some concerns that Lothian was an outlier for neonatal death (2.65 per thousand population) and this was now being tracked on a monthly basis as part of a safety programme. Subsequent to the Review visit the outlier status has been identified as a data error. The neonatal lead works across RIE and St John's on governance and consultant development.

Recommendation: Strengthen governance arrangements to include formal reporting and actions on quality and governance issues such as risk management, incidents and complaints, clinical audit.

Recommendation: Actively seek experiential data from patients and families to inform decision making, by understanding the population and any possible health and/or social inequities that may arise.

- 9.3.9 All infant and child deaths are recorded on Datix, even when expected, in order for them to be reviewed. The Review team was shown data for 2013-5 for RIE and St John's.
- 9.3.10 Although staff are encouraged to report issues on Datix through an online tool, including near misses, managers reported few incident reports and minimal complaints which supports the general impression given to the Review team of staff under-reporting. Assurance about the safety of the service may therefore be misleading, although safety huddles are held each morning to discuss immediate

safety concerns such as staff shortages and bed issues. The incident reporting system sends reports from the medical division to the relevant senior nurse for action but staff did not express confidence that the processes would result in significant change or improvement.

9.3.11 The Review team heard mixed reports about clinical safety concerns on the St John's neonatal unit particularly relating to resuscitation and consultants 'acting down' on the out of hours rota. Midwives reported that they felt they were sometimes leading the resuscitation rather than supporting it and nurses believed that practice in the neonatal unit is variable due to lack of confidence in some medical staff. The Review team were informed that because nurses rotate across both sites, the medical team felt there were no safety issues as they were confident nurses could handle a 23 week infant until the transport team arrives. Nurse staffing sickness levels were relatively high²⁹ in the neonatal unit..

Medical and organisational leadership

9.3.12 The Review team found staff who were passionate about their work and very dedicated to patients. However there were reported to be communication difficulties between and amongst clinicians and management which was damaging morale and resulting in potentially poor patient care. The nursing and medical management streams were very separate and there were no regular meetings involving the senior nurse / doctors and senior management team.

9.3.13 Doctors tended to find the RHSC a good place to work. There was good camaraderie and it was easy to commute to (compared with other units in Scotland). Trainees in particular found the SE Deanery placements relatively accessible, which made them reluctant to move or change roles. They lived locally, were on 10PA contracts (although many worked over and above this) and found the on call arrangements reasonable. As a group, like in most units, they had some issues but reported it to be easier to accept the difficulties than make a fuss. There was reported to be a good atmosphere and lots of staff had worked at the unit for a long time.

9.3.14 The Review team was told of a difficult working environment for many staff at St John's – although others seemed happy to work there. The long term challenges of recruitment, high workload of some senior paediatricians and absence of junior staff had sapped morale. The reputation of the unit had apparently spread beyond Lothian which may be contributing to recruitment challenges.

²⁹ SEAT report – Neonatal nursing sickness absence at St John's (just over 5%) and RHSC (around 7.5%) was the highest in the SEAT region. Neonatal nursing combined sickness and maternity leave was just over 10% at St John's and 14% at RHSC making them the second and sixth highest in Scotland. Predicted rates are 5% (4 sickness, 1 maternity)

9.3.15 The Review team did not see highly effective governance arrangements, and there was a lack of clear vision from the department overall. Feedback from juniors at St John`s in particular indicated a culture where bad behaviour was tolerated, although medical students did not pick this up. Intervention and engagement from more senior managers at NHS Lothian had not stimulated the development of innovative solutions, resulting in a complex mixture of apathy and anger amongst senior clinicians.

9.3.16 There is a sense of insufficient leadership from the top, with management not involving the clinical staff in strategic development nor seeking their ideas, with a focus appearing to be on money rather than quality. The Review team were informed that resources are provided where services are struggling or failing, whilst others are not rewarded for managing well. Some indicated that the research being conducted was not celebrated or recognised by management and that the lack of direction led to ‘firefighting’.

Recommendation: Have an annual event for doctors to celebrate achievement across Lothian, with presentations and posters of audit and research projects and updates regarding educational developments.

9.4 Unscheduled care services

9.4.1 To access primary care services out of hours the public call 111. They can be given advice over the phone and, if needed, are offered an appointment at one of five bases across Lothian. Some referrals come through pharmacy, the ambulance service, or are professional to professional referrals.

9.4.2 Three services are open to midnight and the other two are open 24 hours per day. These are based on the grounds of St John’s hospital and the Royal Infirmary Edinburgh. Access to these services is by appointment only.

9.4.3 There are approximately 260 GPs providing this service, covering shifts from four to 10 hours. There are around 14.5 whole time equivalents nurse practitioners involved with the service which sees around 125,000 patients per year, about 350 per day. Patients are seen and sent home, or seen and referred on as there are no observation facilities in out of hours services.

9.4.4 At present referrals do not come from RHSC to the primary care hub, as they are not co-located. Once RHSC has relocated to the Royal Infirmary site, they may use the primary care out of hours service to reduce pressure on ED.

9.4.5 There is at present an absence of feedback regarding referrals, either for those that did not need to be sent in, or those that should have been sent in. Around

13.7% of those children seen at St John's out of hours primary care centre were referred to the paediatric service there. In 2015 there were 8491 paediatric contacts at the RHSC site for paediatric primary care, 250 did not arrive, but only 1.3% were sent on to RHSC.

9.4.6 If patients are unable to get their own transport, taxis can be provided to the primary care out of hours centres, for all ages, especially children, but this information is not well publicised. Sometimes transport is only one way, especially if the patient appears to be well enough on arrival. The transport costs are around £150,000 per year of a £7.5 million budget.

9.5 Patient and Public involvement

Public engagement

9.5.1 NHS Lothian is obliged to consult on major service changes except for temporary changes on the grounds of safety, and senior management considers that they have a strong track record of public engagement. There has been considerable effort made to communicate with the public and politicians on the matter of this review, although much of this has been reactive in nature, driven by political and media enquiry. The monthly St John's stakeholder group meeting attended by the Review team was not as effective as it could have been, with the debate appearing to be driven by individuals with their own agenda, rather than being led by the Board. Although held in public, with a view to transparency, the public were not allowed to ask questions or participate, nor was the layout of the meeting table conducive to them engaging with the progress of debate.

9.5.2 In recent months, it has been difficult to articulate clearly to the public the detailed nature of the safety challenges facing the service, as there is a strong political lobby that tends to dominate any attempt at discussion. Despite the political and media 'outcry' when the paediatric unit at St John's closed overnight for six weeks during 2015, there were no complaints from those actually using the service, and there was only one complaint when a similar closure took place in 2012. However, there was no active evaluation or seeking of feedback from children, young people or families regarding these closures during this time, either on the wards, in ED or by follow-up survey. This illustrates a missed opportunity to gain valuable insight into the issues affecting patients and families.

9.5.3 It is clear from both the survey and from the discussions at the focus groups run as part of this review, that the uncertainty over the future of St John's has had a tangible impact on public (and indeed staff) perception about the safety and sustainability of the paediatric service at St John's. The RCPCH has received over 1900 responses to its online/paper survey requesting input from staff, patients,

parents-carers and their representatives, and the Health Board has passed on to the RCPCH over 400 written requests to its Chief Officer that the inpatient services at St John's be 'saved'. These are reported in Appendix 8.

9.5.4 The Review team suggests that much more could be done to understand the population's real views going forward and recognise the health inequalities that exist within services as they stand and the impacts of any possible changes. By being transparent about the actual issues being faced by the Health Board and by services, the public have the opportunity to understand and appreciate the reality of the situation and give their own perspectives. This review has begun the conversation with patient and public which can be continued by the Health Board. There are a number of ways in which this can be done:

- Forge links with key community groups and individuals who may be able to inform the decision making process and challenge assumptions made upon population demographics
- Present clear, honest and transparent information directly to the public and encourage feedback from the individuals who use/may need to use services.
- Strengthen mechanisms for collecting feedback and consider the means by which this information can be used to shape, confirm and challenge decisions moving forward
- Work with local schools (including special schools) to involve young people and families in shaping services. This should not just be at a 'cosmetic' level, but in thinking about the practicalities of service design, identifying, understanding and reducing possible health inequities. There is an opportunity to use the challenges and opportunities faced to co-produce innovative, practical and sustainable solutions with the local community.

9.5.5 The RCPCH can provide a number of resources and links to facilitate development of this approach through its **&Us** network engagement service and links with units which have successfully launched engagement schemes.

Public Understanding of Services and Proposed Service Changes

9.5.6 Public understanding of services across West Lothian is generally quite good. People know where to present with an acutely ill child and they are generally aware of the services that are provided by St John's and that a severely ill child or one with complex needs may need to be transferred to RHSC or even to Glasgow.

9.5.7 However, the understanding of what possible changes may mean for their services does not appear to be understood or comprehended. The division of opinion seems to be polarised. People's perception seems to be that any changes will mean the loss or 'downgrading' of children's services at St John's, thus leading to the strong desire to 'save' services at St John's. This opinion is partly informed by

previous service reconfigurations. Despite public meetings and a monthly stakeholder group, there is a strong political and media-fuelled scepticism of any Health Board plans which undoubtedly reflects back to staff and patients.

Patient Information

9.5.8 The information booklet for children and families coming into St John's is comprehensive and available online, yet there is no information online about RHSC facilities or information about managing childhood conditions. This information is especially relevant to families who may need to be transferred to RHSC for more intensive treatment. Transfer to another setting may be traumatic for young people and their families and having the practical information they may need readily available in advance of transfer can help to reduce unnecessary stress and anxiety.

Recommendation: Overhaul the information available online for children, young people and carers at RHSC including advice on coming to hospital and (perhaps) details of management of common conditions, and links to useful websites. Involve CYP in website and information design.

Recommendation: Ensure that adequate information on RHSC is readily available to children, young people and families who are being transferred from St John's.

Seeking views and feedback

9.5.9 The Health Board routinely seek feedback from patients and their families on the care they have received. A one off patient engagement survey three years ago showed 85-92% positive responses and there was reported to be good involvement with families at RHSC, including qualitative interviewing but the Review team did not see systematic cross-organisation programme of engagement or audit of the views of children and families. A monthly survey in ED generated 75 responses in October 2015. Almost all responses were either 'Excellent' or 'good' with 1-3% reporting 'satisfactory' and nobody responding 'poor'. Things to improve were focussed on waiting times but there were numerous positive points raised, particularly around communication, explanation and putting children and their families at ease.

9.5.10 Parents whose children receive specialist treatment reported high satisfaction levels. The 'tell us 10 things' programme seeks to gain feedback from families and children, through comments boxes placed about health services, but this has not been rolled out into RHSC yet and it is not clear how this feedback is incorporated into routine governance or service development.

9.5.11 At the RIE there are two specific mechanisms for seeking and responding to parents. The first is a real time 'Getting Better Together Tree' where parents can post comments and responses are displayed. The second is a twice-yearly questionnaire delivered just prior to discharge for which the results are analysed and fed back to staff. There is a wide ranging programme of QI activity around parental communication and involvement.

9.5.12 The 'Being Open' national policy initiative to work with patients and families who have had adverse outcomes has involved a number of patients and parents/carers and there are patient reps on groups and public forums.

Recommendation: Ensure that there is a clear mechanism for incorporating patient and family feedback into decision making and that where there are gaps, further feedback/information is proactively sought.

Involvement with service design/re-design

9.5.13 There is a strong Maternity Services Liaison Committee, particularly in Midlothian which includes innovative ways of working with parents and is looking at neonatal care.

9.5.14 The RHSC was reported as having a strong Family Council but this does not involve children. A Young People's Advisory Group is linked to the Family Council and was established for patients and/ or their siblings, providing a forum for young people to share ideas and aspirations for the new hospital, although the YPAG webpage has not been updated since 2012. NHS Lothian told the Review team that there was considerable involvement of children, young people and families in the design of the new hospital, and these groups are now involved in the arts and therapeutic aspects of the new design. However the Review team did not meet any members nor see evidence of their work being incorporated in governance or decision making processes.

9.5.15 Although the business case development 5-10 years previously had involved wide consultation, the Review team did not see ongoing involvement of children, young people and families in the development of the new site and the plans for services moving forward. Staff were unable to articulate service developments and decisions that had been specifically influenced by young people's involvement and explained that actively seeking perspectives and opinions with regards to the development of plans for the new services had been discouraged. Most did not know about the Young People's Advisory Group nor how to involve them. There seems to be a lack of clear direction with regards to communication and engagement. It is not 'everybody's business' at present.

10 Conclusions

- 10.1 The RCPCH was pleased to be invited to work with NHS Lothian towards finding a sustainable solution to the workforce issues that had arisen around the St John's paediatric service. The Review team has considered in depth a range of information and examined comparators across the UK in terms of census returns, policy and research. The Review team has also applied their own expertise in developing strategic and operational recommendations for the Board to consider.
- 10.2 One of the most challenging areas of medical management is the communications and development of teams across services, departments and networks of hospitals. The pressures on senior management, not least from the intense political and media scrutiny which they have faced in the last year appear to have made it difficult to fully engage with the clinicians on site and address some of the behaviours and expectations amongst the medical teams.
- 10.3 Publication of this RCPCH review report has been cited widely as a point after which 'decisions can be made' and it is important that this opportunity is not lost and a swift, clear strategy for the future is agreed, clearly communicated and adhered in operational planning.

Recommendation: Commit to development of a clear 3-5 year strategic plan for the future of St John's inpatient paediatric service and the workforce that meets the needs of patients and includes investment in new ways of working.

- 10.4 The priority is engagement of the clinicians in the strategy and new ways of working. This can be tailored around current commitments and restrictions but new contracts and job plans must reflect the whole of Lothian and a commitment to the population rather than a focus on a particular unit. This will provide flexibility not just for management but also in terms of clinicians gaining experience and training opportunities. Nursing is already working toward this approach and development of advanced practice will also assist in supporting the senior medical teams. The importance of shared policies, protocols, SoPs, governance and reporting systems will further develop the 'one Lothian' approach.

Recommendation: Commit to a 'one Lothian' approach to workforce and operational planning in paediatrics with staff rotation, and consistent governance which is clinically and confidently led.

Recommendation: Clearly communicate the vision through engagement with staff, patients, public, stakeholders and the future workforce.

- 10.5 In order to implement a 'one Lothian' model and progress the recommendations in this report, we propose a cross-Lothian 'Children's Board' which considers infant children and young people issues across the region and supports the work of the

Child Health Commissioner. Outputs could include a uniform approach to engagement and communications with patients and families, as well as oversight of governance and data monitoring.

Recommendation: Identify a Board- level Champion to chair a 'Children's Board' which oversees all issues relating to children's services in Lothian.

Appendix 1 - The Review team

Dr David Shortland MD FRCP FRCPCH DCH has been a paediatrician for 26 years in Poole, Dorset, including ten years as neonatal lead and twelve as clinical director. David was the lead clinician for the rebuild of the paediatric department in 2005 and currently leads on Clinical Quality for paediatrics.

Following five years as member, then Chair, of the Clinical Directors' Special Interest Group, in 2006 David was elected as the National Workforce Officer for the RCPCH leading the 2007 national workforce census and designing a cohort study of trainees to provide a clearer understanding of the current and future workforce, helping to define how the role of paediatricians can evolve to provide consultant delivered care and hence safe and sustainable services.

David was elected Vice President (Health Services) in 2009 and played a central role in developing strategy for Child Health Services in the United Kingdom supporting paediatricians through the challenges of radical reform to the health service, working time legislation and service re-design. During David's five years in post he developed a national template for the resident paediatrician and was lead author for "Facing the Future". This document defined 10 quality standards for acute paediatric services and is widely quoted as a template for good practice. David led a national audit of these standards in 2013 and currently chairs a steering group extending the standards approach to care outside hospitals. Since 2014 David has been clinical adviser to the RCPCH Invited Reviews programme and has led a number of high profile reconfiguration, individual and service reviews.

Dr Simon Clark has been a neonatal consultant for 12 years, he is currently the lead clinician for the Jessop Wing, which has 7000 deliveries per year and 52 cots. He was Head of School for Paediatrics in Yorkshire and Humber for five years responsible for the training progression of 380 doctors and the management of 11 training programme directors. Simon has taken part in organised deanery quality management visits, triggered deanery and PMETB visits and organised location specific visits when required. Simon has extensive experience in workforce planning on a unit based, local and regional level. This led him to become the RCPCH's Workforce Officer on Council since April 2014. He was seconded to the group that developed the service specifications and then implemented the Embrace regional transport service for emergency inter-hospital transfers for neonates and paediatric intensive care. He has reviewed plans for potential service reconfigurations as an outside expert. Outside of his NHS work Simon prepares medicolegal reports for neonatal clinical negligence cases.

Carol Williams MSc BA (Hons) RGN RSCN RNT is an Independent Nurse Consultant and Healthcare Advisor who established her business in August 2010, since which time she has led a number of compliance projects and service reviews across a range of services, including community services and complex care, emergency care and hospital

based children's and adult services. Carol was an Area Manager in healthcare regulation at the Healthcare Commission and the Care Quality Commission and has worked at the Evelina Children's Hospital at Guy's & St Thomas' NHS Foundation Trust, London, as Consultant Nurse in Paediatric Intensive Care, Acting Head of Nursing for Children's Services and Lead Nurse for Children's Critical Care.

Carol is a qualified teacher and has taught on undergraduate and Master's nursing programmes for various organisations, including the Royal College of Nursing. She has participated in several inquiries and was one of the team who established the case note review process for the Bristol Royal Infirmary Inquiry.

Carol has been Nursing President of the European Society for Paediatric and Neonatal Intensive Care and chaired the Royal College of Nursing and Paediatric & Neonatal Intensive Care Forum.. She contributed to the development of the National Service Framework for Paediatric Intensive Care and worked with a Department of Health Team benchmarking national paediatric intensive care standards. She has been invited speaker at national and international conferences and co-edited a children's intensive care nursing textbook. Currently, Carol is on the Nursing Advisory Committee of the WellChild charity.

Kate Branchett BA is Patient Voice and Insight Lead for the West Midlands Strategic Clinical Networks and Senate. Kate has a real passion for improving the experience and care of all patients and their families. A relative newcomer to the NHS, Kate has previously worked as a Music Teacher, National Sales and Marketing Manager for a company selling school uniform, Parent Services Administrator for the National Childbirth Trust and most recently GP Carer Support Advisor in surgeries across Worcestershire.

Kate is married and is mum to Ben, 10, Molly, 6 and William, 1. Her interest in healthcare and improving services was sparked by the extremely premature birth of her twin daughters. Izzy was born at 22w4d and did not survive. However, Molly was born 8 days later and although she spent 101 days in neonatal care, she is now a happy, healthy 6 year old. Kate has previously worked with SANDs, BLISS, NCT, her local Maternity Services Forum and the Southern West Midlands Maternity and Newborn Network as a patient/parent representative. She co-authored an inductive study '[Neonatal Palliative and End of Life Care: What Parents Want From Professionals](#)' published in 2012. Kate was vice-chair of the RCPCH Parent and Carer Panel and prior to her employment by the NHS, was also a member of the West Midlands Clinical Senate Council.

Jenni Illman is the Operational Lead for Invited Reviews at RCPCH. She has a background in project management and since joining the College in 2014 she has been involved in the development of clinical guidance for the management of children with a decreased conscious level, and the introduction of the new patient voices platform, RCPCH & Us. Previously she worked at The Royal College of Physicians and the Worshipful Society of Apothecaries in examination management roles with a focus on

process improvement. Jenni is particularly interested in improving education and well-being for children and young people around mental and sexual health, and has been an active volunteer with both SANE and Brook.

Additional advice and Assurance was provided by Dr James Fraser FRCPCH and Professor Stewart Forsyth FRCPCH

Appendix 2 - Abbreviations

ALS	Advanced Life Support
ANNP	Advanced Neonatal Nurse Practitioner
APLS	Advanced Paediatric Life Support
APNP	Advanced Paediatric Nurse Practitioner
ARU	Acute Receiving and Assessment Unit
ASD	Autism Spectrum Disorder
BAPM	British Association of Perinatal Medicine
BiPAP	Bilevel Positive Airway Pressure
BMA	British Medical Association
CAHMS	Children and Adolescent Mental Health Services
CPAT	Child Protection Advisory and Training
CPAP	Continuous positive airway pressure
CPD	Continuing Professional Development
CYP	Children and Young People
DCC	Direct Clinical Care
DGH	District General Hospital
ED	Emergency Department
ENP	Emergency Nurse Practitioner
ENT	Ears Nose and Throat
EWTD	European Working Time Directive
FY	Foundation Year
FY2	Foundation Year 2
GP	General Practitioner
GOSH	Great Ormond Street Hospital
GPST	General Practice Speciality Training
HDU	High Dependency Unit
HFNC	High-flow nasal cannula
HV	Health Visitor
ICU	Intensive Care Unit
LAS	London Ambulance Service
LTFT	Less than Full-Time Training
M&M	Morbidity and Mortality
MBRRACE	Mothers and Babies: Reducing Risk through Adults and Confidential Enquirers reporting

NES	NHS Education for Scotland
NICU	Neonatal Intensive Care Unit
NLS	Newborn Life Support
OOH	Out of Hours
PICU	Paediatric Intensive Care Unit
PILS	Paediatric Immediate Life Support
PSG	Paediatric Services Group
QIS	Qualified in Specialty
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and Child Health
RHSC	Royal Hospital for Sick Children
RIE	Royal Infirmary Edinburgh
SAS	Speciality and Associate Specialist Doctors
SCAMP	Scottish Children's Acuity Tool
SEAT	South East and Tayside Planning Group
SHO	Senior House Officer
SJH	St John's Hospital
SPA	Supporting Professional Activities
SSPAU	Short Stay Paediatric Assessment Unit
WTD	Working Time Directive
WTE	Whole Time Equivalent

Appendix 3 – Reference documents

The following standards apply to the services in Lothian:

Urgent and Emergency care

[Intercollegiate Standards for care of CYP in emergency care settings](#) (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care.

[High Dependency Care for children - Time to Move on](#) (RCPCH-PICS 2015) defines Level 1,2,3 Paediatric Critical care (PCC) units and sets out standards for care in Level 1 and 2 units including network working and commissioning arrangements for England.

[Short Stay Paediatric Assessment Units advice for commissioners and providers](#) (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services.

[Standards for the Care of Critically Ill Children](#) (Paediatric Intensive Care Society, 2010) sets out measurable standards for care from arrival at hospital ED through reception,

assessment, inpatient, HDU/ITU and general care across services. Sections on anaesthesia, retrieval and transfer complete the pack.

[Core Competencies for the care of acutely ill and injured children and young people](#) (NHS Scotland 2006) details for emergency and urgent care settings the procedures and expectations of staff.

[Emergency Care Framework for Children and Young People in Scotland](#) (2006) outlines the Scottish vision for urgent care.

[Chapter 10 - Paediatric anaesthesia service](#) (RCoA 2015) Guidance of the provision of anaesthetic services - one chapter of the RCoA suite of standards.

Paediatrics

[Medical Workforce Census 2013](#) (RCPCH January 2015) The census data provides detailed national information on staffing grades and service provision in community services, collected by biannual member survey.

[Facing the Future – a review of Paediatric services](#) (RCPCH 2015) updates the original 2011 guidance and details ten service standards relating to clinical cover, expertise and child protection.

[Facing the Future Together for Child Health](#) (RCPCH 2015) sets out eleven standards to reduce pressure on hospital services in improve the quality and effectiveness of care closer to home.

[Guidance on the role of the consultant paediatrician in the acute general hospital](#) (RCPCH May 2009) sets out a range of models of paediatric care including consultant of the week, resident on call and includes information on job planning, rotation and competencies for acute care.

[Consultant Delivered care](#) – an evaluation of new ways of working in paediatrics RCPCH April 2012

Neonatal care

[Categories of Care](#) (BAPM 2011) sets out the definitions of intensive, high dependency, special and transitional care for neonates.

[Specialist Neonatal Care Quality Standard](#) (NICE 2011) addresses care provided for babies in need of specialist neonatal services including transfers. Compliance will be measured by collection of data against the [Neonatal National Quality Dashboards](#).

[Service standards for hospitals providing neonatal care](#) 3rd edition (BAPM August 2010) defines medical and nursing staffing levels and links closely with the NICE and DH documents and Quality Standard and Toolkit.

[Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing A Framework for Practice](#) (BAPM June 2014) Sets out staffing and activity criteria to which services should be designed. Includes evidence based standards alongside wide consensus.

[The BLISS Baby Charter and Audit Tool](#) (BLISS 2012) provides a framework for units to examine key aspects of their service provision and to help staff make family centred care a reality.

[Neonatal care in Scotland - a Quality Framework](#) (Scottish Government 2013) sets out expectations on Neonatal services based upon the BAPM guidance.

Nursing

[Defining staffing levels for children and young people's services \(RCN 2013\)](#) updates guidance for clinical professionals and service managers regarding optimal staffing levels in areas where children and young people are nursed, by providing minimum standards and standards relating to workforce planning and workload monitoring.

[Healthcare service standards in caring for neonates, children and young people \(RCN 2011\)](#) sets out the standards to be applied when caring for neonates, children and young people in all health care settings.

[Evidence Based Nurse staffing levels \(RCN 2010\)](#) sets out essential elements to planning or reviewing nurse staffing, regardless of the specific tools used.

[Maximising Nursing Skills in Caring for Children in Emergency Departments \(RCN, RCPCH 2010\)](#) is for emergency department managers, lead consultants and lead nurses. It provides detailed guidance on competence development for nursing staff.

[NHS at Home; Community Children's Nursing Services \(DH 2011\)](#) reviews the contribution community children's nursing services, as a key component of community children's services, can make to the future outcomes of integrated children's services.

[Specialist and advanced children's and young people's nursing practice in contemporary health care: guidance for nurses and commissioners \(RCN 2014\)](#) looks at children's nurses roles and their practice. It is aimed at those developing services for children and young people (CYP), for both commissioners and service providers.

[Career, education and competence framework for neonatal nursing in the UK](#) (RCN 2015) is informed by numerous influential drivers, from a variety of sources, and will be updated regularly.

Adolescent health and transition

[Royal College of Physicians: Acute Care Toolkit for adolescents and young adults](#) recommends ways to face the challenges of acute care for Adolescents and Young Adults (AYAs) and how to implement a whole systems approach, models of care, and suggested education and training.

[Transition – getting it right for young people](#) (DH 2006) and [Transition – moving on well - Good practice guide](#) (DH 2008) set clear standards for managing the transfer of CYP with long term conditions from children's to adult services.

[Lost in Transition – moving young people between child and adult services](#) (RCN 2007) sets out the principles that should be applied in the joint working between paediatrician and adult physician, when a young person with a physical health disorder is moving forward into the care of the adult service.

Involvement and participation

[Not just a phase](#) (RCPCH 2010) sets out mechanisms and tools for meaningful involvement of children and young people.

[You're Welcome Quality Criteria – making health services young people friendly](#) (DH 2007 and 2011) provides voluntary standards of care for ensuring facilities and services are accessible and young-people-focussed.

[Patient Reported Experience Measure for urgent and Emergency Care](#) (RCPCH 2012) is a tool developed intercollegiately by the RCPCH with Picker Institute Europe to measure the experience of paediatric patients 0-16 years in all urgent and emergency care settings including; GP practices, out-of-hours centres, A&E departments and the ambulance service.

Appendix 4 – Sources of information

Documents were provided by NHS Lothian relating to the following areas:

- Board papers and minutes
- Medical and nursing staff lists, staffing structures and rotas
- Clinical activity (attendances, admissions, referrals) and audit data
- Clinical governance materials – structures, minutes, risk registers
- Strategic planning inc. business cases and reports
- Staffing and recruitment strategies and proposals
- Incident reporting, incident summaries and complaints
- Training provision and attendance
- Admissions data and maternity dashboard
- Patient feedback
- Staff feedback
- Correspondence

Appendix 5 – Contributors to the review

The following groups were interviewed during the review, and/or submitted information for consideration by the Review team:

- NHS Lothian Health Board:
 - Chairman
 - Local Authority Non Executive Board Members
 - Chief Executive
 - Chief Officer
 - Acute, Medical Director
 - Health & Social Care Partnership Leads
- Children's Services Operational Management Team:
 - Associate Medical Director for Women's and Children's
 - Director, Women's and Children's services
 - Associate Nurse Director for Children's
 - Clinical Director for Paediatrics
 - Clinical Nurse Managers for Medical paediatrics and PICU/ St John's
 - Child Health Commissioner
 - Allied Health Professional Leads
- St John's Hospital:
 - Consultant Paediatricians and other Medical Staff
 - Advanced Nurse Practitioners
 - Emergency Department Medical and Nursing representatives
 - Lead Obstetrician
 - Clinical Midwifery Manager
 - Clinical Lead for Neonatology

- Clinical Nurse Manager for Neonatology
- Charge Nurse for SCBU
- Paediatric Ward Nursing Team
- St John`s Site Director and Associate Nurse Director
- St John`s Stakeholder Group

- Royal Hospital for Sick Children:
 - ARU Medical Team
 - Community Consultants
 - A&E Consultant
 - Speciality Consultants
 - Trainees
 - Senior Nursing Team

- Royal Infirmary of Edinburgh (Simpson Unit)
 - Neonatal Consultant
 - Nursing Team
 - Advanced Neonatal Nurse Practitioners
 - Maternity Services Team

- SEAT Workforce Planning Manager

- South East Scotland Neonatal MCN Lead

- NHSL Child Protection Lead Nurse and Lead Consultant

- NHSL Clinical Governance Lead

- Training Programme Director

- Dean of Postgraduate Medicine, NHS Education for Scotland

- Clinical Director, Lothian Unscheduled Care Service

- Other Stakeholders
 - Political representatives (SNP and Labour)
 - Local Lobby Groups
 - Charities
 - Patient groups and organisations
 - Parents and Carers
 - Patients (children and young people)

Appendix 6 - St John's Paediatric recruitment 2012-2015

2012

- 4 substantive consultant paediatrician posts advertised
- 1 applicant appointed, still in post

2013 Major international recruitment campaign using external recruitment expert (HAVAS)

- No medical applicants for substantive posts
- 2 ANNPs appointed

Substantive Specialty doctor posts

- 2 recruitment drives
- 1 applicant – appointed, still in post

Clinical Fellows

- Tailored recruitment drive in Myanmar, through personal contacts
- 5 applicants, all interviewed
- 2 appointed to 2 year fixed term contracts
- Contracts not extended as neither doctor achieved the required competencies to work on the out of hours middle grade rota
- Both have now left

2014 Substantive Consultant paediatrician

- 2 applicants, both interviewed
- 1 appointed, still in post

Replacement Consultant paediatrician

- 1 applicant
- Interviewed but not appointable
- Subsequent request from St John's Consultants to defer re-advertisement

2015 International Medical Training Fellowships (Scottish Government sponsored)

- 2 applicants, both interviewed
- 1 offer but candidate subsequently withdrew
- Request from St John's Paediatricians to try to recruit to more junior tier

Junior Tier (FY/GPST level)

- 1 applicant, appointed August 2015

Locum Consultant for Maternity Leave

- No applicants in early 2015
- Repeat advertisement August 2015
- 1 applicant through word of mouth, appointed September 2015

Nursing posts

- 5 vacancies over July – September 2015
- All advertised and recruited to

Appendix 7 – Staffing calculations for St John’s modelling

St John`s hospital – rota staffing options

Option 1 Criteria

- 24/7 Consultant rota
- 24/7 Middle grade rota (SAS, ANPs and Resident Consultants)
- 8 to 8 tier 1 rota (FY and GP trainees)

Modelling the consultant rota - introduction

Given the assumptions in table 1, a team of 8 acute general consultants would be able to provide resident cover (12 hour shifts 9am- 9pm) for an average of fractionally over 2 nights per week (25.36 hours). The assumptions are compared against the data returned by Lothian for the RCPCH 2015 Census where applicable.

Table 1 – Consultant rota assumptions

Assumption	Actual data from Lothian Census return 2015
Each consultant contract averages 10 PAs	Total PAs for 8 consultants = 83
Average Consultant SPAs = 2	Average SPAs = 1.9375
10 General Clinics per week	10 general clinics per week
Clinic length = 1 PA plus 1 hour administration	n/a
Handover length = 0.5 hours	n/a
2 handovers per day (5 core time, 9 out of hours)	n/a
All staff contribute to the rotas equally	

Detailed modelling for consultant rota in PAs

Table 2 sets out the calculations for the consultant rota. For a team of 8 consultants, 64 PAs are available for direct clinical care after deducting an average of 2 SPAs. Clinic work accounts for 12.5 PAs for 10 clinics i.e. 4hrs per clinic plus 1 hour administration. Prospective cover for annual leave and study leave should then be deducted leaving 41.2 PAs. Consultant presence in the hospital for 12 hours per day/ 7 days a week, on-call for 12 hours a day/7 days a week and allowance for handover accounts for a further 32.475 PAs per week for the team

Table 2: Detailed modelling for consultant rota**a) Consultant presence for 12 hours per day e.g. 9am to 9pm**

Weekly Team PAs available for clinical work = $(10-2)*8$		64
Less Clinics = $1.25 \text{ PAs} * 10$	12.5	
Direct Clinical Care (DCC) PAs excluding clinics = $64-12.5$		51.5
Allow for prospective cover = $51.5*0.8$		41.2
To provide daytime/evening presence from 9am to 9pm 7 days per week i.e. 50 hours core time = $12.5 \text{ PAs} (50/4)$ plus 34 hours out of hours = $11.33 (34/3)$	23.83	
To provide 12 hours on call/7 days a week i.e. core time (10 hours*25% attendance/4 plus out of hours 74 hours* 25% attendance /3)	6.79	
Handovers = $0.625 \text{ PAs (core), 1.5 PAs out of hours}$	2.125	
Total non-clinic DCC		32.745
Therefore DCC PAs available for resident night cover ($41.2 - 32.745$)		8.455

8.455 PAs are therefore available for other clinical duties. 8.455 PAs = 25.365 hours if we work on the basis of 1 PA = 3 hours. Therefore the team of 8 consultants would be able to provide resident cover for just over 2 nights per week throughout the year.

An additional consultant making the total 9 would make 44.565 hours (14.855 PAs) available per week equivalent to over half the required night time cover per week.

Two additional consultants would give a theoretical 63.765 hours of night cover (21.255 PAs), equivalent to approximately 5 nights a week. However this latter option would mean that each of the 10 consultants would need have contracts that had an average of 4.5 resident PAs and the RCPCH's guidance on the role of the consultant recommended no more than 4 resident PAs for each consultant. Therefore when the implications are discussed below for tier 2 rotas, they ensure that average consultant cover is kept within this guidance. This means only 48.51 hours of consultant night cover would be available with a team of 10 consultants.

b) Consultant presence from 8.00 am to 10.30 pm/ 7 days per week

Table below relates to 8 consultant model

Weekly Team PAs available for clinical work = $(10-2)*8$		64
Less Clinics = $1.25 \text{ PAs} * 10$	12.5	
Direct Clinical Care (DCC) PAs excluding clinics = $64-12.5$		51.5
Allow for prospective cover = $51.5*0.8$		41.2
To provide daytime/evening presence from 8am to 10.30pm 7	29.25	

days per week i.e. 55 hours core time = 13.75 PAs (55/4) plus 46.5 hours out of hours = 15.5 PAs (46.5/3)		
To provide 9.5 hours on call/7 days a week i.e. core time (5 hours*25% attendance/4 plus out of hours 61.5 hours* 25% attendance /3)	5.44	
Handovers = 0.625 PAs (core), 1.5 PAs out of hours	2.125	
Total non-clinic DCC		36.81
Therefore DCC PAs available for resident night cover (41.2 – 36.81)		4.385

4.385 PAs are therefore available for other clinical duties. 4.385 PAs = 13.155 hours if we work on the basis of 1 PA = 3 hours. Therefore the team of 8 consultants would be able to provide resident cover for just 1 full night per week on this model, although with consultant presence until 10.30, any resident night shift may be shorter.

An additional consultant making the total 9 would make 32.355 hours (10.785 PAs) available per week equivalent to just over half 2.5 full nights per week.

Two additional consultants would give a theoretical 51.5 hours of night cover. However because we need to ensure no more than 4 resident PAs for each consultant, this means that additional available night cover is limited to 32 hours as per the 9 consultant option. This is a result of the increased evening presence for this option.

Tier 2 cover

To model 24 hour tier 2 cover accepting that this will not include any middle grade trainee paediatricians, we can use as a start point the hours available for resident consultant cover available from the calculation above for the consultant rota. The rota can then be made up by the employment of Advanced Nurse Practitioners and SAS doctors or Clinical Fellows, all of whom should have tier 2 competencies in order to comply with Facing the Future Standard 2. The following assumptions are made in the model.

- An advanced paediatric nurse practitioner can contribute 29.6 hours per week cover to the tier 2 rota, calculated as follows:
 - o 37 hour per week contract * 0.8 prospective cover for annual/study leave = 29.6
- No more than 50% of time provided for nurses covers night shifts
- SAS doctors can contribute 27.2 hours to the rota per week as follows:
 - o 40 hrs (10 PAs) – 6 hours (1.5 PAs) * 0.8 prospective cover = 27.2
- Hours undertaken by SAS doctors out of hours are multiplied by a factor of 1.33 as a PA at night is worth only 3 hours.
- All staff contribute to the rotas equally

Detailed modelling

a) With 12 hour consultant presence

To provide 24/7 tier 2 cover, there are a total of 175 hours in a week where presence is needed – 168 hours plus 7 hours for handovers when 2 staff present at same time.

If we assume under an 8 consultant rota that 25.365 hours are covered by resident consultant night cover as per calculation for the consultant rota in table 2a, a further 149.635 hours are needed from other staff.

This modelling has been done on the basis of this remaining 149.635 hours being provided by ANPs and SAS Doctors (St John's already has 2 SAS doctors working 10 PAs each with 1.5 SPAs). Table 3 below sets out combinations of wte ANPs and SAS doctors which would provide this cover given the consultant cover remains constant.

Table 3a – wte combinations of ANPs and SAS doctors required for tier 2 rota when 25.365 hours provided by resident consultant cover (8 consultants on team).

ANP	2	2.17	2.5	2.57	2.96	3	3.35	3.5	3.75	4	4.15	4.5
SAS	3.72	3.5	3.09	3	2.5	2.45	2	1.82	1.5	1.18	1	0.55

Staff required when additional consultants added

If additional consultants are employed, the hours needed from other staff on the tier rota are reduced – tables 3b and 3c look at ANP/SAS requirements when increased night cover can be provided by consultants.

Table 3b – wte combinations of ANPs and SAS doctors required for tier 2 rota when 44.565 hours i.e. provided by resident consultant cover (9 consultants on team).

ANP	1	1.4	1.5	1.8	2	2.22	2.5	2.6	3	3.4	4.4
SAS	4.0	3.5	3.41	3	2.78	2.5	2.1	2	1.5	1	0

Table 3c – wte combinations of ANPs and SAS doctors required for tier 2 rota when 48.51 hours provided by resident consultant cover (10 consultants on team).

ANP	0.9	1.68	2	2.5	3	3.25	3.5
SAS	4	3	2.59	1.95	1.32	1	0.85

b) With 14.5 hours/7 day consultant presence

Table 4b shows possible combinations of ANPs and SAS doctors needed for a tier 2 rota when there are 8 consultants and 13.155 hours of their time per week are available to support the tier 2 rota.

Table 4b – wte combinations of ANPs and SAS doctors required for tier 2 rota when 13.155 hours provided by resident consultant cover (8 consultants on team).

ANP	2	2.5	2.65	3	3.43	3.5	3.83	4	4.5	5
SAS	4.32	3.69	3.5	3.05	2.5	2.82	2	1.78	1.14	0.5

Table 4c shows possible combinations of ANPs and SAS doctors needed for a tier 2 rota when there are 9 consultants and 32.355 hours of their time per week are available to support the tier 2 rota.

Table 4c – wte combinations of ANPs and SAS doctors required for tier 2 rota when 32.355 hours i.e. provided by resident consultant cover (9 consultants on team).

ANP	1	1.5	2	2.3	2.5	2.6	3	3.5	4	4.82
SAS	4.6	4.02	3.38	3	2.7	2.5	2.1	1.48	0.84	0

Tier 1

- **Mixed economy tier – FY2 and GP trainees**

RCPCH Revised Standards for Acute General Paediatric Services (Facing the Future) state in standard 8 that all general paediatric training rotas are made up of at least ten whole time equivalent posts.

Option 2

Modelling criteria:-

- Consultant rota to be 8am to 10.30pm, 7 days a week
- Middle grade rota made up of SAS doctors/ANPs with tier 2 competencies 24 hour, 7 days a week.
- Junior rota – GP trainees/FY doctors 8am to 8pm, 7 days a week.

Consultant rota

Table 5: Detailed modelling for consultant rota – present 8 am to 10.30pm

To provide daytime/evening presence from 8am to 10.30pm 7 days per week i.e. 55 hours core time = 13.75 PAs (55/4) plus 46.5 hours out of hours = 15.5 PAs (46.5/3)	29.25	
To provide 9.5 hours on call/7 days a week i.e. core time (5 hours*25% attendance/4 plus out of hours 61.5 hours* 25% attendance /3)	5.44	
Handovers = 0.625 PAs (core), 1.5 PAs out of hours	2.125	
Total non-clinic DCC		36.81
Allowing for prospective cover non-clinic DCC PAs required =		46.02
Add PAs for 10 clinics	12.5	

Direct Clinical Care (DCC) PAs excluding clinics = 64-12.5		58.52
Each consultant available for 10 PAs less 2 SPAs = 8 PAs		
Therefore general consultant requirement = 58.52/8		7.31

Tier 2 rota to be 24/7 staffed by ANPs and/or SAS docs

Criteria

- No resident cover provided by consultants
- ANPs and SAS doctors not to work more than 50% nights
- Nurses can contribute 29.6 hours to the rota
- SAS doctors can contribute 27.2 hours to the rota (out of hours PAs = 3 hours)

Table 6: Example combinations which will provide tier 2 cover for 24/7 service without overnight consultants and trainees

ANP	2	2.5	3	3.5	4	4.5	5	5.5	6
SAS	5	4.33	3.7	3.06	2.43	1.8	1.15	0.52	0

Tier 1 Modelling

Criteria

- Staffed by FY2 and GP trainees 8am-8pm, 7 days a week.

Assumption

- Each trainee attends one clinic per week (4 hours plus 1 hour admin)
- Each trainee receives 3 hours protected teaching per week
- Each trainee has 2 hours for QI/Audit/Research
- At the times the doctor is supernumerary to the rota
- Prospective cover – 20% of trainee time for annual leave/study leave etc.

Using these assumptions we can calculate the number of hours a doctor has available to provide service on the rota per week.

For doctors on 48 hours = 28.4 hours, for 40 hours = 22 hours

Number of hours rota cover required per week = 84 plus 3.5 for 30 minute handover each day = 87.5

Therefore

for doctors on 48 hours, 3 wte are required for rota ($87.5/28.5 = 3.08$)

for doctors on 40 hours, 4 wte are required for rota ($87.5/22 = 3.98$)

Option 3

Criteria

- Nurse led SSPAU
- Tier 1 rota as per option 2

Appendix 8 – You said, we heard

Outline of stakeholder engagement

As part of this review, it was important for us to listen to the experiences and expectations of the people who use or work within the services in Lothian. We were clear we could not respond to specific complaints, but wished to gain a flavour of how the services were working.

The full report runs to 29 pages so is available as a separate document alongside this report.

RCPCH Invited Reviews Programme

You said, we heard

Contributions to the RCPCH Design Review for Lothian Health Board

June 2016



RCPCH Invited Reviews Programme
June 2016

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Authors:

Ms Karina Pall - Researcher (RCPCH)
Ms Jenni Illman - Operational Lead, Invited Reviews (RCPCH)
Ms Carol Williams - Independent Nurse Consultant and Healthcare Advisor

Published by:

Royal College of Paediatrics and Child Health
5-11 Theobalds Road London WC1X 8SH

Tel: 0207 092 6000
Email: invited.reviews@rcpch.ac.uk
Web: www.rcpch.ac.uk/invitedreviews

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1. Introduction

In September 2015 NHS Lothian Health Board asked the RCPCH to lead an independent review to help shape the provision of safe, high quality and sustainable children's hospital services across Lothian in the future.

Acute hospital services in Lothian are currently provided on two sites, the Royal Hospital for Sick Children in Edinburgh (RHSC) and St John's Hospital in Livingston. The review follows long-standing recruitment difficulties and the temporary closure of overnight beds for children at St John's Hospital in 2012 and 2015.

2. About the review

Invited Reviews are an independent assessment of a service (or services) against agreed terms of reference, in this case RCPCH were asked by NHS Lothian's Acute Hospital Committee to:

- a) Review NHS Lothian's Acute Medical Paediatric service and pathways of care at the Royal Hospital of Sick Children in Edinburgh (RHSC) and at St John's Hospital in Livingston, in terms of current and projected demand, expected quality and standards of care and current workforce arrangements
- b) Recommend what the most reliable, sustainable and affordable model of service for the foreseeable future would be, taking into consideration NHS Lothian's current and realistically projected clinical workforce
- c) Advise NHS Lothian on the best model(s) of care, and the timescales within which each model could reasonably be implemented
- d) Advise NHS Lothian on how associated Acute Medical Paediatric services such as ambulatory care and medical assessment could be enhanced to improve care and maximise local access;
- e) Advise NHS Lothian on outcome measures to provide transparent evidence of the effectiveness of service distribution
- f) Address all five of the above five objectives with clear reference to the standards published within RCPCH's '[Facing the Future](#)' work stream

The Review team comprised two consultant paediatricians, a children's nurse consultant, a lay reviewer with expertise in public engagement, and a member of RCPCH staff. The full review process is detailed within the main report.

More information on invited reviews, including timescales, process and biographies for the Review team, can be found on our [website](#).

3. Local voices

As part of the review, it was important for us to listen to the experiences and expectations of the people who use or work within the services in Lothian. We worked closely with NHS Lothian and the Review team to develop a tailored, meaningful programme of engagement. We ensured we were able to accurately capture and consider local voices, however we were clear we could not respond to specific complaints, but wished to gain a flavour of how the services were working.

Between December 2015 and April 2016 we:

- ran a survey which generated 1,896 responses online and 31 paper responses
- ran five focus groups across West Lothian and Edinburgh attended by 11 parents and carers, and 13 stakeholders
- published an email address for direct contact used by approximately 10 people
- attended the January meeting of the St John's Stakeholder Group
- contacted all MPs, MSPs and Local Councillors across Lothian, and met with all interested representatives
- reviewed the transcripts of the public meetings held by NHS Lothian
- read the 400+ emails sent to the Chief Executive and Chairman of NHS Lothian relating to the future of children's services at St John's

We have read every written contribution and noted those expressed at the focus groups and public meetings. We have also been provided with information from the Health Board's feedback and complaints processes.

Given the anecdotal nature of many the responses, it was never our intention to quote individual cases, and we are cautious about drawing definitive conclusions since respondents are self-selected and not necessarily representative.

Our focus was on how families use the services when a child is unwell, and what arrangements in future would ensure that children continued to receive safe, effective care. We also asked staff to comment on the service, what was good and what could improve it given the difficulties in recruiting medical staff with the expertise to provide some of the more complex care.

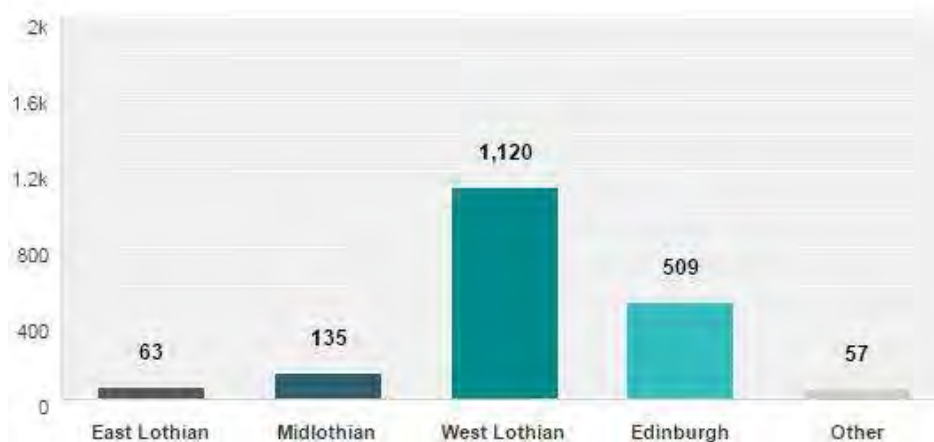
A thematic analysis of findings from the above engagement activities is provided in section 5.

More information about '&Us' - the College's Children and Young People Engagement Team can be found at Appendix 1.

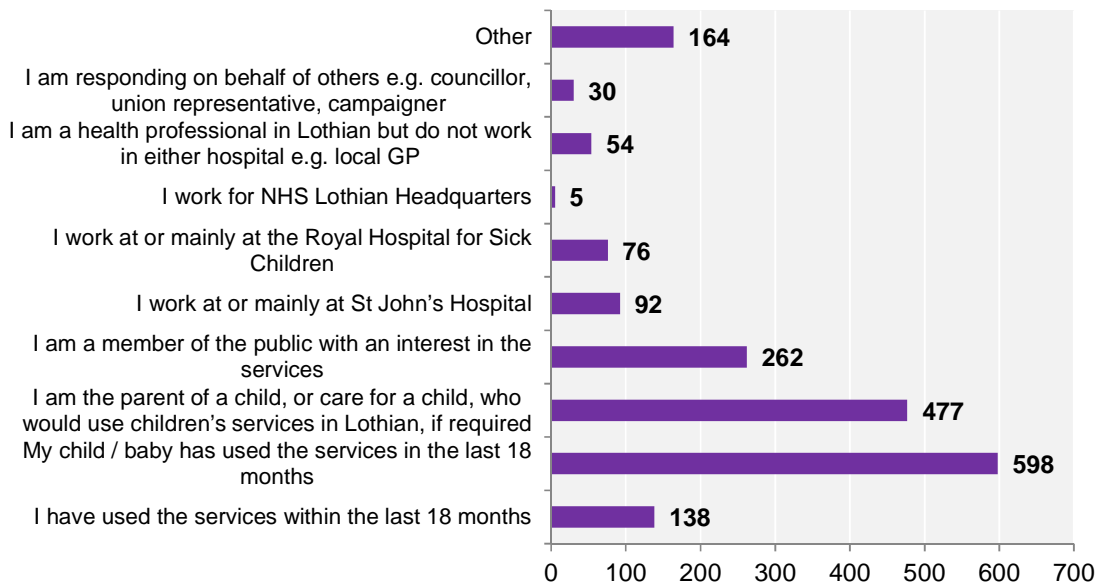
4. The survey

Through the survey we were keen to hear from service users and their carers, staff working within the services and anyone else with an interest in paediatric services in Lothian. We wanted to know families were using and accessing the services, what people thought was working well and what they thought could be improved. This section provides a summary of who completed the survey and which services they used or worked within.

1,896 people responded to the survey online, of these:

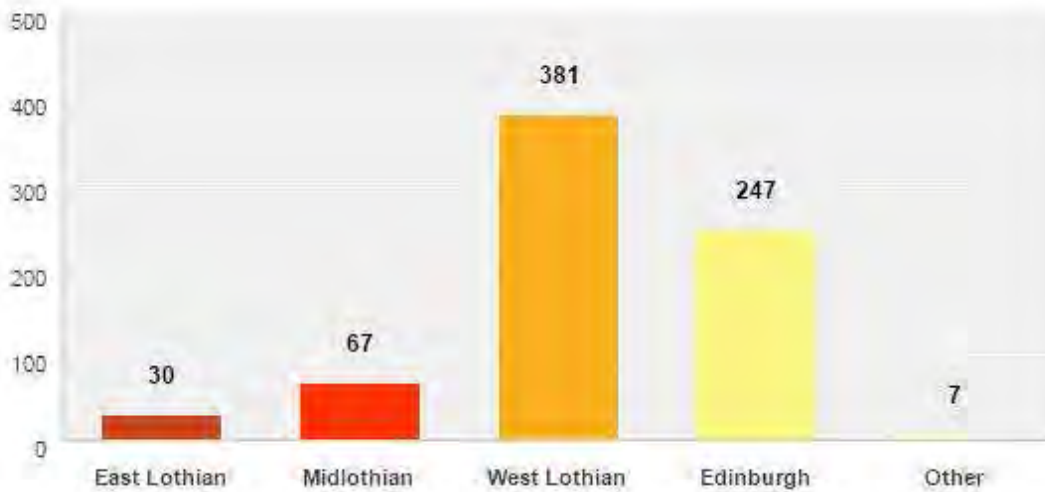


When asked to identify their interest in children’s hospital services:

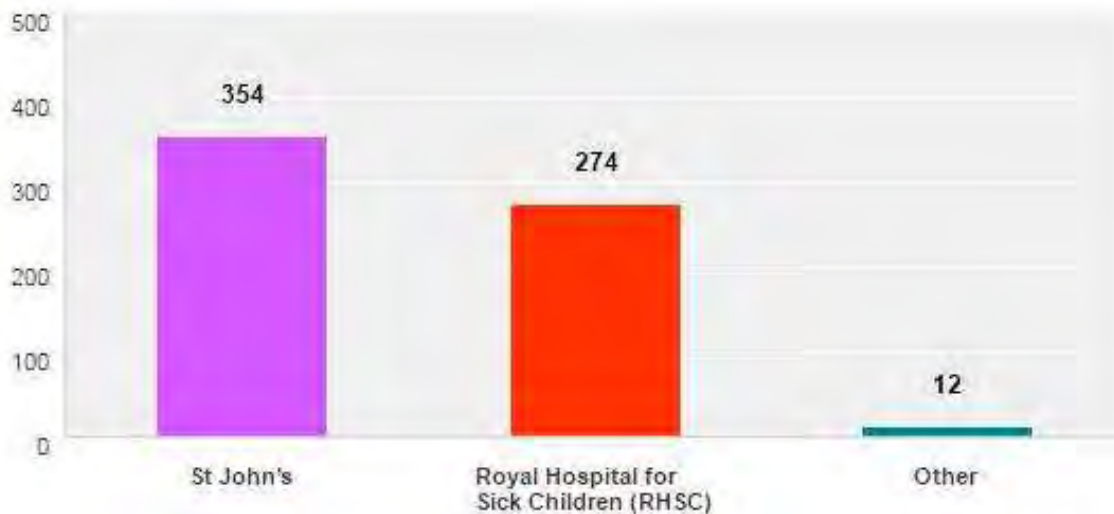


Service users (children and young people, parents and carers)

A total of **736** respondents said they or their children had used children's hospital services in Lothian within the past 18 months; of these, the largest group lived in West Lothian¹:

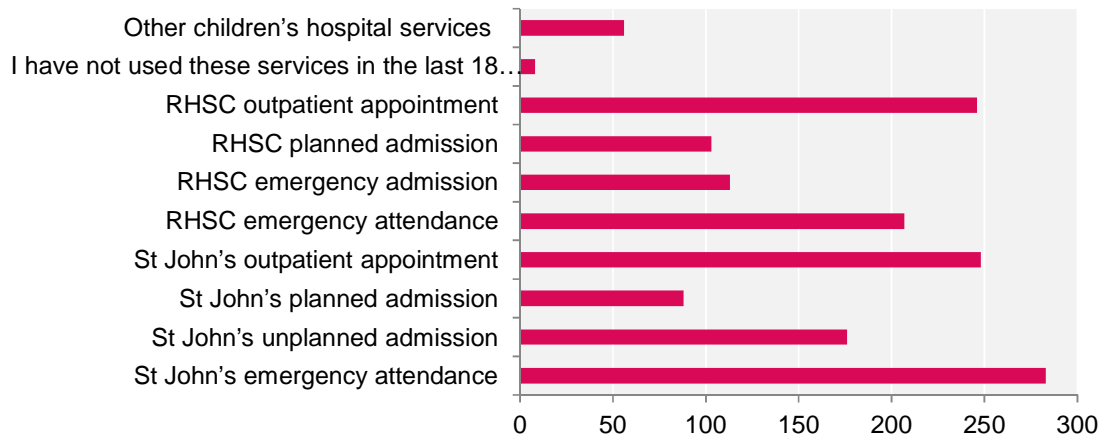


When asked which they considered to be their 'local' children's hospital

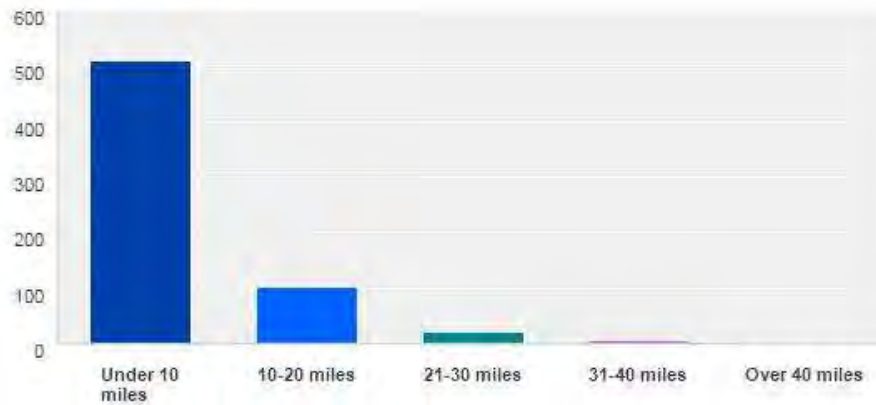


¹ Not all respondents answered all questions, so totals will vary

Respondents had contact with the following services within the previous 18 months²:

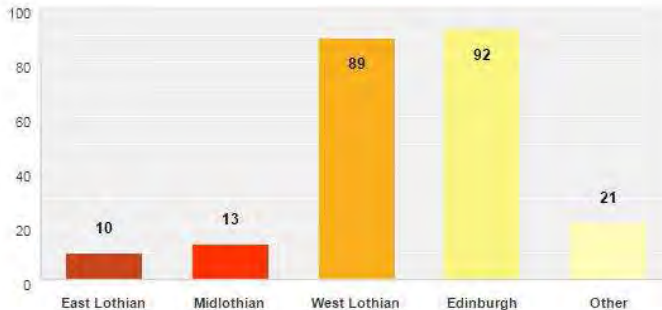


Most had to travel for less than 10 miles to access services and the majority (90%, 474) were travelling to their local services:



NHS Lothian Staff

A total of **227** respondents identified themselves as members of NHS Lothian staff; the largest group lived in Edinburgh. Those who selected 'other' were largely from Fife and the Borders (for their workplaces see p.5):

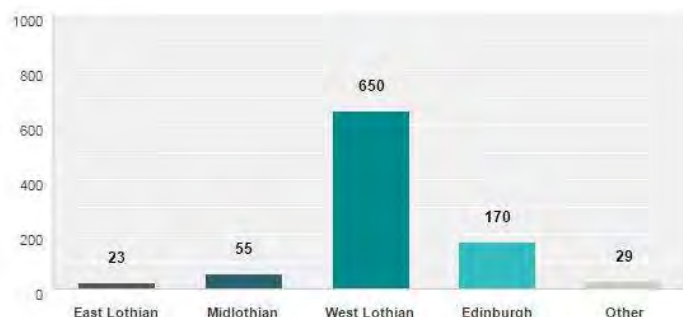


Only 40% of respondents from this category answered any further questions in the survey (these are summarised in section 5)

² Respondents could select more than one option

Other stakeholders

The majority of the remaining **927** respondents (see p.2 for breakdown) lived in West Lothian:



Only 50% of respondents from this category answered any further questions in the survey (these are summarised in section 5)

5. Thematic analysis of stakeholder engagement

Thematic analysis was used as a data analytic tool to understand the patterns and emerging themes from varying stakeholder groups, across three Lothian Hospital sites. Following the identification of four key stakeholder groups, individual responses were reviewed and each statement was coded manually in excel by coloured font. The coding was carried out systematically by reviewing one key stakeholder group/and area at a time. The codes for each stakeholder group/and area were then collated and broader level themes were identified. Related to the findings of each stakeholder group, the key themes were translated into an overarching summary and key bullet points. The process allows detailed and complex description of qualitative data.

It is important to note this analysis provides a summary of the themes emerging from the survey responses. It is a reflection of the individual opinions and experiences of those who chose to respond. It is not intended to be presented as fact. However we would encourage NHS Lothian to work with the various stakeholder groups to explore these issues in more detail.

Themes from service users (children and young people, parents and carers)

On St John's Hospital

What was good about the service?

The main themes underlying the service users' feedback on what is good about the service at St John's Hospital includes; the accessible location of paediatric services for children, the fast and efficient service and the excellent communication between the staff with their patients.

Access to care

Location

- Free and easy on-site parking
- The services are local, so it is easy for relatives to visit
- The local service ensures less travel time, a long commute with a distressed child has been noted as a potentially stressful consequence of taking children to Edinburgh
- Parents note that if the hospital was located further afield they are more likely to call out ambulances services

Efficiency in service

- Seen immediately for a quick and efficient service in ED and the ward
- Prompt diagnosis and treatment
- Appointments on time
- Pathway from referring physician to consultant review carried out quickly and efficiently

Quality of care

Facilities

- Excellent care facilities and specialist treatment
- Play resources available to children for a child friendly environment
- Clean areas
- Secure children's ward
- Good food and subsidised meals for parents where required
- Local service means children can go home & come back if required
- Admits young people up to 16 years

Care delivery

- Great continuity of care within children's service and between women's and children's services
- Follow up and next stages of treatment clearly explained and not a production line
- Rapid admissions policy

- Excellent management of children's conditions
- Thorough investigations
- 24 hour access by phone post discharge
- Young people like the visiting hours & accessibility

Staffing

- Excellent staff members; reassuring, professional, caring, friendly, experienced, excellent bedside manner, understanding and compassionate
- APNP excellent – need more of her

Communication

- Parents and children are made to feel calm and reassured
- Parents involved as experts – family friendly
- Parents noted that they felt fully informed and received thorough explanations of their child's care and aftercare
- Care explained to children
- Concerns taken seriously
- Parents made to feel supported and all staff noted to have listened well
- Leaflets available relating to conditions and procedures

What could have been better?

The main themes underlying the service users' feedback on what could be better about the service at St John's Hospital includes; the condition and cleanliness of the facilities, the space and availability of beds for parents, and the inappropriate food options available for children. Some parents report the need for better treatment and understanding of disability and mental illness by healthcare professionals.

Access to care

Parking

- Can be difficult later in the day when the hospital is busy. Not enough parking spaces allocated

Waiting time

- Length of waiting time and the length of time until the next appointment, however many parents were understanding
- Waiting time at the pharmacy for a prescription

Quality of care

Facilities

- More beds for parents of young children staying overnight
- Cleanliness and condition of ward cots/windows
- Limited space for parents beds
- Noisy areas difficult for children to sleep

- Many parents noted a separate children's waiting area for children in ED, away from abusive and drunk adults
- Inappropriate food options for toddlers
Better shops/cafes in the hospital.

Care delivery

- Better understanding of disabilities and mental illness (including autism)
- Better aftercare in maternity ward, which would have benefited from 1:1 time with midwives
- Poor bandaging
- National guidelines not followed
- Better knowledge about breast feeding protocols
- Medication administered at the incorrect time
- Follow up appointment was not quick enough so bone has reset in wrong position
- Limited therapy services provided for children i.e. only at limited times
- Failure to recognise respiratory illness in ED, so sent home

Staffing

- Lack of leadership
- Conflicting advice
- More regular staff than locums, for continuity of care

Communication

- Better communication between ED doctors and parents
- Better communication between the hospital and out of hours GPs
- Bullying of staff and preventing them discussing concerns about the service

On the Royal Hospital for Sick Children

What was good about the service?

The main themes underlying the service users' feedback on what works well about the service at the Royal Hospital for Sick Children includes; a child friendly service with good communication skills between the healthcare staff and patients, parents report staff listen to concerns.

Access to care

- Seen quickly/promptly especially in ED
- Access to allergy expert and nurses for full assessment
- Easy access during weekend/bank holidays when the GP is not available
- Local service
- Travel costs reimbursed for families on income support when they and their children are attending outpatient appointments

Quality of care

Facilities

- Child friendly area with lots of toys and a good children's play area in outpatients
- Separate from adult hospital so is child friendly
- Oncology Ward has facilities for adolescents
- Children with long term conditions will be seen in OPD from 14 years
- Drop in for children 12 years and above available two evenings a week

Care delivery

- Children are carefully monitored and care is individually tailored to suit the child's needs
- Good aftercare
- Plenty of time in consultation
- Planned course of action

Staffing

- Supportive staff, knowledgeable, helpful
- Professional, highly skilled and competent
- Friendly
- Staff put children at ease and are reassuring

Co-ordination

- Well organised
- Received priority of care for a serious case

Communication

- Parents are well informed by staff
- Good patient-staff interaction
- Staff listened to concerns
- Staff treated patients/families with respect
- Consultants answer questions
- ED staff explain things well
- Parent Council at RHSC – advertised in hospital entrance

What could have been better?

The main themes underlying the service users' feedback on what could be better about the service at the Royal Hospital for Sick Children includes; more staffing, better co-ordination between departments and better care when administering medication. Parents have also noted poor food options available for children.

Access to care

Access

- Parking difficulties
- Bad signage to hospital, difficult to find
- Difficult to navigate with prams
- More disabled parking
- Difficult to reach on public transport
- Some parents have received parking fines
- Admits children up to 13 years of age: new children from 14 years are admitted to adult ward
- Travel costs not automatically reimbursed for families on income support when travelling to their children in hospital – they have to apply for a grant. One child told us she had been in hospital alone as her mother did not have money to travel to Edinburgh and had to look after her siblings

Timings

- Long appointment waiting times
- Long waiting times to get an appointment with consultant/specialist
- Very late follow up appointments
- Appointments to be quicker
- Better timelines for referral and procedure

Quality of care

Care delivery

- Received less antibiotics than we needed to be able to fully follow through the prescribed dose
- Forgot to give child anaesthetic before inserting needle
- Following daughters ENT surgery no aftercare provided
- No follow up appointment
- Can feel like a production line
- Poorly developed transition pathways for young people moving to adult services (at 19 years)

Facilities

- Small waiting room, cramped, chaotic, could be bigger, parents report that some children had to sit on the floor, and parents were standing
- More pleasant consultants room
- Ward very noisy for babies to sleep
- Hospital was overcrowded
- Less rigid ward routine
- Better cleanliness and hygiene
- Many young people unable to access the drop in for adolescents
- Lack of privacy

Toilets

- More easily accessible for parents and carers
- More accessible for people with buggies

Meals

- No vegetables or fresh salad mainly unhealthy foods, no healthy foods sold in the vending machines
- Better food for children

Staffing

- One senior member of staff verged on incompetent
- Staff seemed under pressure, more staffing may have eased this
- Slow triage service
- Staff to be more child friendly when dealing with an unwell child
- Felt under resourced
- The receptionist was bored, disinterested and not very helpful
- More staff to respond to alarms
- More epilepsy support nurses

Co-ordination

- Lack of consistency between opinions and advice provided by medics
- Some parents are frustrated with having their child examined multiple times by multiple people
- Parents felt that it would be easier if records could be shared between different areas to avoid being seen by multiple healthcare professionals

Communication

- Unaware if tests showed that things are the same, better or worse
- Rushed appointments
- Not always kept up to date
- Information exchange between consultants and nurses
- Better communication between community and hospital practitioners
- Parents may not be seen as expert about their child – staff can be ‘cold’
- Parent Council difficult to contribute to due to lack of child care, cost of travel and parking

Themes from NHS Lothian Staff

From St John's Hospital Staff

What works well?

The main themes underlying the St John's Hospital staff feedback on what currently works well includes; the quick and efficient care provided to local patients and the availability of a separate paediatric ward staffed with specialist paediatric expertise. There is a good working relationship between departments and most staff report that the location of this 24 hour service easily accessible to the local population.

Access to care

Services

- Reliable access to local paediatric services for ED, out of hours emergency admissions, critical care and obstetrics
- Services (assessment unit, PICU, theatre inpatients and medical admissions) work together to provide children and families of West Lothian with 24 hour care
- Paediatric ward is open 24/7 so parents can visit at any time
- Suggestion that without this current level of cover, there may be a large number of GP and ED referrals transferred by ambulance to the new Sick Children's base at RIE
- The lab service support ensures prompt diagnosis of serious conditions
- St John's provides critical mass of acute services for paediatrics and obstetrics
- Day case surgical procedures are offered locally

Location

- St John's Children's Ward provides fast, efficient service for local children
- A local service that is easily accessible for families
- Suggestion that there would be huge investment in ED support, ambulance journeys, as well as ambulance staff training, if paediatric support was further afield
- There is free parking available at St John's which is not available at RHSC in Edinburgh

Waiting times

- Quick assessment of sick children
- Children are usually seen promptly by senior doctors (often consultants within an hour of arrival) and children with an acute problem are seen quickly (either through an urgent outpatient appointment on the Children's Ward or GP referral to the Assessment Unit)

- The length of stay for most patients is short; children are discharged quickly
- Staff note that children have efficient management plans which leads to quick turnaround of patients which may require admission if sent to RHSC for assessment

Quality of Care

Co-ordination

- Children will usually have one paediatric consultant responsible for their care who can coordinate all their health needs and act as a single point of contact rather than children attending multiple subspecialties
- Good local relationships with GPs, HV, out of hours and local care providers that meaning communication is easier
- Excellent relationships with ED and anaesthetists at St Johns

Staffing

- Dedicated and hard-working team
- The neonatal unit and the out of hours ward is covered by the same staff which is described as a good use of resource
- Good support and cooperation with paediatric consultants when caring for critically ill children
- A mutually supportive, positive working relationship with paediatric colleagues in anaesthetics/ICU
- NHS staff dedication despite serious staff shortages
- The paediatric service currently has excellent middle grade in the form of an APNP and specialty doctor

Patient/clinician relations

- Good long term relationship with babies and their parents, particularly important for babies who have problems from birth

Team working

- Good working relationship between the departments
- Paediatric and critical care staff can manage sick children locally and if they deteriorate and require critical care management staff support each other in managing the patient until the patient can be retrieved
- Staff ensure everyone is happy within the work environment
- Excellent support from the paediatric team
- Great support for junior ED medical staff overnight
- Good communication and support from colleagues

What could work better?

The main themes underlying the St John's Hospital staff feedback on what could work better includes; the understaffing particularly of middle grade health professionals. There is also concern that the current staffing arrangement of relying on locum doctors is not sustainable

Access to care

Waiting times

- Due to that fact that there is only one retrieval team in Scotland, delays can sometimes be several hours before a patient can be retrieved
- Patients and parents wait (up to 2) hours in pharmacy for medicines

Resources

- More beds to be allocated to theatre cases

Uncertainties around closure

- Some staff feel that the uncertainty over the future of the paediatric unit at St John's Hospital should be resolved and to ensure that the children's ward does not close
- Some staff felt that uncertainties of closure made recruiting staff difficult

Quality of care

Co-ordination

- Better engagement from junior doctors/nurse practitioners with patients that are labelled as 'surgical', particularly for basic care issues
- To improve the problems with continuity of care which are brought about by multi-site working

Staffing

- To increase recruitment of senior and middle grade staffing to reduce workload pressures on existing staff
- The service relies on locums, many staff feel this is not sustainable
- More ward staffing on theatre days
- The staff nurses work long hours without breaks

Training

- Improved analgesia admin skills by theatre recovery nursing staff
- St Johns is an excellent placement for paediatric doctors in training
- Requires investment in training more APNPs
- Theatres is not prepared properly, radiology staff are not appropriately trained. It should be at RHSC

Management

- To remove the pressure of meeting targets
- Staff find it difficult to report numbers and bed status to the co-ordinator particularly when they are caring for patients during busy periods

Communication

- The communication/ collaboration between medical and surgical child services could be improved
- Staff feeling able to speak up without consequences for career and reputation

From the Royal Hospital for Sick Children Hospital Staff

What works well?

The main themes underlying the Royal Hospital for Sick Children Hospital staff feedback on what currently works well includes; staff are noted to go the extra mile and are committed to providing high quality care despite the lack of resources. Individualised and specialist care is provided to patients.

Access to care

- Access to multidisciplinary teams with specialist opinions for acute admissions
- Access to HDU/PICU care
- Access to paediatric anaesthesia service for emergency and elective care in and out of hours
- Dedicated surgical day-case unit for all surgical sub specialities
- Consultant led care for inpatients

Quality of care

Almost all respondents to this question made comments about the high quality of care delivered by RHSC staff, including:

- Continuity of care for long term patients
- The individualised patient care
- Quick and efficient acute care
- Good community services and easy referral
- Efficient discharge processes

Staffing

25/38 respondents referenced how supportive the RHSC staff are / how committed they are to providing a good service / how they often go above and beyond to deliver great care / positive team working within the hospital. Many commented that this was despite working within a difficult environment which is often stressful and short staffed due to sickness/leave.

- Committed, caring and dedicated staff, who are noted to go above and beyond to deliver high quality healthcare
- Despite lack of staff and resources staff note a strong sense of team working and support
- A good academic and educational working culture
- Multidisciplinary and collaborative team working
- Seamless and integrated service between the hospital and community
- Onsite clinical management team

What could work better?

The main themes underlying the RHSC staff feedback on what could work better include communication from/between senior management and hospital staff both in terms of day-to-day activities and as part of larger decision-making and implementation of change. This has led to some respondents reporting a lack of transparency and teamwork from NHS Lothian management, which has been interpreted by some as dishonesty. Understaffing is noted as an issue leading to an increased workload, stress and absenteeism. The majority of respondents feel that the service relies on their goodwill which is not appreciated by management.

Access to care

- Transport is an issue at RHSC, the tertiary hospital setting may disadvantage patients that travel from afar
- Better equity of care across the two sites (RHSC and St Johns)
- More paediatric trained staff in emergency department

Quality of care

- There is little integration between the hospital paediatricians and CCH team in West Lothian. Phlebotomy is performed on the paediatric ward and there is now satisfactory access for paediatric cases seen by the CCH team. Historically, this has been a problem

Management/communication

- The majority of RHSC staff (around 2/3rds) noted the need for better communication between managers and staff at all levels
- Senior management is disrespectful to colleagues particularly to female colleagues (this was in one anonymous respondent's lengthy set of comments, but is included here due to the seriousness of the allegation)
- There is no management presence at the Consultant meetings (weekly) or the Paediatric Steering Group meetings (monthly). Presence is variable at the Medical Staff Committee meetings (3 monthly)
- There is lack of consultation with staff before new working practices/ changes are implemented
- Lack of medical leadership to ensure adequate provision of services
- Little understanding of work load and daily tasks of staff
- Poor performance management of underperforming individuals
- Some staff reported workplace bullying (this was a small minority of respondents however was included for the same reasons as above)

Morale

- Staff feel undervalued and believe this leads to absence and a reduction in goodwill to continue to achieve the standards and values it strives for, yet this is not reflected in the manner in which staff are treated by management, either in pay or conditions
- Doctors are not recognised or appropriately remunerated for their work

- Management are noted to not address staff concerns

Resourcing

17/39 respondents mentioned resourcing within RHSC

- Recruit more admin staff, registered/trained paediatric nurses/ registrars
- More staff could result in better morale and make workload more manageable
- Unequal share of resources and investment across specialities and wards within RHSC
- The RHSC staff note that funding has been spent to maintain St Johns Hospital Children's ward with minimal investment in the general paediatric services at RHSC
- Better computer systems required
- Chronic shortage of access to paediatric OPD facilities for CCH medical and nursing staff
- No capacity for the review patients to be seen
- A better alternative (that has been suggested many times) would be to expand the Consultant staff to address patient safety concerns, and meet increasing demand for OP appointments. There are many ideas on how to reduce OP referrals, but need appropriate time to take these forward

Training/education

- Staff suggest better training and support to improve high turn-over and long term sick leave
- Training and education opportunities are available for nursing staff, however due to staffing constraints training cannot be supported
- SPA time is not allocated for clinical supervision and as a result is carried out in clinicians spare time
- Better understanding/training regarding hospital policy and processes

Political

- The St. John's issue has bubbled up repeatedly and is now so toxic it prevents any progressive discussion. Consultants at St. John's are not equally allowed to express their opinions or ability to innovate due to suppression.
- Political will driven by votes means no form of effective service configuration can occur
- More transparent Scottish government policy towards structure of services

Note: We carried out some further analysis on these data given the strong words used in the 'what could be better?' section. There were 76 respondents but only 9 provided their email address (which was optional, but this figure is comparatively very low) so it has not been possible to follow-up to seek further information or clarity on the information possible, nor to seek permission to share answers with NHS Lothian. Respondents were not asked to identify their occupation; from the free-text comments we infer that some are not doctors (e.g. therapists, admin staff), so it's important to bear this in mind when considering the comments above.

Themes from other stakeholders

From East Lothian Residents

What works well?

The main themes underlying the East Lothian Stakeholder feedback on what works well in the hospital services includes; the local access and relatively short waiting times for children to be seen by a healthcare professional. Stakeholders also noted that the staff in ED are responsive and efficient.

Access to care

Waiting times

- Speed of care
- Having a dedicated ED
- Same day assessments for emergencies
- Local to travel

Quality of care

Staffing

- Responsiveness and efficiency of ED staff
- Consultants respond to messages left with their secretaries when more information is required
- Highly valued services by families and professionals

What could be better?

The main themes underlying the East Lothian Stakeholder feedback on what could be better about the hospital services; the co-ordination of care for children with complex needs, better communication between hospital and the community, particularly with CAMHS and social workers

Access to care

- Waiting times for respiratory and allergy services
- Better access to rheumatology advice
- Shorter waiting times for out-patient appointments
- GP appointment booking and availability
- More East Lothian out-patient appointments
- Families have to 'come to the services' which is a challenge for East Lothian residents as the public transport infrastructure connecting East Lothian to Edinburgh and West Lothian is limited
- Parking (at RIE)

Facilities

- Better facilities for parents/carers
- Play facilities/rooms should be open longer and at weekends in the wards.

Quality of care

- Better consistency of provision with the CAMHS service
- Better implementation of agreement of care plans with families and other professionals (including health professionals)

Co-ordination

- A lead clinician would be helpful, particularly for children with complex needs when there are lots of specialities involved
- More investment in the other Hospitals in NHS Lothian rather than centralisation at the RIE site
- Specialist clinics could be better co-ordinated and potentially delivered in locally based medical centres/community hospitals, avoiding the need for EL families to travel distances, increasing appointment uptake rates

Staffing

- More CAHMS staffing
- More health visitors to support children/families in community and reduce hospital referrals
- Staff having a 24/7 children's nursery on site, preferably free, subsidised or commissioned

Communication

- Better communication with community i.e. GP/HV staff
- Better email advice services from different paediatric departments
- Difficult to contact and there seems to be limited discussions/feedback with social work when they are involved

From Edinburgh Residents

What works well?

The main themes underlying the Edinburgh Stakeholder feedback on what works well about the hospital services includes; good access to hospital services through GP referral, or via NHS24. Stakeholders noted dedicated and committed staff, good communication between patients and healthcare professionals in addition to information sharing

Access to care

- Good access which includes GPs referring patients, direct or via NHS24 out of hours
- Quick service in Edinburgh ED

- Some stakeholders felt it may be more efficient bypassing NHS 24 and take their children directly to RHSC
- GP referral to RHSC; ability to attend RHSC with ill child without referral

Location

- Local services within Edinburgh (the Royal) or West Lothian (St. Johns)
- Having a hospital in West Lothian will take a huge amount of burden of RHSC
- RHSC is centrally located and easily accessible with a number of buses going within close proximity of the hospital

Facilities

- The parents unit is vital for parents with terminally ill children to enable them to support their kids through their illness
- Direct access to a nurse specialist by phone
- Children's hub at sick kids

Quality of care

- The RHSC emergency system works well, with a fast and effective admissions procedure
- Brilliant access to specialist care when needed and well supported MDTs
- Good outpatient care
- Follow up outpatient appointments
- Staff at RHSC deliver high standard of care
- Out of Hours Surgery at the Western deliver high standards of care

Co-ordination of care

- Good discharge arrangements
- Triage and response time
- Respectful of primary care
- Nurse triage at ED

Staffing

- Great medical and nursing teams
- Staff are brilliant with the children - caring, patient, attentive, always willing to go the extra mile
- Excellent service providing support to OOH and ED overnight
- Dedicated and committed staff
- Children's ward at St. John's is difficult to staff
- Staff in RHSC are excellent, exceptional and understanding

Communication

- There is excellent communication between the consultants and GPs regarding patient management
- Information sharing

What could be better?

The main themes underlying the Edinburgh Stakeholder feedback on what could be better about the hospital services includes; better communication between departments regarding patients care and appointments, and better information/awareness about services available to patients. Stakeholders also note a shortage of beds during winter/busy periods and better service provision for teenagers (aged 13+ years).

Access to care

- Waiting times
- When calling NHS24 there can be a wait of up to a few hours for a call back
- More paediatric services
- Consistency of provision of services in regional hospitals
- Lack of direct liaison with GPs/primary care
- Currently patients over the age of 13 years are referred to adult ED service in NHS Lothian. Children under 16 should go to children's emergency department, as is the case in other Scottish health boards

Location

- Parking
- Lack of clarity on where to go in the West of Edinburgh with an acute appointment
- Allow accident and emergency clinics for children at local hospitals
- Better located therapy based groups for children with complex needs

Resources

- Acute hospital services being delivered in Edinburgh for Lothians, and retention of specialist services that are currently in Edinburgh

Facilities

- Support system for kids and parents who are unable to stay in with their children during hospital stays due to other childcare restraints
- Often a shortage of beds during winter. Old and outdated building/infrastructure at RHSC
- RHSC, no play facilities
- RHSC out of hour's service doesn't cater well for children
- Neonatal and labour ward beds in Simpson's are in too short supply

Quality of care

- Better ED waiting area for distressed children and their parents
- Consistency of provision of services in regional hospitals

Co-ordination

- Care not always joined up e.g. children with complex needs

- More involvement with pharmacies

Staffing

- More staffing to cope with demand
- Provision of health visitors as they are grossly overstretched
- Addition of paediatric trainees to the department
- The lack of paediatric surgical services at St John's Hospital.

Communication

- Wider provision and more information about services
- Awareness amongst patients and families on the services available
- Accountability in communication and professionals listening to parents, as they are the experts on their child.
- Better empathy skills by doctors
- The information available about our services on web and social media at RHSC
- Better communication between departments

From West Lothian Residents

What works well?

The main themes underlying the West Lothian Stakeholder feedback on what works well about the hospital services includes; specialist services accessible at the RHSC and local services available at St John's Hospital. The service can be easily accessed via GP and the ability to get access to both outpatient and inpatient paediatric services

Access to care

- Local access/ Local children's wards (especially West Lothian)
- Ability to get paediatric appointments in local health centres
- Local Services available at St John's Hospital, specialist services available at RHSC
- Local access to both outpatient and inpatient paediatric services
- Paediatric patients can be admitted via ED at St John's Hospital
- Accessing the service via GP
- Having a second facility in West Lothian rather than a single base in Edinburgh. The size and population of West Lothian needs and justifies a second base in West Lothian
- Fast effective referral from GP to hospital service diagnosed and released with follow up care instructions in a very quick manner
- Children are prioritised in out-of-hours GP and accessing that via NHS24 works pretty well. The Paediatric ward at St John's seems to be well run and the staff keep you very well informed. I'm not sure if it is in scope for this survey but the maternity and neonatal services at St John's are

outstanding. If the service was less good or further away then our third baby would not be with us now

Quality of care

- ED and triage for children
- NHS24 dialling into the ED in advance of your getting your child to hospital
- Professionalism and speed with which severity of condition is diagnosed and treated
- Treatment proficiencies
- A Paediatric 'Centre for Excellence' where everything is in place and adequate training is available to deliver a safe effective service for all conditions and severity of admissions
- Standard of care at RHSC Edinburgh

Staff

- Overall the care provided by Consultant, middle stage doctors ANP and nursing staff is excellent, when the department is fully staffed
- Expertise is maintained locally
- All staff work together
- The team of nursing staff and members of the MDT work well together delivering holistic care
- Qualified staff and services offered are wide ranging
- Having a 24 hour staffed, functional children's ward at St. John's
- ANPs excellent but limited funding to access training for additional posts

Communication

- Excellent liaison with GP's over acutely ill children
- Good community links - staff giving up their time to visit nurseries to talk about the role of a nurse

What could be better?

The main themes underlying the West Lothian Stakeholder feedback on what works could be better about the hospital services includes; uncertainties around the closure of St Johns, more paediatrics integrated into the community and the difficulty around recruiting doctors

Access to care

- Better parking and signage to departments
- St. John's children's ward to be open 24/7
- More specialist treatment available in local Hospitals rather than having to be transferred to Edinburgh
- Waiting times for appointments
- Better parking
- Improved medical and specialised nursing services

- No closure of St John's (main issue)/ Stop all the uncertainty regarding the children's unit at St John's and keep it open and staffed for the sake of children and their families in West Lothian

Paediatric services

- GPs having a paediatrician within the local surgeries and generally paediatrics to be more integrated into community services
- Stop removing/downgrading services from St John's
- Paediatric services to be available 52 weeks of the year

Quality of care

- Support after diagnosis
- More beds for higher dependency patients / urgent care
- Better provision for the 12 to 16 year olds

Staffing

- More specialists
- Less middle management
- More paediatric community nurses
- Difficulty in recruiting doctors
- Better consideration of rotas
- Service is described as fragile due to staffing issues particularly at St John's
- Better training for staff around dealing with children with autism
- Funding the current staffing models is unsustainable
- Lack of Doctors trained in paediatrics

Communication

- Easier access to information
- Better communication across services including transition into adult services and support within local areas

Political

- From the beginning of the high profile debate (2011) senior board members and the deanery were keen to conceal the difficulties from elected representatives until it was too late to manage the situation appropriately in the public domain. The debate should have been had in an open and transparent fashion

Other

- Insurance that the children's services will not be taken away/ the threat of the children's ward being closed or not open all the time is a big worry to parents

From Midlothian Residents

What works well?

The main themes underlying the Midlothian Stakeholder feedback on what works well about the hospital services includes; the caring and dedicated staff that accommodate for children with special needs, the high standard of paediatric care

Access to care

- Great service offered by RHSC
- The RHSC service on the whole is efficient and will get more efficient when it moves into new premises in the autumn of 2017

Quality of care

- Paediatric services are provided at a very high standard
- A world renowned facility is available to East of Scotland children

Staffing

- Caring staff that also accommodate for special needs
- Staff are professional and knowledgeable
- Dedicated expert staff within the RHSC that deliver the acute service
- Support for junior staff in training and minimises risk to this patient group

What could work better?

The main themes underlying the Midlothian Stakeholder feedback on what could be better about the hospital services includes; clarity around the uncertainties of hospital closure, comparable services across hospitals and more speciality clinics in St John's

Access to care

- Less waiting times.
- The facilities are old and there is a long walk from surgical admission to theatre including use of lifts. Obviously the new hospital should help
- Child mental health services
- More general provision for non-urgent but still significant problems with children's health is needed
- Funding and security for the service
- Stop the threats on closing these services
- Consider parking for parents. The drop in centre helps parents who have long time in hospital but parental accommodation is limited. Please consider that a lot of children using the service regularly have special needs so need special accommodation
- There could be more support for children with ASD in hospital
- More speciality clinics at St Johns with support from Sick Kids

- Better provision for overnight so children can be seen acutely at SJH
- Parking at RHSC

Quality of care

- A child centred approach using Art, Drama and Music
- Comparable services across children's health services
- Better condition of buildings

Staffing

- More staff

Communication

- Listening to what people want

Co-ordination

- GP support and skills of practitioners within the community e.g. nurses skilled in taking paediatric bloods rather than patients being sent up to the emergency department etc.

Appendix 1 - Children and Young People's Engagement Team



The **Children and Young People's Engagement Team (CYP Team)** aims to:

- Ensure that children's rights are understood, protected and promoted
- Create opportunities for children and young people (aged 10 – 25) and their families to inform and influence all aspects of College work
- Collaborate with networks of children, young people, families and professionals across the UK to improve child health experiences and services.

The voice of children and young people extends to other areas of College work including education and training of paediatricians, research and policy, business development, health promotions, media, publications and more.

Our work is delivered through three strategic themes; *Inform, Child Rights, Influence*. Strategic voice of children and young people will be supported through partnership work with children, young people, families, health care professionals, formal and informal education providers, social care, local and central government and the voluntary and community sectors.

The strategic voice programme includes;

& Us® - children, young people and families

- Social media platforms, monthly opportunities newsletter
- Consultations through online surveys and the **& Us®** Roadshow
- Supporting strategic voice in governance
- Engagement projects e.g. UK wide Takeover Challenges, young assessors projects, delivering training

Engagement Collaborative - child health / health care engagement leads

- virtual and biannual meeting of child health / health care engagement leads from health, social care, education, voluntary sector and government
- Share good practice through an online QI hub and through a monthly bulletin
- Collaborative consultation responses
- access local champions and experts in engagement

Consultation offer

Stage one – promotion, awareness raising via **& Us®** and the Engagement Collaborative

Stage two – workshops via Engagement Collaborative leads, **& Us®** roadshow

Stage three – bespoke design and delivery of consultation programmes

Contacts

If you would like more information about the CYP Team, consultation offer or potential for joint working, please contact

Emma Sparrow
Engagement Manager

Hana Najsrova
Participation Coordinator

Children & Young People's Engagement Team | Royal College of Paediatrics and Child Health
| 5-11 Theobalds Road | London | WC1X 8SH | Phone: 020 7092 6000 | Fax: 020 7092 6001 |
www.rcpch.ac.uk/and_us | Email: and_us@rcpch.ac.uk

Registered Charity in England and Wales: 1057744 | Registered Charity in Scotland: SCO38299 | PATRON
HRH The Princess Royal



@ RCPCH_and_Us

