

## BOARD MEETING

**DATE:** WEDNESDAY 24 JUNE 2015

**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.*

## AGENDA

### Agenda Item

### Lead Member

Welcome to Members of the Public and the Press

Apologies for Absence

### 1. **Items for Approval**

1.1.	Minutes of the Previous Board Meeting held on 1 April 2015	BH	*
1.2.	Running Action Note	BH	*
1.3.	Performance Management	AMcM	*
1.4.	Healthcare Associated Infection Update	MJ	*
1.5.	Corporate Risk Register	DF	*
1.6.	Human Resources & Organisational Development Strategy: July 2015 - March 2018	AB	*
1.7.	Schedule of Board and Committee Meetings for 2016	BH	*
1.8.	Acute Hospitals Committee - Minutes of 2 February & 7 April 2015	KB	*
1.9.	Audit & Risk Committee - Minutes of 20 April 2015	JMcD	*
1.10.	Finance & Resources Committee - Minutes of 11 March & 13 May 2015	GW	*
1.11.	Healthcare Governance Committee - Minutes of 24 March 2015	MB	*
1.12.	Staff Governance Committee - Minutes of 29 October 2014, 11 February & 29 April 2015	AJ	*
1.13.	Strategic Planning Committee - Minutes of 12 March & 9 April 2015	BH	*
1.14.	East Lothian Community Health Care Partnership - Minutes of 30 October 2014 and 5 March 2015	MA	*
1.15.	East Lothian Shadow Health & Social Care Partnership - Minutes of 26 February 2015	MA	*
1.16.	Edinburgh Community Health Care Partnership - Minutes of 11 February & 15 April 2015	SA	*
1.17.	Midlothian Shadow Health & Social Care Partnership - Minutes of 19 February 2015	PJ	*

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

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1.18.	West Lothian Community Health & Care Partnership Sub-Committee - Minutes of 16 April 2015	FT	*
1.19.	West Lothian Community Health & Care Partnership Board - Minutes of 7 April 2015	FT	*
1.20.	Patients' Private Funds - Annual Accounts 2014/15	SG	*
2.	<b>Items for Discussion</b> (subject to review of the items for approval) (9:35am - 12:00pm)		
2.1.	Annual Accounts for the Year Ended 31 March 2015 <i>(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.)</i>	SG	®
2.2.	Workforce Risk Assessment	DF/MJ	*
2.3.	Acute Services Performance Update	JC	*
2.4.	Quality Report	DF	*
2.5.	Financial Position to May 2015	SG	*
2.6.	Health and Social Care Integration - Integration Joint Boards	AMcM	*
2.7.	Primary Care and Lothian Unscheduled Care Services	AMcM	*
2.8.	Improving Older People's Care in Edinburgh - 2015-2017	AMcM	*
2.9.	Public Social Partnerships - A Vehicle for Delivery	AMcM	*
3.	<b>Next Development Session:</b> Wednesday 15 July 2015 at 9:30 a.m. in the Boardroom, Waverley Gate.		
4.	<b>Next Board Meeting:</b> Wednesday 5 August 2015 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 1 April 2015	BH	®
7.	Matters Arising		
8.	Patient Experience and Feedback (Complaints Review Update)	MJ	p
9.	Annual Review Arrangements	AMcM	*
10.	Any Other Competent Business		

#### Board Meetings in 2015

5 August 2015  
7 October 2015  
2 December 2015

#### Development Sessions in 2015

15 July 2015  
2 September 2015  
4 November 2015

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## LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 1 April 2015, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG

### Present:

**Non-Executive Board Members:** Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mrs K Blair; Dr M Bryce; Councillor D Grant; Professor J Iredale (from 11am); Mr P Johnston; Mrs A Meiklejohn; Mrs A Mitchell; Councillor F Toner; Mr G Walker and Dr R Williams.

**Executive and Corporate Directors:** Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mr J Crombie (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).

**In Attendance:** Dr D Armstrong (for item 7); Ms J Bennett (Associate Director of Quality Improvement and Strategy – for item 7); Mr J Forrest (Joint Director West Lothian Community Health and Care Partnership - for item 11); Dr P Graham (Head of Applied Psychology Adult Mental Health – for item 11); Ms L Irvine (Strategic Programme Manager – for item 11); Mrs R Kelly (Associate Director of Human Resources – for item 13); Mrs L Tait (Associate Director of Strategic Planning – deputising for Professor A McMahon) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Ms M Johnson, Mr A Joyce, Ms J McDowell, Professor A McMahon and Mr G Warner.

### Declaration of Financial and Non-Financial Interest

The Chair reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Mrs Meiklejohn declared a potential interest under agenda item 2.9 'Improving Access to Psychological Therapies' as this was an area covered by her professional portfolio.

#### 1. Welcome and Introduction

1.1 The Chairman welcomed members of the public to the meeting. He also congratulated Mr Crombie on his appointment as Chief Officer: University Hospitals and Support Services Division.

#### 2. Items for Approval

2.1 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.

- 2.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated 'For Approval' papers without further discussion.
- 2.3 Minutes of the Board meeting held on 4 February 2015 – Approved.
- 2.4 Minutes of the Special Board meeting held on 4 March 2015 – Approved.
- 2.5 Running Action Note – Approved.
- 2.6 Performance Management – The Board received an update on the existing performance against current 2014/15 HEAT targets and other relevant standards.
- 2.7 Royal Bank of Scotland Bulk Cash Service – The Board approved the resolution for the Royal Bank of Scotland to provide a 'bulk cash and / or consolidated cash' service. The Board also agreed that the head of financial control and one other bank signatory, as detailed in the Boards Scheme of Delegation, have authority to sign the application for the provision of 'bulk cash and / or consolidated cash' service. It was agreed that the Chairman sign the 'resolution of Lothian Health Board' on the Board's behalf.
- 2.8 Strategic Planning Committee Revised Remit and Membership – The Board agreed the revised terms of reference of the Strategic Planning Committee, including changed membership to reflect changes to responsibilities and structures. It was recognised that the terms of reference of the committee would be subject to further review and confirmation once the Integration Joint Boards (IJBs) were formally in existence. The Board agreed that future meetings of the committee in 2015 would take place bio-monthly in April, June, August, October and December.
- 2.9 Corporate Risk Register – The Board approved the recommendation set out in table 1, which had been agreed by the Audit and Risk Committee. The Board also approved the recommendations for removal of risks from NHS Lothian's corporate risk register as set out in table 2 which were supported by the Audit and Risk Committee, with the exception of medical workforce sustainability which was recommended to remain on the corporate risk register. The amended corporate risk register at table 3 was approved. The Board noted that NHS Lothian was outwith its risk appetite on corporate objectives where low risk appetite had been set. Other papers on the Board agenda set out actions to improve results eg HAI and unscheduled care.
- 2.10 Healthcare Associated Infection Update – The Board acknowledged receipt of the new format for Healthcare Associated Infection reporting template for February 2015 (appendix 1); acknowledged receipt of the Healthcare Associated Infection reporting template for March 2015 (appendix 2); noted NHS Lothian's staphylococcus aureus bacteraemia March 2015 target was a rate of 0.24 per 1000 beds ( $\leq$  184 incidences). The current rate was 0.34 (254 incidences) meaning that the target had been breached. The Board supported the antimicrobial team activities in relation to the antimicrobial prescribing review and the reduction of antimicrobials associated with clostridium difficile. The Board acknowledged and supported ongoing actions to address gaps identified within the response to the Vale of Leven inquiry recommendations.

- 2.11 Unscheduled Care – The Board noted the unscheduled care performance and the effect of winter on overall performance and further noted the additional resource dedicated to supporting effective service delivery during winter 2014/15. The Board further noted the range of strategic measures being proposed to maintain and improve performance while operating within financially sustainable levels.
- 2.12 Edinburgh Partnership Community Plan 2015/18 – The Board acknowledged the extensive work of partners in developing the community plan and welcomed the associated strategic priorities which resonated with NHS Lothian’s corporate objectives. The Board noted the submission for approval to the Edinburgh Partnership Board with subsequent approval then being sought from the Scottish Government.
- 2.13 Committee Chairs and Memberships - The Board agreed to appoint Mr George Walker as Chair of the Edinburgh Shadow Integration Joint Board.
- 2.14 Audit and Risk Committee – Minutes of 19 February 2015 – Adopted. The Director of Public Health and Health Policy commented that whilst she was the lead Director with ownership and oversight for the risk around information governance that this would be an issue in all operational units who would need to manage the risk appropriately.
- 2.15 Healthcare Governance Committee – Minutes of 21 January 2015 – Adopted.
- 2.16 Finance and Resources Committee – Minutes of 21 January 2015 – Adopted.
- 2.17 Strategic Planning Committee – Minutes of 15 January and 12 February 2015 – Adopted.
- 2.18 East Lothian Health and Social Care Partnership Shadow Board – Minutes of 22 January 2015 – Adopted.
- 2.19 Edinburgh Community Health Partnership Sub-committee – Minutes of 13 November 2014 – Adopted.
- 2.20 Midlothian Health Community Health Partnership Sub-committee – Minutes of 15 January 2015 – Adopted.
- 2.21 West Lothian Community Health and Care Partnership Board – Minutes of 3 February 2015 – Adopted.
- 2.22 West Lothian Community Health and Care Partnership Sub-committee – Minutes of 12 February 2015 – Adopted.

### **Items for Discussion**

## **3. Waiting Times Performance, Progress and Elective Capacity Investment**

- 3.1 The Board noted that at the end of February 694 patients had waited more than 12 weeks and remained on the waiting list with 564 treated in month beyond the guarantee. It had been agreed with the Scottish Government to move to an end of

March position of no more than 489 patients with the final position likely to be around 440 subject to further validation.

- 3.2 It was reported that from April and beyond there would be a need to recalibrate the recovery plan and further meetings would be held with the Scottish Government to optimise support and sustain delivery. The paper for the next Board meeting would discuss resource and capacity increases.
- 3.3 The number of outpatients waiting over 12 weeks was 3621 at the end of February. The position was being tracked on a specialty by specialty basis. In the last few months of the calendar year work had been undertaken to calibrate spend, vacancies and sickness absence rates. Within ENT there had been a focus on return appointments which had been successful in reducing numbers. The outpatient target for the end of March was 2500 patients on the waiting list.
- 3.4 The Board were advised that the local delivery plan guidance for 2015/16 recalibrated targets for outpatients to 95% to be treated within 12 weeks. If Lothian delivered to a level of 2500 on an ongoing basis then this would achieve that requirement.
- 3.5 It was reported that the 18 week performance from referral to treatment for February remained stable at 85.6%. Both 31 and 62 day performance against cancer was above 95% across the final quarter of 2014 as a whole. It was noted that diagnosis to treatment in respect of 62 weeks required ongoing development. The position in respect of diagnostic endoscopy was improving particularly with respect to surveillance components with 2 consultant vacancies having been appointed to. In addition 2 new nurse endoscopists had been appointed with a further 2 under going training with a qualification date of June 2015. It was anticipated that this revised delivery model would result in significant improvement in numbers and performance over the summer.
- 3.6 The Board noted that audiology performance was stable and would be at zero in the next few months. The IVF performance position was also stable.
- 3.7 It was noted in relation to performance around the referral to treatment guarantee that Lothian's position was around the Scottish average of 2600. It was confirmed that best practice from other areas was being adopted with particular reference around inpatient TTG (Treatment Time Guarantee) and reducing the outpatient position in order to improve RTT (Referral to Treatment Time) performance. It was agreed that this type of background information would be included in future Board papers.
- 3.8 The point was made in order to provide Board members with assurance that it would be important to link other papers and areas into the Acute Hospitals Committee to demonstrate where the system was not meeting targets that plans were in place to address this position. It was suggested that this position was some way from being achieved.
- 3.9 In terms of the Child and Adolescent Mental Health Services (CAMHS) trajectory the indication was that the target would be met. The question was raised about whether sufficient steps had been taken to avoid the position slipping back. The Board were advised work was underway looking at how demand and capacity was being managed. It was noted that later in the meeting the Board would be considering a paper on improving access to psychological therapies. It was noted in respect of

CAMHS (Child and Adolescent Mental Health Services) that the key issue was around the number of children waiting more than 18 weeks and the level of activity at the front door although these numbers were beginning to reduce. Currently the mean waiting time was 9 weeks with the ability to flex capacity to address those patients with the most significant needs. There would also be a requirement to work with primary care to manage demand moving forward as well as other providers for less intensive work.

- 3.10 The Vice Chair commented that she would welcome a more detailed look at this area given the national interest in young people and mental health. The Board noted that the next Board seminar would focus on children's services and would include a briefing on CAMHS.
- 3.11 The Chair of the Finance and Resources Committee commented that the committee had requested a capacity analysis and it would be useful in future Board papers to hear about the impact of investment. It was noted that work was underway to produce a report calibrating capacity to investment. It was noted that in terms of recruitment that this position was now more positive and would allow potential reduction in the use of external capacity as well as embedding new appointments into core capacity.
- 3.12 The Board received the update on performance and progress on inpatient, outpatient and other waiting times. It was agreed that future reports should include additional explanatory narrative as well as details of resource and capacity increases as well as the outcome from investments.

#### **4. Quality Report**

- 4.1 It was noted that the quality report was a distillation of reports from various sources and that respective Executive Directors would be able to provide further detail. The update reports on healthcare associated infection and unscheduled care had been included as part of the consent agenda. A detailed report on Person Centred Culture – Feedback and Complaints would be discussed later in the meeting.
- 4.2 The Board noted in respect of the 17 February 2015 HSMR (Hospital Standardised Mortality Ratios) that none of the 3 acute hospitals were statistical outliers and had demonstrated reductions from the October – December 2007 baseline.
- 4.3 The sickness absence rate had increased in recent months possibly as a consequence of seasonal variances. This issue would be covered as part of the staff survey presentation to be made later in the meeting.
- 4.4 The number of inpatient falls with harm had reduced although this picture had not been replicated in the pressure ulcer performance and this had been discussed at the March meeting of the Healthcare Governance Committee as this was felt to be a good marker of patient care. Concern was expressed that pressure ulcer performance had not improved and it was important not to lose sight of this. The suggestion was made that the revised reporting mechanism was taking some time to evidence performance improvement.
- 4.5 The Chair of the Healthcare Governance Committee stressed there was no complacency around pressure ulcers and that the committee recognised these caused concern and distress to patients and their families. It was important to

recognise that this was a national and international issue and that through the Healthcare Governance Committee a wider look was being taken around practice elsewhere as continuing with current practice would not provide the solution. This further work would be reported through the Healthcare Governance Committee.

- 4.6 In respect of complaints it was suggested that until the nature of the issues were broken down it was not possible to have assurance on performance from a governance perspective. A detailed report had been submitted on the issue to the Healthcare Governance Committee and would be brought forward to a future meeting of the Board. It was acknowledged that the data contained in the current Board paper could have been more up to date. A detailed report on feedback and complaints would be considered later on the agenda.
- 4.7 The Board were advised that the Health Improvement Scotland (HIS) Care of Older People in Acute Hospitals Programme and the Board's own self assessment would be important in identifying the care provided to older patients including the avoidance of pressure ulcers. It was noted that the HIS approach to the inspection methodology had changed and was now partly based on self assessment followed up by site visits.
- 4.8 A Board wide stroke service review would provide clarity about the need for 1 model of service and would include a swallow assessment as well as details of how to resource the preferred model of care. There was optimism that the review would impact positively on performance.
- 4.9 The Board received the review of the quality dashboard and exception reporting to inform assurance requirements.

## **5. Financial Position to February 2015**

- 5.1 The Board noted that work continued to close down the 2014/15 financial position. The final report was due within the next 10 days. It had been disappointing that there had been a significant adverse movement in the month for prescribing following the release of the December data. Consideration would require to be given to this potential impact once the local and national position was better understood.
- 5.2 The February results represented a challenging position with an operational overspend of £30m broken down between LRP (Local Reinvestment Plan) and the financial baseline. There was a need to recognise that the carry forward of LRP and the overspend would need to be managed moving forward. In addition the extra £4m made available to waiting lists in the current year would not be available in the following financial year.
- 5.3 The Director of Finance advised the Board that the financial position for the year remained one of breakeven with further non recurrent resources being required to achieve this. This would make the 2015/16 financial position even more challenging.
- 5.4 The point was made that this was a positive position given the challenges the Board had faced in the current year and this was a tribute to all those involved. The shortfall in LRP delivery remained concerning as was the reliance on non recurrent resources. It was felt there was therefore a need to test how solid the assumptions were within the forward financial plan. The Board noted that there were no concerns



about capital spend performance. The Director of Finance commented that LRP was one of the major risks for 2015/16 and the position had not yet been resolved.

- 5.5 The Chairman echoed the positive performance in obtaining financial breakeven albeit by using non recurrent resources. The reasons behind the prescribing position were discussed in detail with it being noted this also featured on the Community Health Partnership agenda. The point was made that whilst all local prescribing was undertaken using the local formulary when a drug became unavailable the alternatives were almost always more expensive and this had a major impact on prescribing budgets. It was suggested that a piece of national work was needed around the short supply of some drugs and how to finance this position.
- 5.6 The Board noted the recommendations in the circulated paper.

## **6. Financial Plan 2015/16 – 2019/2020**

- 6.1 The Director of Finance commented that Board members would be aware of the challenges faced in reaching a position where a financial plan could be presented to the Board for 2015/16 in support of the local delivery plan. The paper before the Board also set out an indicative plan for 2016/17 to 2019/20.
- 6.2 It was explained there was an important nuance in presenting the plan to the Board compared to previous years where a balanced financial plan had been presented. This year the financial plan set out how financial balance could be achieved in year, and as referred to in reporting the financial position the plan did not have the benefit of flexibility carried into the year from 2014/15 and for that reason carried with it significant risks.
- 6.3 The Board noted that the financial plan had been considered at various stages by the Finance and Resources Committee and it was therefore not proposed to go through the detail of the plan which was attached to the Board paper.
- 6.4 The Director of Finance commented she would wish to make the following key points before turning to the risks. It was noted most importantly that the plan was only balanced non recurrently with a recurring shortfall of £14m offset by £14m off non recurring monies to bridge the gap. The Board were advised there were 2 potential sources of funds to address non recurring gaps. The first source was delivery of the full 3% efficiency target plus the carry forward from 2014/15 although the plan was predicated, or indeed required £30m of cash efficiency to be delivered in year resulting in an overall target of £48m. The second source was NRAC (National Resource Allocation Committee) where a recent re-run of the formula had indicated that NHS Lothian was once again moving away from parity as its population grew and aged. For this reason NRAC benefit of £11m had been assumed in 2016/17. The best outcome was that the system delivered the full target of LRP and utilised NRAC to support other service pressures.
- 6.5 The Board noted that a parallel process had been put in play as the financial plan had developed and that the intention of this had been to ensure the impact of the financial plan was clear at business unit level.
- 6.6 The Board were advised that in terms of the risks associated with the plan that these could be grouped into the following 3 themes – income; LRP and expenditure and capacity and potential constraints of capacity.

- 6.7 In signing off the LDP there was an implicit assumption that income assumptions were agreed although the Director of Finance felt there were still risks. The Board noted that the way in which the PPRS (Pharmaceutical Pricing Regulatory Scheme) benefit was going to be distributed was still not entirely clear because of the desire to prioritise this funding against orphan, ultra orphan, end of life and IPTRs (Individual Patient Treatment Requests) while still being concerned to ensure final funding flows matched where the expenditure fell.
- 6.8 The Board noted that waiting times funding was made up from 2 separate components. The first was £3m from Barnett Consequentials with the other £2m being made from Scottish Government existing budgets. It was noted that the latter was dependant on performance although funding would have to be spent in order to deliver that performance.
- 6.9 The Board were advised in respect of LRP and expenditure that there were 2 components to this. The Board were reminded of the difficulties faced in the current year in delivering LRP. In the year moving forward it was noted that there had been a very good response in terms of schemes identified and that this process had happened earlier than in previous years. The Finance Core Steering Group was providing focus and although there was around £32m of schemes on the table the majority of these would require significant management input to deliver. It had been agreed that the Finance and Performance Review Committee would partake a specific focus on efficiency and productivity in the year moving forward. There was also an expectation from the Scottish Government that more detail would be provided in future reporting mechanisms.
- 6.10 The Board noted that the Finance and Resources Committee had requested further work be undertaken around a number of issues. It was noted work was in progress and that the financial plan was the starting point to develop this further. The Board were advised there was a need to find ways of improving the risk profile through a robust process of performance management review with individual directors. If it became evident that the financial was not delivering then there would be a need to take quick action. This meant if LRP or other anticipated income streams were not available there would be a need to have discussion about what was not deliverable and the subsequent impact on targets. This discussion would need to take place through the Board committees and the Board itself.
- 6.11 The Chair commented that the Board had been fully kept up to date on the challenges around developing the financial plan and had received appropriate assurances. The financial plan had been through a robust process including discussion at a Board Development Session in order that Board members could understand the risks around what was achievable. The Chairman suggested the issue for the Board was whether they accepted the need to produce a balanced plan and more dynamically manage this in terms of the actuality of the risks.
- 6.12 A request was made for more assurance around alignment between the financial plan and the workforce plan particularly as so much was dependant on service redesign and people working differently. Issues around bed management and bed reduction also needed to be clarified particularly at a point in time when the City of Edinburgh Council was reducing its budget as this potentially impacted on Gylemuir and areas of the acute sector which were dependant on bed management.

- 6.13 The Board were advised that the workforce and financial plan were closely aligned. It was noted that 70% of costs were based on payroll and it would therefore not be possible to have a balanced financial plan without a balanced workforce plan. It was recalled that the intention was to achieve a significant reduction of 840wte posts over the coming financial year with a detailed workforce report requiring to be submitted to the Scottish Government by the end of June.
- 6.14 It was noted in terms of workforce planning that in addition to post reductions that issues around skill mix were being addressed through a recently established working group based on the principles of partnership. The final workforce report would be referred to the Lothian Partnership Forum as both the Chief Executive and the Employee Director require to sign it off prior to it being submitted to the Scottish Government.
- 6.15 The Chief Executive commented that issues around beds were difficult. The Board noted beds were currently open for winter demand purposes and in an ideal world these would close in spring with this being one of the reasons why they were funded non recurrently. He reminded the Board that the strategic plan referenced policy choices needed in respect of investing money in the correct place and supporting people as close to home as possible. The Chief Executive felt there was a need for a brave new approach to be adopted in future whilst recognising there would still be a need to have targeted investment in acute beds to address demographic issues and increases in demand for services predominantly utilised by older patients.
- 6.16 The Board noted that that the second major type of bed was those relating to delayed discharges with most of these being located at the Royal Victoria Hospital. These beds were also non recurrently funded. As part of LRP proposals the intention was to run down and close these beds although this would now be more challenging in respect of the City of Edinburgh Council's budgetary position. Any recurrent resource would be used to fund community investment. The Chief Executive reported that the gap in the City of Edinburgh Council was striking and the Leadership Group was looking at different scenarios associated with this in terms of social care capacity and the danger that delayed discharge performance might worsen because of the lack of appropriate capacity. The Chief Executive reminded the Board that as accountable officer he had a responsibility to ensure that financial resources were properly utilised.
- 6.17 The Board noted that the least worst decision would be to spend money that was not available in the correct place which would be community capacity rather than inpatient beds. The Chief Executive commented this was the brave decision he had referred to earlier which was made more difficult to achieve because of the issues around the social care budget particularly in Edinburgh.
- 6.18 The Director of Finance in response to a request for more information around the efficiency plans advised that a host of these would go back to the Finance and Resources Committee for detailed discussion.
- 6.19 A further request was made that specific proposals should come to the Board for discussion. The Chair assured the Board that there was no question of anything not coming forward if it represented a significant change. The key issue would be how this information came forward to the Board with a possibility of it being through the Board committee papers.

- 6.20 The Chairman of the Finance and Resources Committee advised as previously reported that the focus of the committee would change with Directors being invited to attend meetings to discuss in detail their proposals for LRP. Board members would be welcome to attend these sessions as they already had open access to attending meetings of the Finance and Resources Committee. The point was made that there was no option other than to present anything other than a balanced budget as this was a legal requirement. The Director of Finance had shown how to achieve a balanced budget but with risks which if performance managed should be achievable. The alternative solution would have been a need for a prioritisation of what could be delivered and if necessary if problems were identified in respect of the financial plan delivery then this debate would still need to be held. The Chair of the Finance and Resources Committee commended the work to move to the current position. He advised he was happy for the detail of proposals to be brought to the Board if this was felt to be appropriate. The importance of appropriate links with the Strategic Planning Committee were stressed.
- 6.21 Councillor Toner advised he would welcome the opportunity to discuss resources more widely as he was seeking assurance there would be sufficient resource to deliver services in all geographical areas and made specific reference to the position in East Lothian. It was noted at this point it was difficult to give such an assurance giving the increases in demand being experienced and the reduction in resources and this would represent a challenge for the individual partnerships. It was reported that the financial plan wherever possible attempted to match increases in uplifts made by the local authorities. It was noted however that a process of due diligence was needed and this would form part of the strategic plan work moving forward. It was noted until this due diligence had been undertaken it would be difficult to provide the assurances sought.
- 6.22 The point was raised that what was before the Board was a financial plan and not quantified budgets. It was noted that Integration Joint Boards (IJBs) needed to be fully involved in the process moving forward and there was a need to consider how the Board's governance committees reflected this requirement. Opportunities should be considered to pump prime initiatives especially around preventative work where the benefits could be shared across the system. It was noted that the current year represented a unique position given the stage of development of the IJBs. The expectation was once parameters had been agreed that further work would be undertaken around LRP and that IJBs could make their own decisions. It was noted whilst the Board was responsible for allocations to the new partnerships that good governance dictated that this should be undertaken in an open and transparent way that reflected that some local authority budgets were increasing whilst others were decreasing. It would be important to be able to state what had been transferred to IJBs from health services and if the IJB did not feel it was sufficiently funded then this would be the starting point for further discussions. The breakdown of budget to business units and the 3 sources of NHS income were discussed in detail. It was recognised that the process of due diligence would lead to a further level of detail and that local authorities would also need to demonstrate a process of openness and transparency. The Director of Finance would be discussing further the process detail with the 4 Integration Joint Boards.
- 6.23 The Chair commented that over the previous 6-9 months that significant progress had been made and he welcomed the input of the Finance and Resources Committee in reaching the current position. The key issue was now to manage the risk and resources in a more dynamic way than had been the case in the past.

6.24 The Board approved the 2015/16 financial plan, recognising the inherent risks and noted the indicative financial plan for 2016/17 – 2019/20.

## **7. Person Centred Culture Feedback and Complaints Report**

7.1 The Chairman welcomed Ms Bennett and Dr Armstrong to the meeting and advised that they were attending to provide support to the Person Centred Culture and Feedback and Complaints components of the paper.

7.2 The Board noted in the past there had been significant concerns expressed about the performance of the complaints function. In partial response to this Dr Armstrong along with a colleague had been commissioned to deliver a series of 'power of apology' workshops attended by all senior members of staff. Following on from this successful exercise she had been commissioned to undertake a report reviewing the complaints process and proposing a complaints management model for NHS Lothian. The Scottish Public Services Ombudsman (SPSO) principles had been adopted as a starting point from which to move forward.

7.3 The Board noted that the Armstrong report was honest in identifying problem areas and proposed solutions and recommendations. As part of the process for finalising the report there had been a number of well attended consultation sessions which had included enthusiastic input from a number of Non Executive Board members.

7.4 It was reported if the Board approved the report and the direction of travel proposed then a detailed action plan would be produced and used to project manage the process moving forward. It was agreed that responsibility for the complaints function should be transferred to the Director of Nursing and AHP's as it dovetailed appropriately with her other responsibilities.

7.5 The report and its direction of travel was welcomed as was the intention to move to early resolution of the issues identified. It was noted from the consultation process there had been significant interest in people volunteering to be complaints champions. The main theme from the workshop sessions had been that staff had welcomed the empowerment opportunities which would need to be taken forward on an organisational culture framework basis. It was reported that the action plan was being worked on and would be shared with Board members on a virtual basis prior to being submitted to the Healthcare Governance Committee.

7.6 The Board noted that the report was interesting particularly in respect of comments about the care and treatment of patients and how their families were involved in a positive manner. There had been significant comments about food with the view being expressed by a number of Board members that NHS Lothian should have a commitment to provide quality and healthy food as this supported patients in their recovery. The Vice Chair advised this was an issue that had been raised in other forums and it was hoped that the new catering strategy which was currently out to consultation would address this position. The Director of Human Resources and Organisational Development advised that the action plan for patient feedback and complaints would be included as part of the current years local delivery plan.

7.7 Mr Walker advised he was uncomfortable about the report as he felt it had been pitched at a highlevel and he would have expected more actions. He noted from the report it appeared that the implementation plan should already have been produced. It was his opinion that the unavailability of the plan was unacceptable given the

Board had been raising concerns about performance in this area for around 2 years. He was concerned that progress in addressing the recommendations in the report were already behind schedule and he sought assurances given this position that regular update reports would be provided to the Board.

- 7.8 The Board noted that the Healthcare Governance Committee had been involved in the preparation of the report and whilst the Chair of the committee shared the anxieties about timelines she felt that the issue was about more than just fixing a system and represented wide ranging organisational change. It the strength of the Person Centred Culture was embedded it was felt this would sustain the change needed in the longer term. The point about needing to adhere to deadlines was however accepted.
- 7.9 Mr Walker commented notwithstanding all that had been said that the paper before the Board was not accurate and he was not prepared to support it on that basis.
- 7.10 The Chief Executive thanked Dr Armstrong for her report. He advised that he had met with the Scottish Public Services Ombudsman who was taking an interest in NHS Lothian's complaints performance. The Chief Executive acknowledged there was a need to up the ante around timescales and advised that Mr Crombie's recent appointment would release the Director of Nursing and AHPs to concentrate on issues around healthcare associated infection and the patient experience culture programme. He agreed with the suggestion that the action plan should be approved virtually and brought back to the next Board meeting. It was suggested in terms of the inaccuracy in the paper that he felt something had been lost in translation causing this anomaly.
- 7.11 The Board noted in terms of the remainder of the paper dealing with the Person Centred Culture approach that a systematic approach had been adopted to collecting input at the frontline. The Person Centred Collaborative in primary care would be integrated into the 'house of care' model run by public health.
- 7.12 The Board agreed the recommendations contained in the circulated report and that in particular corporate responsibility for feedback and complaints transfer from the Director of Human Resources and Organisational Development to the Nurse Director with effect from 1 May 2015. The Board also agreed to receive the implementation action plan at its next meeting.

## **8. Local Delivery Plan 2015/16**

- 8.1 The Board noted that the local delivery plan (LDP) 2015/16 represented NHS Lothian's contract with the Scottish Government. The IJB's strategic plans would dovetail with the LDP particularly in respect of the 6 improvement priorities set out in the LDP guidance. The Board noted that the LDP was aligned to the strategic plan.
- 8.2 It was pointed out that the issue of risk was important particularly in respect of finance with this position being summarised in appendix 5 of the LDP. It was noted that the LDP had been submitted to the Scottish Government on 20 March in draft form and had reflected previous feedback received from them.
- 8.3 The Boards attention was drawn in particular to the identification of primary care priorities which had emerged following the January Board Development Session which had included input from the GP Sub-committee. A key priority moving forward

was the care of frail elderly people and it would be an organisational priority to start to address this issue. Attention was drawn to the development of a headroom practice initiative which developed the Person Centred Approach. There was also a need to pickup and address priorities around the delayed discharge position.

- 8.4 The Chairman commented that the LDP represented an amalgamation of a lot of other issues that had been discussed either at Board committee level or at the Board itself and should therefore not come as a surprise to any member of the Board.
- 8.5 The Vice Chair commented that it would be important that the LDP was not just a document for submission to the Scottish Government and that it should be possible to corral and look at specific issues on a colour coded basis in order to demonstrate downstream progress. The Associate Director of Strategic Planning undertook to annotate the LDP on this basis and would discuss issues around this with the Vice Chair outwith the meeting.
- 8.6 The emphasis on primary care was welcomed as a priority for the Board. It was anticipated that the Strategic Planning Committee would reference this commitment in its ongoing discussions when approving strategies and plans.
- 8.7 The Chief Executive commented that a lot of the existing work undertaken by the Strategic Planning Committee would in future be undertaken by IJBs particularly in respect of primary care and the use of unscheduled care in hospitals as well as working with the third sector. Discussion had been held at the Strategic Planning Committee about the best way to influence IJBs in this work. The development of an overarching plan for primary care and the detail therein would be led by the IJBs.
- 8.8 The point was made in response that emerging strategic plans represented work in progress and that Community Planning Partnerships needed more detailed debate through the community planning process in respect of how devolved services would be delivered in conjunction with the NHS Board and the IJBs. It was suggested that the logical point for this debate would be at the launch of the IJBs.
- 8.9 The Board approved the Local Delivery Plan 2015/16 for submission to the Scottish Government on or around 2 April 2015. The Board also noted the LDP would continue to be the contract between the Scottish Government and NHS Lothian. Separate guidance had been produced for Integration Joint Boards to support the development of their strategic commissioning plans which would need to be aligned to the LDP.

## **9. Corporate Objectives 2014/15**

- 9.1 The Board received an update on the delivery of the 2014/15 corporate objectives noting that the final report would be submitted to the next Board meeting. It was noted that amber status had been removed because it had been felt to be subjective in nature.
- 9.2 The point was made that green status had been recorded for improving staff and patient safety with this position being questioned given performance around pressure ulcers and hospital associated infections. It was agreed that this issue would be discussed further at the Healthcare Governance Committee.

- 9.3 The point was made that the report contained a significant number of red performance areas and in the final report it would be important to detail the actions being taken against each of these red areas to mitigate the position. It was agreed for future reports any red areas required an action statement.
- 9.4 The Board noted the recommendations contained in the circulated paper and agreed to receive a final report at its June meeting.

## **10. Corporate Objectives 2015/16**

- 10.1 The Board noted that the 4 corporate objectives were focussed on the Triple Aim and an additional change enabling objective. The actions aligned with the 6 improvement priorities identified by NHS Scotland within the Local Delivery Plan 2015/16. It was noted that metrics, risks and dependencies had been identified for each action.
- 10.2 The Board noted that detailed oversight of progress with the objectives and actions had been aligned to appropriate governance committees including the accountabilities of the Integration Joint Boards. Progress updates would be reported on a quarterly basis to the Board. The Board noted that the corporate objectives had looked at the highlevel risks and dependencies that related to the delivery of the objectives. It was noted that a key matrix was the link back to the standards detailed in the LDP.
- 10.3 The Chairman welcomed this report commenting that responsibility and accountability would be exercised through appropriate governance committees. It was important that the corporate objectives were a monitoring tool rather than a management instrument and he was confident that review of the objectives could be undertaken through the appropriate governance committees.
- 10.4 It was noted however that if responsibility for monitoring the objectives was being delegated to committees then it would be important that a standardised template process was adopted in order to ensure consistency in reporting issues to the Board.
- 10.5 The Board agreed the corporate objectives for 2015/16 and agreed that the detailed oversight of progress would take place at the appropriate governance committees with an update report being provided to the Board on a quarterly basis.

## **11. Improving Access to Psychological Therapies**

- 11.1 The Chairman welcomed Mr Forrest, Dr Graham and Ms Irvine to the meeting.
- 11.2 The Board received an update report on the current psychological therapy performance and the steps being taken to improve access to services. It was noted non recurring financial support available in 2014/15 would not be available in 2015/16. The key challenge was therefore to prioritise future service provision.
- 11.3 A review of the service had identified a number of challenges key amongst which had been the need for consistent service provision across Lothian. Work to date had included the creation of a cohesive service model on an evidenced base and the delivery of services to appropriate standards. Performance had been compounded



by issues around the implementation of TRAK and patient information services at the same time as significant service redesign was being considered.

- 11.4 An update report was provided of a number of changes made to improve service delivery including a pan Lothian review of the service delivery model; work with IJB partnerships to determine ownership and local nuances; rollout of information systems to provide better data; work around the level of productivity that could be expected from the resources; team prioritisation of cases; maximisation of group sessions to maximise capacity; adopting a purist approach to definitions.
- 11.5 The Board noted that based on the above information data had been gathered on what was needed to develop the appropriate levels of capacity. This would require significant investment that was currently not available on a recurrent basis.
- 11.6 The point was made that despite this extensive work it was not reflected in performance outcomes within the service as the number of people requiring to be seen was increasing. There was now however a clear understanding of pressures as the result of improvements made in data gathering.
- 11.7 Positive feedback was received from a visit made by a Board member to clinical psychology services to learn about governance links. It was reported that the visit had been inspiring and that although work pressures were evident so was empowered leadership that could be used elsewhere. Dr Graham welcomed the feedback and would take forward the useful comments.
- 11.8 The importance of utilising technology like i-APPs to provide GP nurse support to reduce referrals to the acute sector and give people services faster and nearer to home was stressed. Dr Graham advised negotiations were currently underway about accessing services quicker and stopping barriers including consideration of trauma services. It was noted that some of the i-APPs services were useful in targeting milder issues with session for session outcome measures being positive.
- 11.9 The Vice Chair welcomed the update on access to services advising that feedback from people who used the service through stakeholder group engagement had been positive about the proposals for service models. Clarification was sought on whether the number of people waiting to use the service was more than the number of people currently accessing the service. It was noted that mental health dashboards had been developed and were included in stakeholder reports to the Mental Health Programme Board where focussed discussions about access to psychological services had been discussed over the previous 18 months. The Programme Board also discussed the recently issued funds to NHS Lothian through the recently announced Scottish Government allocation for mental health innovation.
- 11.10 The report was welcomed although it was pointed out that whilst striving to make best use of resources it would be important not to stifle innovation. There was a requirement to reflect on interventions other than purely psychological input.
- 11.11 The Board noted in Lothian a psychological therapies model has been developed and published around chronic unrelenting depression which was continually evidence based. It was noted that there was evidence of statistically significant results around moves from severe to mild depression which had demonstrated the need not to adopt an overly rigid approach.

11.12 The Board noted the recommendations contained in the circulated report and the work in progress to continue to improve access to psychological therapies.

## **12. Impact of Research in NHS Lothian**

12.1 Professor Iredale advised he felt it was timely to bring forward a report to the Board on the impact of research in NHS Lothian. He commented that NHS Lothian was a very research friendly Board. He felt that both the Chair and Chief Executive understood the importance of research. The importance of research in terms of dynamism and culture as well as improving the life of patients should not be underestimated.

12.2 The Board noted that the Research Excellence Framework 2014 to which every UK University Medical School had to make a submission had for the first time mandated the submission of examples of research impacts. Impacts were worked up case studies describing how research undertaken since 1993 had a demonstrable impact on society. In the form of case studies each of these impacts fell into 1 of the following 4 broad areas:

- Improving clinical practice case studies which were primarily about innovation, service redesign, patient outcomes, quality of care, changes to guidelines or clinical practice.
- Boosting the economy. Case studies which had a primary or strong focus on economic growth (eg wealth creation through novel devices or partnerships with industry, cheaper treatment).
- Benefits to society case studies which were focussed on societal issues and / or public understanding of health issues.
- Beyond border. Case studies which were primarily about international and developing world health care.

12.3 The Board noted of the 35 case studies submitted across the medical disciplines by the University of Edinburgh that the paper had selected those for which NHS Lothian employees or honorary contract holders led or played a major role in developing. These studies provided a detailed snapshot of the extraordinary range of impacts from research activities which take place in laboratories and hospitals. To provide an overview in the period 2008 – 2014 from the £1.99m of grant income which underpinned those studies with a measurable health economic impact annual cost savings for the NHS in the UK were generated of £294m representing an annual return on public funding of a minimum of £147 for every £1 of grant income awarded. The University of Edinburgh impacts demonstrated reach to in excess of 100 countries worldwide in all continents of the world and affected millions of individuals. These examples demonstrated how the University of Edinburgh and NHS Lothian staff had influenced and defined practice for those delivering patient care, health care delivery organisations and national governments and global bodies – including the World Health Organisation (WHO).

12.4 The Board noted that the studies by the University of Edinburgh and NHS Lothian into diverse medical problems such as the use of blood during transfusions and work on the causes and problems associated with childhood obesity had been credited with saving lives in more than 100 countries worldwide. Results had also helped to improve healthcare for millions of people in the UK whilst cutting down on the amount of NHS care they required.

- 12.5 The Board noted that researchers had helped to cut heart attack rates with a user friendly scoring system that helped doctors identify patients at the highest risk so that they could deliver appropriate care. Another study had safely reduced the use of blood transfusions during surgery saving precious blood donations and around £100m each year. Edinburgh stroke research had improved both diagnosis and treatment of the condition saving thousands of lives and helping thousands more to avoid disability.
- 12.6 Professor Iredale commented that these studies encapsulated the extraordinary strength of medical research that took place in Edinburgh where University and NHS researchers worked hand in glove to deliver real benefit for the NHS, the community and the country. Additionally there were superb examples of staff making a real difference to the lives and health of individuals in the developing world.
- 12.7 The University and NHS Lothian's clinical research was rated in the top 5 in the UK for quality and breadth. The Medical Director advised that he was exceptionally proud of NHS Lothian's reputation in clinical research and the well established ties with the University of Edinburgh. The point was made that the quality of the research undertaken in Lothian should be used to overcome some of the challenges in recruiting people and this could add value to the marketing strategy when advertising posts.
- 12.8 The Board noted the worldwide reach of the impacts and the significance of many of these examples for improved quality of care in the NHS setting.

### **13. Staff Survey Results – Presentation**

- 13.1 The Chairman welcomed Mrs Kelly to the meeting.
- 13.2 The Board noted that previously the staff survey had been undertaken every 2 years although it had now moved to become an annual event. The results of the survey had already been presented to the Corporate Management Team, Staff Governance Committee and the Lothian Partnership Forum. It was noted that the baseline data had been integrated and more detailed results were being provided to service users such as CHPs with further work being undertaken in respect of acute services. The next staff survey would be run in August 2015.
- 13.3 The Board received a detailed presentation on the outcome of the staff survey copies of which were provided to Board members immediately following the meeting.
- 13.4 The Board welcomed the presentation and the generally positive outcome. Concern continued to be expressed about bullying and harassment and the fact that only about 50% of staff were aware of the Boards Values into Actions. It was noted that medical and dental response rates to the survey had been low.
- 13.5 The Board noted that the staff survey was a snapshot at a particular moment in time. It was felt that one of reasons why the results were so much more positive than the previous year was to do with the significantly increased number of people who had completed the survey which gave a much more accurate picture as low response rates tended to focus on views at the extreme of the spectrum. It was noted that employee relations were conducted through partnership arrangements with the Trades Unions and in general terms there was very positive relationships in place.

- 13.6 It was pointed out that the Board was piloting iMatter in a number of areas which was a staff engagement measurement tool which would provide more regular temperature readings of how staff felt the organisation was performing. There was confidence that IIP (Investors in People) reaccreditation would be achieved in the near future. In addition the new communications strategy was being implemented and evaluated by the Acting Head of Communications with the results being fed back through the Staff Governance Committee.
- 13.7 The point was raised in respect of appraisal and development how the survey results compared with the Human Resource view of uptake. The Board were advised that the national system was difficult to use and this was one of the reasons why people did not follow the technical process through to completion. In many instances only the very final part of the process needed to be completed for the appraisal and documentation record to conclude. Discussions were being held with national colleagues about how to make the system more user friendly. The Board were reminded that in the previous year the system had recruited 17% of its total workforce meaning a number of people would not yet have gone through the appraisal and documentation process. In addition sickness and absence rates had to be considered. It was felt that an achievement rate of around 80% was positive for an organisation, NHS Lothian sat just below that level.
- 13.8 The Board received the results of the staff survey results for 2014.

#### **14. Date and Time of Next Meeting**

- 14.1 The next meeting of the Board would be held between 9.30am and 12.30pm on 24 June 2015 (later in the month to accommodate the process for signing off the annual accounts) in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.
15. A short special private Board meeting would be held immediately prior to the Board Development Session on 6 May 2015 to approve Edinburgh and East Lothian organisational structures.

#### **16. Invoking Standing Order 4.8**

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

**RUNNING ACTION NOTE**

<b>Action Required</b>	<b>Lead</b>	<b>Due Date</b>	<b>Action Taken</b>	<b>Outcome</b>
<b>Renewing NHS Values</b>				
<ul style="list-style-type: none"> <li>• Arrange engagement sessions for service teams.</li> </ul>	<b>AB</b>	31/03/2015	<i>The Associate Director of Workforce is leading on this process. Meetings with management teams and partnership leads across NHS Lothian are being held to determine what they consider are the next priorities in embedding our values.</i>	<b>In progress</b>
<ul style="list-style-type: none"> <li>• Development of the Implementation Plan to be included as a separate Board seminar.</li> </ul>	<b>AB</b>	31/05/2015	<i>The Associate Director of Workforce is leading on this process. This will be developed after the above is completed.</i>	<b>In progress</b>
<b>NHS Lothian Homeopathy Service</b>				
<ul style="list-style-type: none"> <li>• Cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014.</li> </ul>	<b>AMcM</b>	1 April 2014	<i>Judicial review still pending. NHS Lothian is represented by CLO.</i>	<b>In progress</b>
<b>Scottish Public Services Ombudsman Case 201200092</b>				
<ul style="list-style-type: none"> <li>• Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance.</li> </ul>	<b>SRW</b>	Ongoing	<i>A quarterly Customer Relations and Feedback Quality Report now goes to the Healthcare Governance Committee and the Board. This report goes into detail about complaints, trends and actions. It has been agreed that an external expert will now drive forward the review into how NHS Lothian handles all feedback and how it uses that feedback for quality improvement and service delivery purposes. There will also be a complete review of the role and function of the Customer</i>	<b>In progress</b>

Action Required	Lead	Due Date	Action Taken	Outcome
			<i>Relations and Feedback Team. A report on the options available will be produced by the end of January 2015.</i>	
<b>Workforce Risk Assessment</b>				
<ul style="list-style-type: none"> <li>• Further consideration is needed in a future paper around overall developments, staffing, culture &amp; values and their impact on individual areas including service redesign.</li>   <li>• The Medical Director and Director of Human Resources &amp; Organisational Development would take away the points raised and come back with proposals about how scope the job offer to candidates to make the posts as attractive as possible.</li>   <li>• The Director of Human Resources &amp; Organisational Development to bring a paper to a future Board meeting detailing how long posts had been vacant and by vacancy group. The report would show comparable data comparisons with other large organisations and examples of work being done to make jobs more attractive to include consideration of the benefits or otherwise of making regional appointments.</li>   <li>• The Medical Director would consider how best to bring a paper to the Board to address the fundamental capacity issue in primary care.</li> </ul>	<p style="text-align: center;"><b>AB</b></p> <p style="text-align: center;"><b>AB/DF</b></p> <p style="text-align: center;"><b>AB</b></p> <p style="text-align: center;"><b>DF</b></p>	<p style="text-align: center;">Autumn 2014</p> <p style="text-align: center;">TBC</p> <p style="text-align: center;">TBC</p>	<p><i>This work will be undertaken in the HR&amp;OD Strategy which will come to the Board following consideration by the Staff Governance Committee.</i></p> <p><i>A paper on recruitment will be discussed at the Staff Governance Committee and then taken to the Board</i></p> <p><i>A paper is being considered at the February Board meeting.</i></p> <p><i>There is going to be a second Board Development Session with Primary Care colleagues to discuss this topic, and a new GMS contract is due in 2017. I think we have taken this action as far as we can, particularly as it involves changes to the GMS contract. We will monitor progress through the Workforce Risk Assessment Paper.</i></p>	<p style="text-align: center;"><b>In progress</b></p> <p style="text-align: center;"><b>In Progress</b></p> <p style="text-align: center;"><b>Completed</b></p> <p style="text-align: center;"><b>Completed</b></p>
<b>Integration Process &amp; Milestones</b>				
<ul style="list-style-type: none"> <li>• The four draft integration plans would be submitted to the Board in December.</li> </ul>	<b>AMcM</b>	December 2014	<i>All four schemes submitted and three have now been signed off by the</i>	<b>December Board</b>

Action Required	Lead	Due Date	Action Taken	Outcome
			<i>Cabinet Secretary and will be placed before Parliament for 28 days. West Lothian being resubmitted for formal approval on the 26 May.</i>	<b>4 schemes submitted to Scottish Government by 31 March</b>
<b>Strategic Plan</b>				
<ul style="list-style-type: none"> <li>An updated strategic plan to be brought to the Board in February 2015 to allow work to be concluded and to align with the timescale for the financial planning for the Board and establishment of new integration bodies for 2015 /16. The Board to also receive an implementation plan to deliver the health and inequalities strategy as part of the overall strategic plan in 2014 as well as a similar implementation plan to delivery the cancer strategy to the same timeframe.</li> </ul>	<b>AMcM</b>	February 2015 Board	<i>The Strategic Planning committee has now changed its remit and focus around delivery and implementation of the strategic plan. Full programme of work has been developed for the year.</i>	<b>Progress Report signed off</b>
<b>Integrating Children Services in Lothian</b>				
<ul style="list-style-type: none"> <li>Formal consultation on the proposals to be undertaken between May &amp; July 2014.</li> </ul>	<b>AMcM</b>	July 2014	<i>Children's integration agenda across all four partnerships. First meeting of the new Edinburgh Children's Board of Governance is on the 10 June.</i>	<b>Plans in place. Board Development session will focus on the children's agenda</b>
<b>Staff Survey Results</b>				
<ul style="list-style-type: none"> <li>The Board would receive a further presentation once the Staff Governance Committee had considered the survey outcomes in detail.</li> </ul>	<b>AB</b>		<i>A presentation will be provided at the April 2015 Board meeting.</i>	<b>In progress</b>
<b>CAHMS and Psychological Therapies</b>				
<ul style="list-style-type: none"> <li>An update paper to be brought to the Board early in 2015.</li> </ul>	<b>AMcM</b>	February 2015	<i>Paper on performance around psychological therapies taken to April Board. New SG allocation of circa</i>	

Action Required	Lead	Due Date	Action Taken	Outcome
			<i>£560,000 is being split 50:50 between CAMHS and psychological therapies to support service development and capacity to meet demand.</i>	
<b><u>Integration Update</u></b>				
<ul style="list-style-type: none"> <li>Update report to future Board meetings.</li> </ul>	<b>AMcM</b>	December 2014	<i>As above</i>	<b>Draft Schemes and agreed delegation of services signed off at March 'Special' Board</b>
<b><u>Unscheduled Care Update</u></b>				
<ul style="list-style-type: none"> <li>Paper to December Board meeting.</li> </ul>	<b>MJ</b>	4 December	<i>Paper on December Board agenda</i>	
<b><u>Revised Corporate Communications Strategy</u></b>				
<ul style="list-style-type: none"> <li>Arrange further discussion either at a development session or at a future Board meeting.</li> </ul>	<b>AB</b>	Ongoing	<i>Paper to future Board meeting.</i>	
<b><u>Waiting Times, Performance, Progress &amp; Elective capacity Investment (01/10/14)</u></b>				
<ul style="list-style-type: none"> <li>Discuss investments and outcomes at the November Board Seminar.</li> <li>Future reports should include additional explanatory narrative as well as details of resource and capacity increases as well as the outcome form investments.</li> </ul>	<b>JC</b>  <b>JC</b>	December 2014  Ongoing	<i>Full update report on Board agenda. Investments and outcomes that were discussed at the November Board Seminar.</i>	<b>Being developed as part of 2015/16 Capacity Plan</b>
<b><u>Complaints Function</u></b>				
<ul style="list-style-type: none"> <li>A review of the complaints functions was being undertaken to a tight timescale with the intention being to bring a paper to a</li> </ul>			<i>The complaints review is ongoing and on scheduled. The report is</i>	



<b>Action Required</b>	<b>Lead</b>	<b>Due Date</b>	<b>Action Taken</b>	<b>Outcome</b>
<p>future Board meeting to cover all of the complaints issues and to agree with the Board the level of granularity and frequency of future dedicated complaints papers to the full Board.</p> <ul style="list-style-type: none"> <li>It was agreed that the Director of Human Resources and Organisational Development would circulate a copy of the report to Board members. The main report would be submitted to the April Board meeting after discussion at the March meeting of the Healthcare Governance and Risk Committee.</li> <li>An update report and action plan to the June 2015 Board meeting.</li> </ul>	<p><b>AB</b></p> <p><b>AB</b></p> <p><b>MJ</b></p>	<p>June 2015</p>	<p><i>due at the end of January 2015. Progress has been reported to the Healthcare Governance Committee. Workshops have been organised for February. This work is on target for the April Board meeting.</i></p>	<p><b>In Progress</b></p>
<b>Consultant Vacancies</b>				
<ul style="list-style-type: none"> <li>It should be possible to make recruitment advertisements more specifically focused around Edinburgh with the precedent already having being set through the Edinburgh and Lothian's Health Foundation. The suggestion was made that such an approach could be piloted for the next 20 vacancies.</li> </ul>	<p><b>AB/DF</b></p>		<p><i>Done. All jobs now advertised as "Edinburgh and the Lothian's".</i></p>	<p><b>Completed</b></p>
<b>Corporate Objectives 2014/15 (1 April 2015)</b>				
<ul style="list-style-type: none"> <li>Final report to be submitted to the June 2015 meeting with a narrative required on any red performance actions.</li> </ul>	<p><b>AMcM</b></p>	<p>June 2015</p>	<p><i>Taken to April Board and signed off</i></p>	
<b>Corporate Objectives 2015/16</b>				
<p>Quarterly updates to be submitted to the Board.</p>	<p><b>AMcM</b></p>	<p>Quarterly</p>	<p><i>As above</i></p>	

**NHS Lothian**

Board Meeting  
24 June 2015

Director of Strategic Planning, Performance Reporting & Information

## **SUMMARY PAPER - PERFORMANCE MANAGEMENT**

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

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

Of the standards and measures considered, 15 are graded red and 4 green.	3
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17 June 2015

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# **NHS Lothian**

Board Meeting  
24 June 2015

Director of Strategic Planning, Performance Reporting & Information

## **PERFORMANCE MANAGEMENT**

### **1 Purpose of the Report**

- 1.1 The purpose of this report is to provide an update to the Board on the most recently available information on NHS Lothian performance against HEAT targets and standards. The data as reported is through both local and national systems. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

### **2 Recommendations**

- 2.1 Receive this update on the existing performance against HEAT targets and other relevant standards.

### **3 Discussion of Key Issues**

- 3.1 The HEAT system sets out targets and measures which the NHS Boards are monitored and the following table sets out NHS Lothian's current position against these, with a more detailed description of these being provided under item 4 of the paper where these are not provided elsewhere of the agenda.
- 3.2 Appropriate performance against delivery of targets is maintained through lead directors, committees and local management groups; the performance management paper provides an overview of that achievement.

## Summary of Performance Position

Description	Current Status	Lead Director	Detail Available at:
Smoking Cessation.	Red	AKM	Section 4.1
Early Access to Antenatal Care	Green	AMcM	Section 4.2
Carbon Emissions	Red	AB	Section 4.3
Energy Efficiency	Green	AB	Section 4.3
Psychological Therapies	Red	JF	Section 4.4
Child and Adolescent Mental Health	Red	JF	Section 4.4
Delayed Discharge	Red	JC/DF/PG /EM/DS	Acute Services Performance Update
Reduction in Emergency Bed Days	Red	JC/DF/PG/ EM/DS	Section 4.5
Clostridium difficile Infection (CDI) and Staphylococcus aureus Bacteraemia (SAB)	Red	MJ	Healthcare Acquired Infection Update
Cancer 31 day performance	Red	JC	Acute Services Performance Update
Cancer 62 day performance	Red	JC	Acute Services Performance Update
Stroke Bundles	Green	JC	Section 4.6
Inpatients and Daycases	Red	JC	Acute Services Performance Update
Outpatients	Red	JC	Acute Services Performance Update
18 Weeks	Red	JC	Acute Services Performance Update
Diagnostics	Red	JC	Acute Services Performance Update
Surveillance Endoscopy	Red	JC	Acute Services Performance Update
Audiology	Red	JC	Acute Services Performance Update
IVF	Green	JC	Acute Services Performance Update

## **4 Key risks and areas to highlight:**

### **4.1 Smoking Cessation.**

(Responsible Director: Director of Public Health and Health Policy)

The latest data available from ISD on Smoking Cessation covers up to 30/09/2014 and shows that the Board's performance was 488 successful quits against a target of 830.

### **4.2 Early Access to Antenatal Care**

(Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

The latest data provided by ISD covers up to 30/09/2013 and shows that the Board's performance was 84.9% against a target of 75%. This was 9.9% above target.

The performance in March 2015 was 91.77% overall. Our focus remains on those not being booked within 12 weeks. Actions being taken to mitigate risks are:

- Meetings with ISD to ensure consistency of reporting and comparing of data.
- Regularly reviewing real time data on Maternity TRAK re: Quintiles linked to booking and births.
- Using data collected to inform work with Community Planning Partners and using the Early Years Collaborative methodology to engage women.

### **4.3 Carbon Emissions and Energy Efficiency Last updated February 2015**

(Responsible Director: Director of Human Resources and Organisational Development)

Over the period from April to December 2014, reduction of CO<sub>2</sub> is 1.94% worst than target at 17,620 tonnes of reported emissions against a target of 17,284.

Reduction of energy was 4.27% better than the target of 596,290 GJ at 570,857.

### **4.4 Child and Adolescent Mental Health Services and Psychological Therapies (Responsible Director: Joint Director, West Lothian)**

#### **Child and Adolescent Mental Health Services**

In April 49% children and young people seen for a first treatment appointment were seen within 18 weeks. The overall number of people seen for first treatment appointments has been reduced due to the decrease in capacity with 144 children and young people being seen for the first time in April compared to 188 in March and 210 in February.

This is a drop in performance from the previous month of March where 62% were seen within 18 weeks. This has been due to a number of factors including a reduction in capacity due to staff leaving, maternity leave, clinical accommodation issues and a significant increase in referrals to the service in the last quarter of 2014 which has continued in the first 3 months of 2015. In this period the service has seen an average increase of 51 referrals per month compared to the same period the previous year.

## **Psychological Therapies**

In April 39% of patients seen for a first treatment appointment were seen within 18 weeks. The services are continuing to focus on those with the longest waits. The number of patients waiting over 18 weeks increased to 1,254 in April compared to 1,237 patients waiting over 18 weeks at the end of March.

Extensive Demand and Capacity Modelling clearly indicates that demand for psychological therapies and Child and Adolescent Mental Health Services continues to outweigh current capacity. Although additional recurring funding for CAMHS was secured in June 2014 referrals have continued to increase. No additional recurring funding for psychological therapies has been secured - non recurring funding for psychological therapies was allocated but the impact of this is not sufficient to address the current patients waiting and the pace of referrals received.

NHS Lothian has recommended that a substantial part of the recently announced Scottish Government Mental Health Innovation funding is allocated to support further innovative approaches to deliver psychological therapies and CAMHS. In addition to this, recognising that additional recurring and non-recurring funding is required, active discussions are underway with the Corporate Management Team to prioritise recurring funding for Psychological Therapies.

Detailed action plans focusing on improving data governance and governance processes; service redesign including enhancing group provision when clinical condition and evidence base support the delivery of group interventions and the Introduction of patient focused booking are in place and the implementation of these has been accelerated to ensure that productivity and efficient is maximised.

An accelerated and comprehensive Action Plan which includes revised trajectories, is being finalised at the time of writing, this will be shared with Board members in due course.

## **4.5 Reduction in Emergency Bed Days**

(Responsible Directors: Chief Officer and Joint Directors)

The Board's performance at 4,853 against a target of 4,745 places is 2.2% above target.

The HEAT target reduces month-on-month by 0.3% with the aim of reducing by 8.7% to 4,709 between April'11 and March'15. Currently the monthly target is at 4,745 (Dec.'14). The latest provided figures (ISD, May 2015) show that for the previous rolling year (Jan.'14-Dec.'14) NHS Lothian has seen an overall decrease of 13.5% (interim) in bed days. Lothian had reported ahead of target in the previous month (0.38%) but increases to the previous 6-month data has returned a slight increase for the rolling year. The likelihood is delays in SMR01 returns.

## **4.6 Stroke**

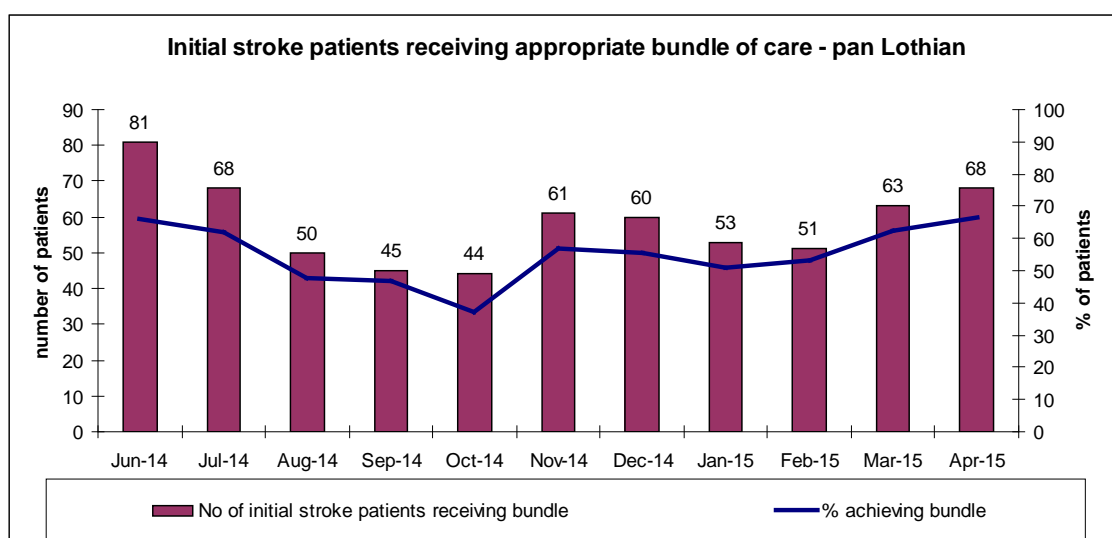
(Responsible Director: Chief Officer)

Health Boards are expected to ensuring that by March 2016, an increased number of patients admitted to hospital with a diagnosis of stroke must receive all the key elements of the stroke care bundle

The Stroke Care Bundle measures performance against all of the key elements of acute stroke care currently measured in the Scottish Stroke Care Standards, i.e. admission to stroke unit (90% by day after admission)  
 CT scanning (90% within 24 hours)  
 swallow screening (90% on day of admission)  
 aspirin administration (95% by day after admission)

Health Boards have been asked to submit a local target and action plan of how they plan to increase the number of patients in their local area receiving the Stroke Care Bundle. Lothian's local target for 2014/15 was agreed at 65% and the 2015/16 target has been set at 70%.

April's performance across Lothian was 66.7%, above trajectory, continuing the trend over recent months.



## 5 Risk Register

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

## 6 Impact on Inequality, Including Health Inequalities

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

## **7 Involving People**

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

## **8 Resource Implications**

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

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17 June 2015

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Board Meeting  
24 June 2015

Executive Nurse Director

### SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION UPDATE

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"> <li>Progress against Health Efficiency Access Treatment Targets</li> </ul>	3.1
<ul style="list-style-type: none"> <li><i>Staphylococcus aureus</i> Bacteraemia: NHS Lothian's target is to achieve a rate of 0.24 per 1000 bed days (<math>\leq 184</math> incidences) by March 2016 with a current rate of 0.41.</li> </ul>	3.2
<ul style="list-style-type: none"> <li><i>Clostridium difficile</i> Infection: NHS Lothian's <i>Clostridium difficile</i> Infection target is to achieve a rate of 0.32 per 1000 bed days (<math>\leq 262</math> incidences by March 2016 with a current rate of 0.37.</li> </ul>	3.3
<ul style="list-style-type: none"> <li>Norovirus outbreaks: since August 2014 there have been 75 incidents of gastro-enteritis investigated in NHS Lothian, with 379 patients and 80 staff affected.</li> </ul>	3.4
<ul style="list-style-type: none"> <li>Carbapenemase Producing Enterobacteriaceae: the emergence of multidrug resistant bacteria has been of increasing concern for a number of years and particularly since the identification of resistance to carbapenems.</li> </ul>	3.5
<ul style="list-style-type: none"> <li>Meticillin Resistant <i>Staphylococcus aureus</i> Screening Programme: the latest quarterly report for NHS Lothian provided by Health Protection Scotland in April 2015 indicated compliance with Clinical Risk Assessment of 64% and compliance with swabbing 86%.</li> </ul>	3.6
<ul style="list-style-type: none"> <li>Ebola Preparedness: internationally the incidences of Ebola have been reducing there are still pockets of high risk areas such as Sierra Leone. Within NHS Lothian there is an ongoing Ebola Preparedness Group investigating lessons learned from training session provided by the Army Medical Services.</li> </ul>	3.7
<ul style="list-style-type: none"> <li>Antibiotic Prescribing Guidelines: the first set of results since implementation of the revised guidelines showed a reduction in usage of broad spectrum "4C" antibiotics and an increase in gentamicin use.</li> </ul>	3.8
<ul style="list-style-type: none"> <li>Healthcare Environmental Inspectorate: carried out an unannounced inspection at the Western General Hospital on 26-27 May 2015. The draft report is anticipated to be received by the board on 24 June, to be returned with action plan 2 July and publication date of 20 July 2015.</li> </ul>	3.9
<ul style="list-style-type: none"> <li>Vale of Leven: the Scottish Government Health Department has requested Board provide an update on their action plans which were submitted in January 2015.</li> </ul>	3.10

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## HEALTHCARE ASSOCIATED INFECTION UPDATE

### 1 Purpose of the Report

- 1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Executive Nurse Director in advance of the meeting.
- 1.2 The data reporting is in the new monthly report format as agreed with Clinical Management Group and Clinical Governance combining infection control and antimicrobial data and patient safety data (Appendix 1).

### 2 Recommendations

- 2.1 The Board is recommended to:
  - acknowledge receipt of the new monthly report format for Healthcare Associated Infection Reporting Template for June 2015. (Appendix 1)
  - acknowledge receipt of the Healthcare Associated Infection Reporting Template for June 2015. (Appendix 2)
  - note NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days ( $\leq 184$  incidences) by March 2016 with a current rate of 0.41.
  - note NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days ( $\leq 262$  incidences by March 2016 with a current rate of 0.37).
  - acknowledge and support ongoing actions to address gaps identified within the response to Vale of Leven Inquiry recommendations.

### 3 Discussion of Key Issues

#### 3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2016

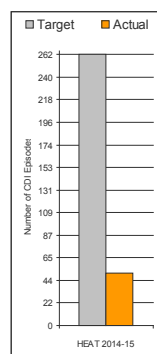


Figure 1: No. of CDI Episodes 2015-16

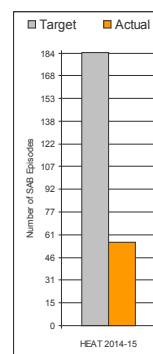


Figure 2: No. of SAB Episodes 2015-16

3.2 Staphylococcus aureus Bacteraemia: NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days ( $\leq 184$  incidences) by March 2016 with a current rate of 0.41.

There were 21 episodes of *Staphylococcus aureus* Bacteraemia in May 2015 (1 Meticillin Resistant *Staphylococcus aureus*, 20 Meticillin Sensitive *Staphylococcus aureus*), compared to 35 in April 2015 (6 Meticillin Resistant *Staphylococcus aureus*, 29 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian SAB chart suggests increase in trend over the last 12 month period, appendix 1 (chart 3.2).

Target Date	Target	Actual
Year Ending 31/3/2013	213	255
Year Ending 31/3/2014	219	243
Year Ending 31/3/2015	184	282
Year Ending 31/3/2016	184	56*

\* Cumulative to date

### 3.2.1 Key Messages:

- NHS Lothian remains vulnerable to *Staphylococcus aureus* Bacteraemia.
- Optimising care of invasive devices and avoiding use wherever possible remains the key priority.
- Actions are focussed on audit and education to improve this, focusing on preventable bacteraemia
- Review of data for 2014-2015 noted *Staphylococcus aureus* Bacteraemia in Intravenous Drug Users accounted for 43 of the episodes reported. Investigations into the increased incidence and education, awareness raising of the risk to recreational drug users is being addressed by Health Protection, Police Scotland and Harm Reduction teams.

3.3 Clostridium difficile Infection: NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days ( $\leq 262$  incidences by March 2016 with a current rate of 0.37).

There were 22 episodes of *Clostridium difficile* Infection in patients aged 15 or over in May 2015, compared to 29 in April 2015. NHS Lothian CDI chart suggests decrease in trend but still not in line with the HEAT target, appendix 1 (chart 3.1).

Target Date	Target	Actual
Year Ending 31/3/2013	418	364
Year Ending 31/3/2014	313	425
Year Ending 31/3/2015	262	393
Year Ending 31/3/2016	262	51*

\* Cumulative to date

### 3.3.1 Key Messages:

- Updates on progress against the Vale of Leven action plan have been requested by Scottish Government Health Department. The initial request was for information to be returned by 24 June however in order to meet their requirement of information being shared with:
  - Area Clinical Forum
  - Local Patient involvement group/network
  - Area Partnership Forum

prior to submission, NHS Lothian has agreed an amended deadline of 31 July 2015.

- The CDI policy review has been completed and published with associated documents on Infection Prevention & Control Intranet.
- Antimicrobial data would indicate since the introduction of Gentamicin there are some positive early results in the reduction in the use of 4C\* drugs associated with increased risk of *Clostridium difficile*. However, more data is required before it can be seen if this is a longer-term trend. (\*Clindamycin, cephalosporins, ciprofloxacin (fluoroquinolones) and co-amoxiclav).
- Datix adverse events show since February there has been 989 medication error reports of these 17 were relating to gentamicin these have or are being investigated and monitored (Table 4.1 in Appendix 1).

3.4 Norovirus: since August 2014 there have been 75 incidents of gastro-enteritis investigated in NHS Lothian, with 379 patients and 80 staff affected. In comparison to 92 episodes for the same period for season 2013/14, with 560 patients and 122 staff affected. There have been 432 bed days lost so far for season 2014/15, in comparison to 675 for the same period for season 2013/14.

3.5 Carbapenemase Producing Enterobacteriaceae (CPE): the emergence of multidrug resistant bacteria has been of increasing concern for a number of years and particularly since the identification of resistance to carbapenems. Carbapenems are often viewed as the last therapeutic option to treat complex infections caused by multidrug resistant bacteria and this makes the increase of CPE a major public health concern.

In 2005 a major review article predicted that the continued worldwide spread of carbapenemases would result in a clinical catastrophe and cause a future public health crisis. The current epidemiological situation of Carbapenemase Producing Enterobacteriaceae in Europe is worse than had been predicted.

Warning from European Antibiotic Resistance Surveillance System:

- The rapid emergence and dissemination of strains with carbapenemase production are threatening the effectiveness of this last line therapeutic option.
- Many pharmaceutical companies have withdrawn from antibiotic research and development resulting in no new antibiotics active against Gram-negative bacteria being produced.

This threat has been recognised and Scottish Government have established a multi disciplinary Short Life Working Group to review and develop actions across Scotland for surveillance of CPE.

It has been acknowledge by Health Protection Scotland within NHS Lothian there has been good progress to establish initial systems to identify patients at risk ahead of the national guidance. This includes identification and management of patients at risk of CPE colonisation through

- Identification of patients who have had healthcare contact outside Scotland in year prior to admission.
- Monitoring of previously known positive cases
- Screening protocol in RIE ITU since early 2012
- Priority Isolation of colonised patients

- Prudent antimicrobial prescribing which can lead to the development of multi and extremely drug resistant organisms)

During April 2014 to March 2015 it is estimated there were 97 inpatients identified with an extremely drug resistant Gram negative bacteria from clinical specimens. This figure does not include outpatient or community locations.

- 3.6 Meticillin Resistant *Staphylococcus aureus* Screening Programme: the latest quarterly report for NHS Lothian provided by Health Protection Scotland in April 2015 indicated compliance with Clinical Risk Assessment (CRA) of 64% and compliance with swabbing 86%. The annual report for 2014-15 for NHS Lothian also indicated an overall CRA compliance of 64% and compliance with swabbing 78%.
- 3.7 Ebola Preparedness: Although internationally the incidences of Ebola have been reducing there are still pockets of high risk areas such as Sierra Leone. Within NHS Lothian there is an ongoing Ebola Preparedness Group investigating lessons learned from training session provided by the Army Medical Services to review our current approach to training and provision of skills associated with Personal Protective Equipment. Following the success of the visit in April to the Army Medical Services Training Centre, further open days are being arranged. More details will be circulated when available. The first open event is anticipated to be 24 July 2015.
- 3.8 Antibiotic Prescribing indicators: in clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines was just below the target level for all three acute sites and ranged from 85 to 90%. Documentation of indication for antibiotic treatment was at the target level of 100% for all three acute sites but documentation of antibiotic duration was below target level at 40 to 70%.

The results for the prescribing indicator for oral antibiotic prescribing in downstream medical wards showed that documentation of antibiotic indication was above target at 100% for all three acute sites, compliance with antibiotic policy was also above target but documentation of oral antibiotic duration was below target for all the sites at 40 to 60%.

Antibiotic Prescribing Guidelines: revised UHS Antibiotic Prescribing Guidelines were implemented on 2 February 2015 to facilitate use of more narrow spectrum and less broad spectrum antibiotics for empiric treatment of infection. The first set of results since implementation of the revised guidelines showed a reduction in usage of broad spectrum "4C" antibiotics and an increase in gentamicin use. Possible adverse effects of increased gentamicin prescribing are being closely monitored.

- 3.9 Healthcare Environmental Inspectorate: The report from the unannounced inspection at the Royal Infirmary of Edinburgh on 28-29 April 2015 will be available from the 22 June 2015.

The Healthcare Environment Inspectorate carried out an unannounced inspection at Western General Hospital on 26-27 May 2015. It is anticipated that the draft report will be sent to the Board for factual checking on 24 June with the factual

accuracy and action plan to be returned to the Inspectors by 2 July. The final report is anticipated to be published 20 July 2015.

Work is ongoing collating information within the revised Healthcare Associated Inspectorate Self Assessment template with the deadline to return to the Inspectorate with associated evidence being 12 June 2015.

- 3.10 Vale of Leven Enquiry: The Scottish Government Health Department has requested Boards provide an update on their action plans which were submitted in January 2015. Work is ongoing collating progress updates against the 50 recommendations noted within the actions that have been identified as mostly implemented or partially implemented within NHS Lothian.

## **4 Key Risks**

4.1 The key risks associated with the recommendations are:

- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Based on current data for both *Clostridium difficile* Infection and *Staphylococcus aureus* Bacteraemia NHS Lothian is currently reporting amber for progress against the Health Efficiency Access Treatment Target.
- Multi Drug Resistant, Extreme Drug Resistance and Carbapenemase Producing Enterobacteriaceae pose an increasing risk to patient morbidity and mortality.

## **5 Risk Register**

5.1 The Healthcare Associated Infection Corporate Risk Register 1076 is currently graded high due to reported incidences of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection impacting on negative trend to achieving Health Efficiency Access Treatment Target. The risk register covers Norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

## **6 Impact on Inequality, Including Health Inequalities**

6.1 Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. Accordingly, changes made are reducing the burden of Healthcare Associated Infection.

## **7 Involving People**

7.1 Patient public representatives are actively involved during the Healthcare Environment Inspectorate inspections, with one member sitting on the Healthcare Environment Inspectorate Steering Group. Other patient public representatives sit on the Infection Control Committees for Acute and Community and Lothian Infection Control Advisory Committee.

## **8 Resource Implications**

- 8.1 Infection Prevention and Control is an invest to save service. The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection is variable, depending on increased length of stay and additional treatment requirements.

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10 June 2015

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### **List of Appendices**

Appendix 1: Clinical Management Group Monthly Infection Report June 2015

Appendix 2: Healthcare Associated Infection Reporting Template for June 2015

**NHS Lothian Monthly Infection and Antimicrobial Report - June 2015**

**Date produced:** 8th June 2015

This report is in development. The initial focus for development has been the acute sites. A more comprehensive report is available quarterly. Brief commentary is provided alongside each figure.

Note that for data on infections, infections are attributed to the clinical area from which the sample was sent.

**Contacts**

Infections data [janathan.daniel@nhslothian.scot.nhs.uk](mailto:janathan.daniel@nhslothian.scot.nhs.uk)

Antimicrobial data [eilidh.fletcher@nhslothian.scot.nhs.uk](mailto:eilidh.fletcher@nhslothian.scot.nhs.uk)

**Primary Data sources**

**Prescribing data:** Ascribe (to June 2014); JAC (from June 2014)

**Activity data:** TRAK oracle

**Infections data:** Apex labs system

Please see individual sheets for other data sources

**Abbreviations**

**DDD** - Defined Daily Dose

The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults.

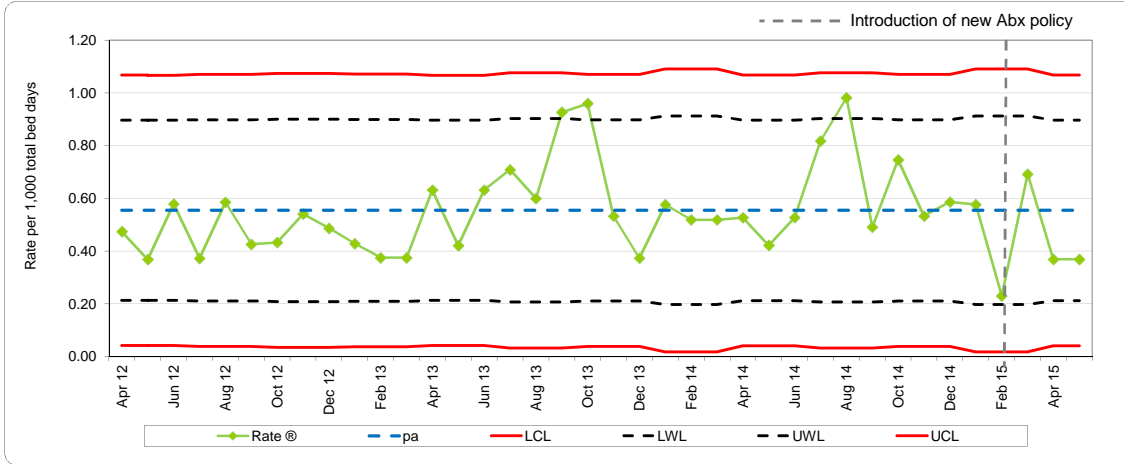
**OBD** - Midnight Occupied Bed Days

**CDI** - Clostridium difficile infection

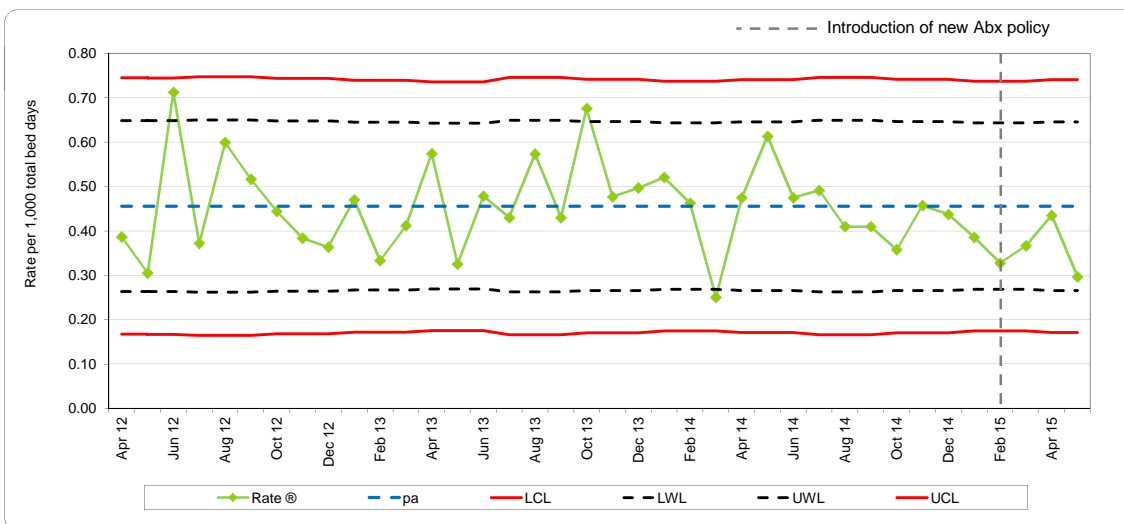
**For SPC charts:** **pa** - process average, **LCL** - lower control limit, **LWL** - lower warning limit



1.1 u-chart - NHS Lothian CDI rate per 1,000 bed days for 15-64 year age group (Apr 2012-May 2015)

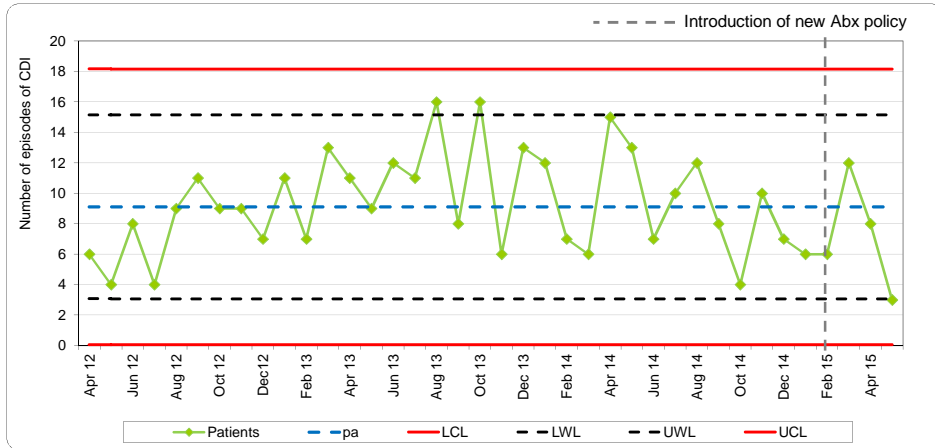


1.2 u-chart - NHS Lothian CDI rate per 1000 OBDs for 65 year and over age group (Apr 2012-May 2015)

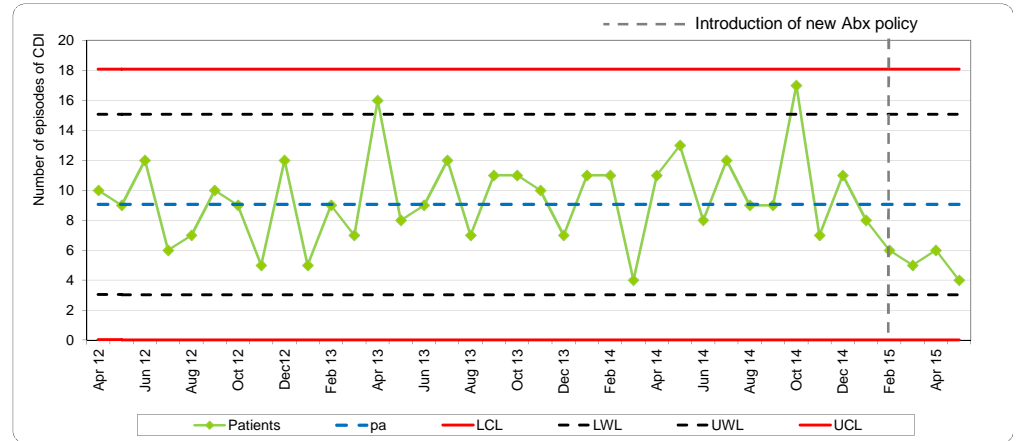


Source: IPCT  
 All data  
 NHS Lothian has seen a decrease in trend but still not in line with the HEAT target.

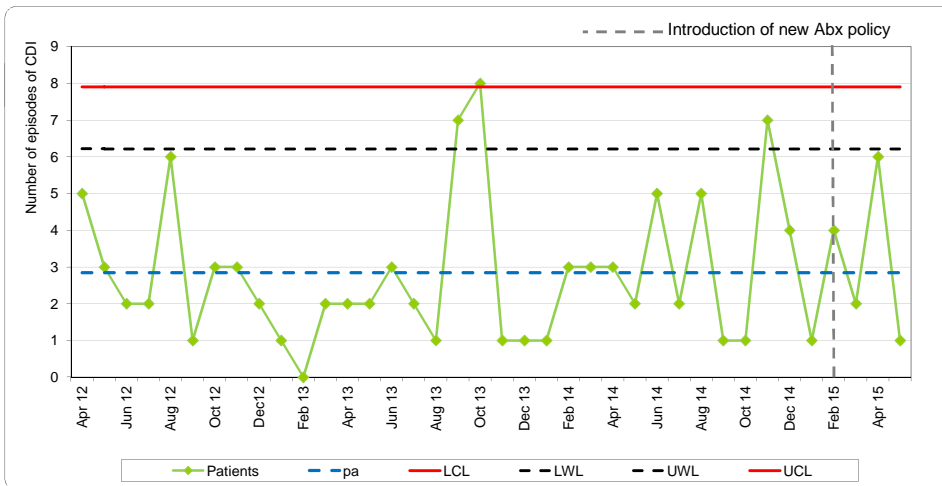
1.3 c-chart of number of episodes of CDI per month in RIE in pts aged 15+ (Apr 2012-May 2015)



1.4 c-chart of number of episodes of CDI per month in WGH in pts aged 15+ (Apr 2012-May 2015)

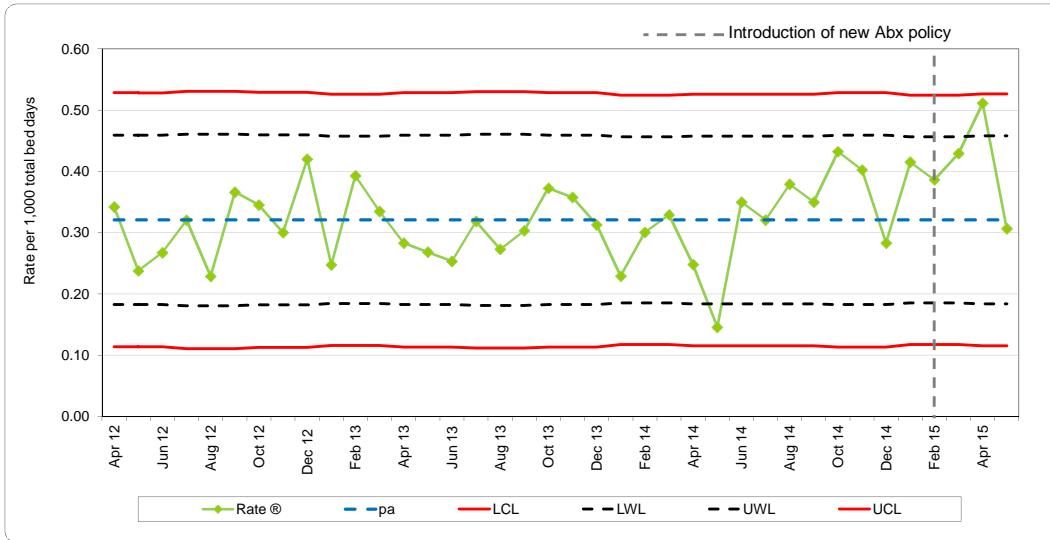


1.5 c-chart of number of episodes of CDI per month in SJH in pts aged 15+ (Apr 2012-May 2015)



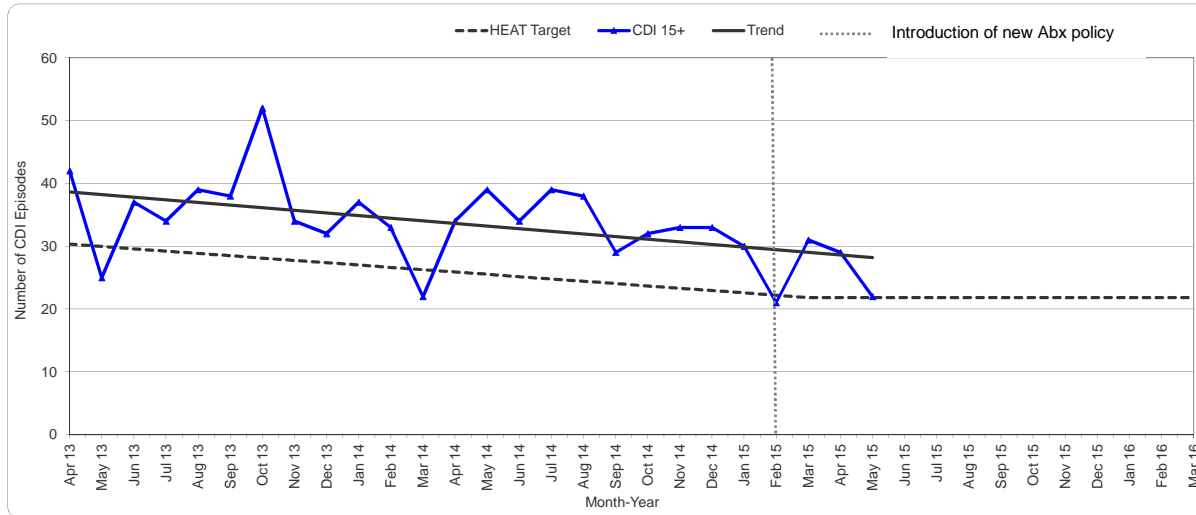
Source: IPCT  
 All data  
 Reduction in CDI episodes since the introduction of new antibiotic policy.

2.1 u-chart - NHS Lothian *Staphylococcus aureus* Bacteraemia rate per 1000 OBDs (Apr 2012-May-2015)



Source: IPCT  
 All data  
 NHS Lothian has seen an increase in trend  
 over the last 12 month period.

3.1 CDI Progress against HEAT target - NHS Lothian

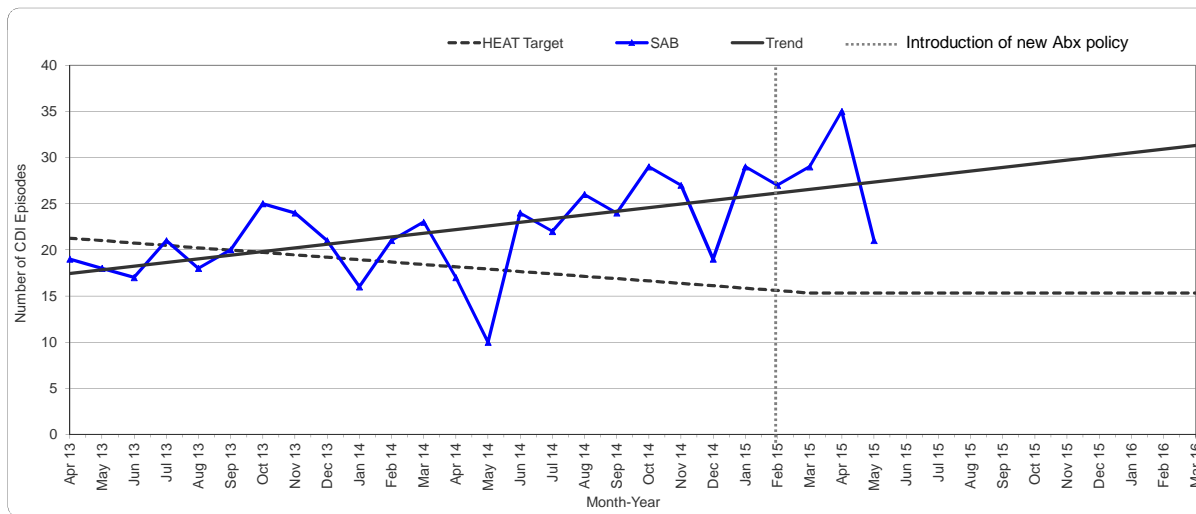


Source: IPCT  
All data

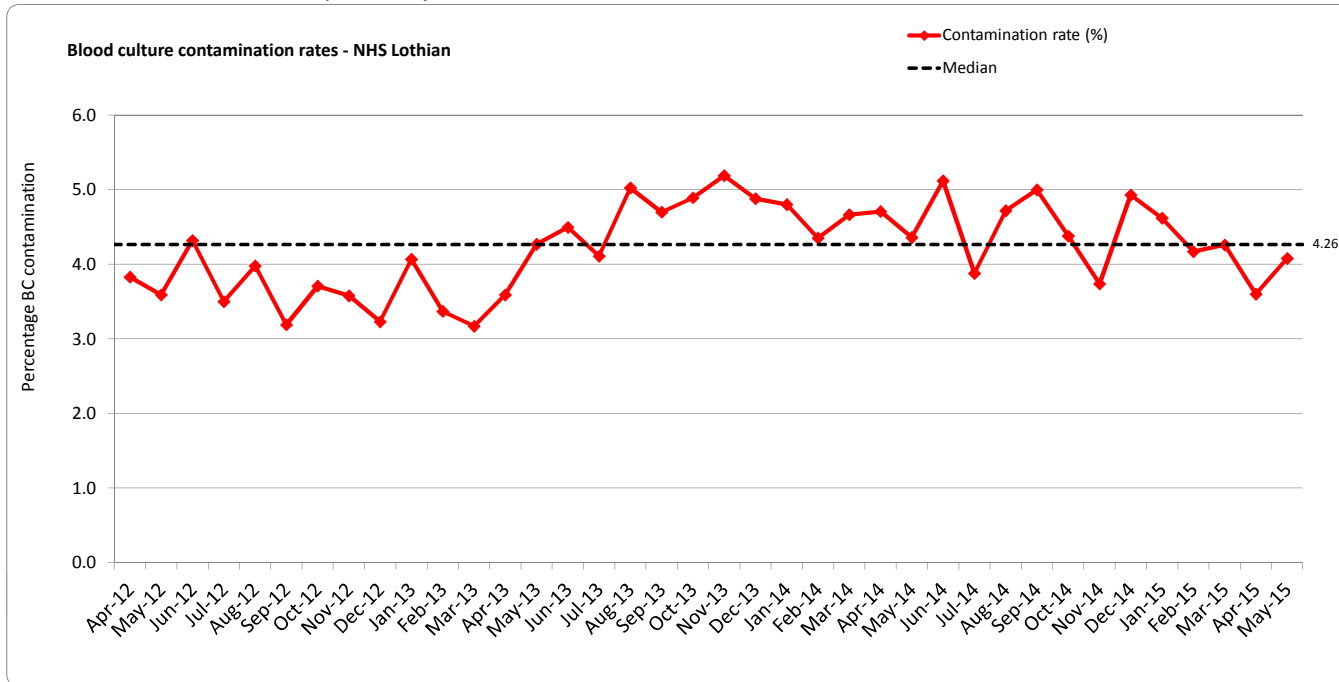
NHS Lothian's Clostridium difficile Infection Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days (<262 incidences) by March 2016 in patients aged 15 and over, with a current rate of 0.37 (51 incidences). NHS Lothian has seen a decrease in trend but still not in line with the HEAT target.

NHS Lothian's Staphylococcus aureus Bacteraemia Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days (<184 incidences) by March 2016 with a current rate of 0.41 (56 incidences). NHS Lothian has seen an increase in trend over the last 12 month period.

3.2 SABs progress against HEAT target - NHS Lothian



3.1 Blood culture contamination rates - Apr 2012 - May 2015



Source: IPCT  
 All data  
 No change in rate over last year.

**Notes:**

During May 2015 there were 3,653 sets of blood cultures taken in NHS Lothian. Of these, 149 (4.08%) of the blood culture was considered to be contaminated.  
 During the previous 12-month period, there were a total of 45,233 blood cultures collected of which 4.38% were considered to be contaminants.

## 3.2 Ward closures

No up to date aggregate data are currently available.

## 3.3 Number of wards that have exceeded CDI trigger levels (Jun 2014 to May 2015)

LocationDescription	2014-06	2014-07	2014-08	2014-09	2014-10	2014-11	2014-12	2015-01	2015-02	2015-03	2015-04	2015-05	Grand Total
RIE Combined Assessment Area 6	0	0	0	1	0	0	0	0	0	2	0	0	3
RIE Ward 105	0	3	1	0	0	2	1	0	0	1	0	0	8
RIE Ward 107	2	0	1	1	1	2	1	2	0	0	1	0	11
RIE Ward 118 ITU	0	0	0	0	0	0	0	0	1	3	0	0	4
RIE Ward 120	0	0	0	2	0	0	0	0	0	0	1	0	3
RIE Ward 206	0	0	1	1	1	2	2	0	0	0	2	2	11
RIE Ward 207	1	0	0	0	1	2	0	0	1	0	1	0	6
RIE Ward 208	0	0	1	0	0	0	0	1	0	2	0	0	4
SJH Medical Assessment Unit	1	0	2	0	0	0	1	0	2	0	1	0	7
SJH Ward 8	1	0	0	0	1	1	1	0	1	0	2	0	7
WGH ARAU Beds	1	2	1	0	2	0	1	1	1	0	2	0	11
WGH ARAU Trolleys	0	2	1	0	1	0	1	0	0	0	1	0	6
WGH Ward 2	0	0	0	0	2	0	1	0	0	0	0	0	3
WGH Ward 24	1	1	0	0	2	0	0	0	0	0	1	0	5
WGH Ward 27	0	3	0	1	0	0	0	1	1	0	0	1	7
WGH Ward 42	1	0	2	0	0	0	1	0	1	1	0	1	7
WGH Ward 43	2	0	0	0	0	0	1	1	0	1	0	0	5
WGH Ward 53	0	0	0	1	2	0	1	0	0	0	0	0	4
WGH Ward 56	0	0	1	2	0	0	1	1	0	1	0	0	6
WGH Ward 8 Unit	0	1	0	0	2	0	0	0	0	1	0	0	4
AAH Charles Bell Pavilion 1	0	0	0	0	0	1	1	2	0	1	0	0	5
GP: Parkgrove & East Craigs Medical Centre	2	0	0	0	0	1	0	0	0	0	0	0	3
GP: Tranent Medical Practice	0	1	0	2	0	0	1	0	0	1	0	0	5

Source: IPCT

All data

These represent clinical areas where there have been > 2 CDI in the given time period - the highlighting illustrating how many CDIs there have been in the given time period.

4.1 Monthly medication error Datix reports - all NHS Lothian sites

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Number of medication error reports	213	259	215	219	261	215	213	221	190	273	261	265
Number related to gentamicin	1	5	3	-	1	-	1	-	2	6	6	3
% related to gentamicin	0.5%	1.9%	1.4%	-	-	-	-	-	-	2.2%	2.3%	1.1%

Source: Datix, All data  
 The antimicrobial policy changed in Feb 2015. Following an apparent decline in medication datix reports in February, the number of medication error Datix reports increased in March and April in the RIE and NHS Lothian in general - driven by the increase in the RIE and WGH (see below). Please use the gentamicin figures for the most recent month with caution and see the notes below .

4.2 Monthly medication error Datix reports - Royal Infirmary of Edinburgh

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Number of medication error reports	42	66	60	68	73	55	51	54	43	66	83	67
Number related to gentamicin	0	2	3	0	0	0	1	0	1	2	3	1
% related to gentamicin	-	-	5.0%	-	-	-	-	-	-	3.0%	3.6%	1.5%

Chart 4.1 NHS Lothian Medication error Datix reports

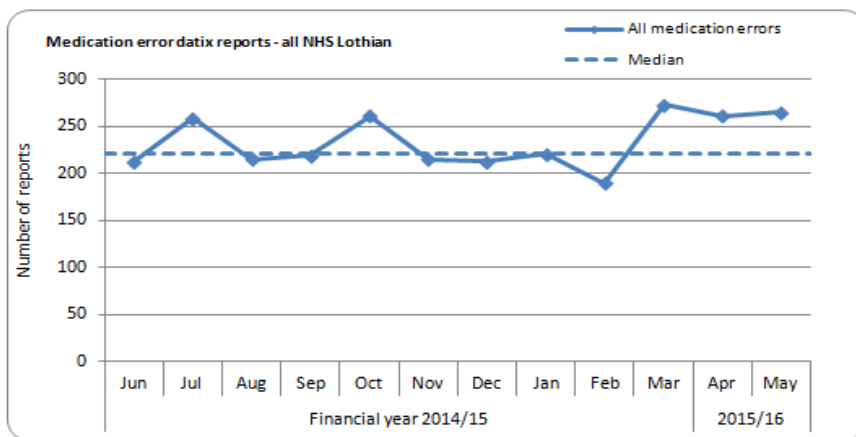
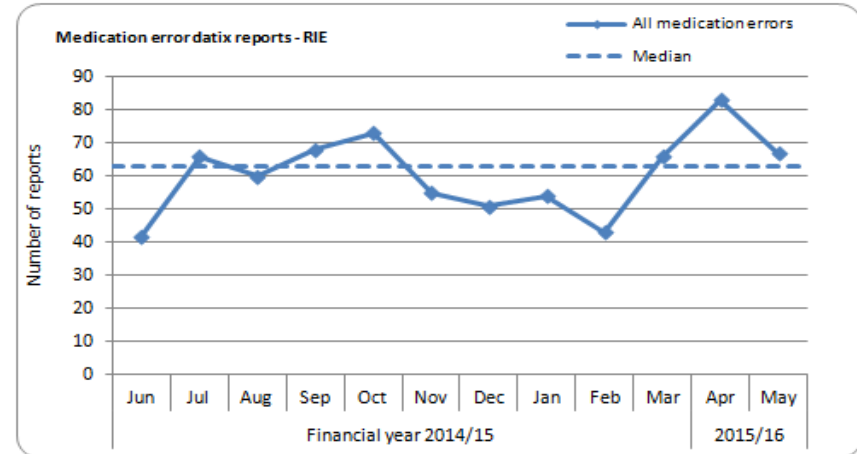


Chart 4.2 RIE Medication error Datix reports



4.3 Monthly medication error Datix reports - Western General Hospital

	Financial year 2014/15											2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Number of medication error reports	62	69	52	61	59	57	59	63	49	82	49	76	
Number related to gentamicin	1	2	-	-	-	-	-	-	-	-	2	1	
% related to gentamicin	-	2.9%	-	-	-	-	-	-	-	-	4.1%	1.3%	

Source: Datix, All data  
 The antimicrobial policy changed in Feb 2015. Following an apparent decline in medication datix reports in February, the number of medication error Datix reports increased considerably in March and May in WGH, but only a small percentage have been attributed to gentamicin. Figures for SJH have remained relatively stable. Please use the gentamicin figures for the most recent month with caution and see the

4.4 Monthly medication error Datix reports - St John's Hospital

	Financial year 2014/15											2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Number of medication error reports	15	26	18	18	27	16	22	23	20	20	17	22	
Number related to gentamicin	-	-	-	-	-	-	-	-	-	1	-	-	
% related to gentamicin	-	-	-	-	-	-	-	-	-	5.00%	-	-	

Chart 4.3 WGH Monthly medication error Datix reports

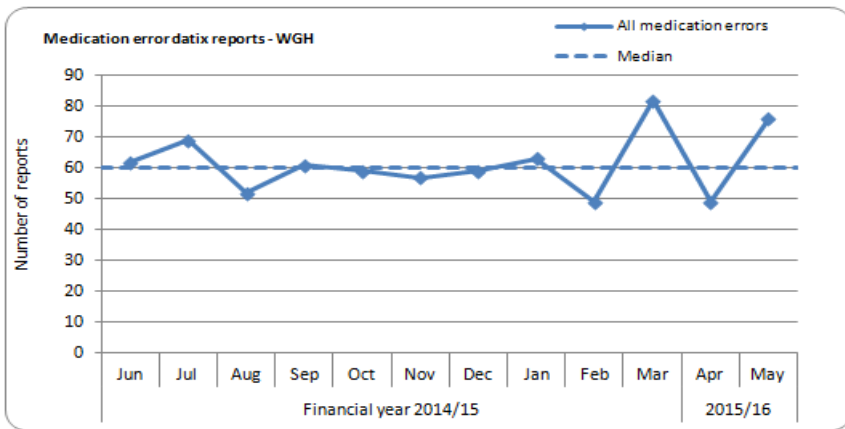
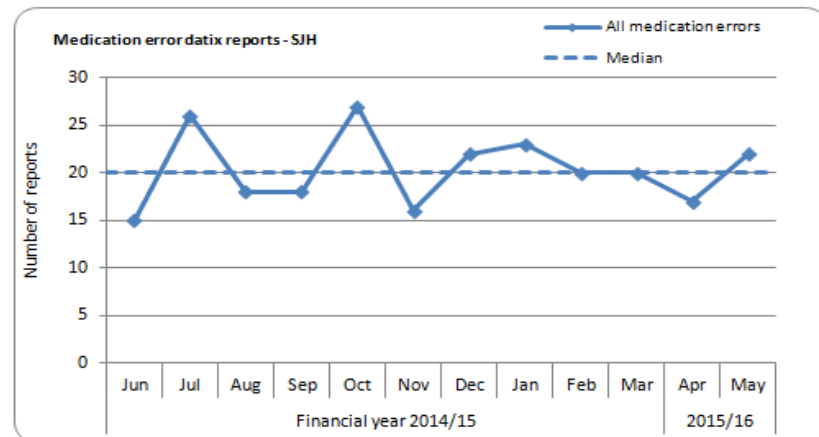


Chart 4.4 SJH Monthly medication error Datix reports





**Adverse events - medication adverse events in and number related to gentamicin**

**Source:** DATIX; data extracted 03/06/2015

**Notes:**

**1:** Data as at 03/06/2015.

**2:** Adverse events are recorded in 'real-time', therefore the total number of medication error reports for May (to date) are assumed to be accurate. However, it is not mandatory to record the drug involved when initially recording a medication adverse event and this is often only added to the database once the adverse event has been investigated.

For this reason, please use the gentamicin adverse events figures for May with caution.

# NHS Lothian

## Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	1	1	4	3	4	1	3	1	2	6	1
MSSA	24	21	25	20	26	23	18	25	26	27	29	20
Total	24	22	26	24	29	27	19	28	27	29	35	21

## Clostridium difficile Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	10	15	18	9	14	10	11	10	4	12	7	7
Age 65 plus	24	24	20	20	18	23	22	20	17	19	22	15
Total	34	39	38	29	32	33	33	30	21	31	29	22

## Hand Hygiene Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
AHP	96.92	95.49	96.95	96.74	93.92	94.86	95.49	95.23	95.76	96.40	96.31	-
Ancillary	91.45	91.60	90.19	90.77	94.70	91.58	93.19	89.28	92.33	92.08	87.92	-
Medical	92.84	94.96	93.22	93.69	94.39	93.45	90.91	94.02	92.93	93.09	92.79	-
Nurse	98.58	98.11	98.48	98.23	98.20	98.19	98.09	98.55	98.62	98.22	98.17	-
Board Total	96.75	96.75	96.74	96.70	96.65	96.37	95.97	96.63	96.69	96.61	96.22	-

## Cleaning Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	96.14	96.44	96.25	95.60	96.10	95.70	95.10	94.95	95.40	94.55	94.25	00.00

## Estates Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	97.05	96.93	96.46	96.80	96.40	97.20	97.10	96.65	96.60	94.75	95.85	00.00

## ROYAL INFIRMARY OF EDINBURGH

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	0	1	1	0	1	0	2	0	0	1	0
MSSA	3	3	4	5	2	1	1	4	7	2	2	2
Total	3	3	5	6	2	2	1	6	7	2	3	2

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	1	2	6	2	2	2	2	1	0	5	2	1
Age 65 plus	6	9	6	6	2	8	5	5	6	7	6	2
Total	7	11	12	8	4	10	7	6	6	12	8	3

### Cleaning Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	96.83	97.09	97.07	96.60	97.01	96.63	96.72	96.27	96.55	96.62	96.92	00.00

### Estates Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	96.08	96.92	96.63	95.82	96.33	97.98	96.10	95.45	95.47	95.99	96.45	00.00

## WESTERN GENERAL HOSPITAL

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	0	0	0	2	1	0	0	1	1	0	0
MSSA	2	1	2	4	3	5	1	1	3	3	6	3
Total	2	1	2	4	5	6	1	1	4	4	6	3

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	4	6	5	2	7	2	2	4	3	3	3	2
Age 65 plus	4	6	4	7	10	5	9	4	3	2	3	2
Total	8	12	9	9	17	7	11	8	6	5	6	4

### Cleaning Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	97.16	97.52	96.87	95.01	96.33	94.02	93.55	92.89	93.42	93.22	94.53	00.00

### Estates Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	99.35	99.04	98.31	97.86	98.24	97.75	97.73	98.17	97.83	96.50	95.36	00.00

## ST JOHNS HOSPITAL

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	0	0	1	1	0	0	0	0	0	0	0
MSSA	0	2	0	0	0	0	0	1	0	2	0	0
Total	0	2	0	1	1	0	0	1	0	2	0	0

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	1	1	0	0	0	2	1	0	1	0	0	0
Age 65 plus	4	1	5	1	1	5	3	1	3	2	6	1
Total	5	2	5	1	1	7	4	1	4	2	6	1

### Cleaning Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	95.83	95.13	95.05	93.83	95.43	95.38	95.02	95.76	95.92	94.51	94.52	00.00

### Estates Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	95.82	94.42	93.51	94.75	95.29	95.63	95.43	95.53	95.01	94.97	95.97	00.00

## LIBERTON HOSPITAL

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	0	0	0	0	0	0	0	0	0	1	0
MSSA	1	1	1	0	3	0	0	0	0	0	0	0
Total	1	1	1	0	3	0	0	0	0	0	1	0

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	3	2	0	1	0	0	0	1	1	1	1	0
Total	3	2	0	1	0	0	0	1	1	1	1	0

### Cleaning Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	95.65	97.67	97.61	96.83	97.70	97.02	96.71	96.87	96.77	96.23	96.96	00.00

### Estates Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	93.47	96.93	95.94	93.66	95.12	97.43	98.11	98.04	97.99	98.61	97.37	00.00

## ROYAL HOSPITAL FOR SICK CHILDREN

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	1	0	0	1	0	1	1	0	0	1
Total	0	0	1	0	0	1	0	1	1	0	0	1

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	1
Age 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	1

### Cleaning Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	94.50	95.18	95.20	93.67	94.21	95.13	95.83	94.11	94.47	91.83	92.61	00.00

### Estates Monitoring Compliance (%)

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Board Total	99.28	99.19	99.87	97.59	97.21	98.29	99.00	96.61	97.91	95.15	95.82	00.00

## COMMUNITY HOSPITALS

Community Hospitals include the following hospitals and care facilities

- Astley Ainslie Hospital
- Corstorphine Hospital
- Ellen's Glen House
- Ferryfield House
- Findlay House
- Marie Curie Hospice Edinburgh
- Midlothian Community Hospital
- Roodlands Hospital
- Royal Edinburgh Hospital
- Royal Victoria Hospital
- St Columba's Hospice
- St Michaels Hospital
- Tippethill Hospital

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	0	0	0	0	1	0	1	0	0	0	0
MSSA	1	0	0	0	1	0	0	0	0	0	0	0
Total	1	0	0	0	1	1	0	1	0	0	0	0

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	0	0	0	0	0	1	2	2	0	1	0	0
Age 65 plus	3	2	0	1	0	0	2	0	1	0	0	1
Total	3	2	0	1	0	1	4	2	1	1	0	1

## OUT OF HOSPITAL INFECTIONS

### *Staphylococcus aureus* Bacteraemia Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
MRSA	0	1	0	2	0	1	1	0	0	1	4	1
MSSA	17	14	17	11	17	16	16	18	15	20	21	14
Total	17	15	17	13	17	17	17	18	15	21	25	15

### *Clostridium difficile* Infection Monthly Case Numbers

	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
Age 15-64	4	6	7	5	4	3	4	3	0	3	2	3
Age 65 plus	4	4	5	4	5	5	3	9	3	6	6	8
Total	8	10	12	9	9	8	7	12	3	9	8	11



Board Meeting  
 24 June 2015

Medical Director

**SUMMARY PAPER - CORPORATE RISK REGISTER**

This paper summarise the key points in the full paper.

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

	Para
<ul style="list-style-type: none"> <li>• The top 4 risks at Very High 20 are:-                             <ul style="list-style-type: none"> <li>○ Healthcare Associated Infection</li> <li>○ Achieving the 4-Hour Emergency Care standard</li> <li>○ Achieving the Delayed Discharge targets at 2 and 4 weeks</li> <li>○ The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.</li> </ul> </li> </ul>	3.2.1
<ul style="list-style-type: none"> <li>• Table 1 sets out an update of the NHS Lothian Corporate Risk Register as approved by the April 2015 Board.</li> </ul>	3.2.2
<ul style="list-style-type: none"> <li>• A number of emerging risks are being examined by the RMSG in June 2015, for inclusion in the Corporate Risk Register. These include General Practice Workforce Sustainability, Nursing Workforce Sustainability and Compliance with Mandatory Training.</li> </ul>	3.4
<ul style="list-style-type: none"> <li>• A Risk Register review has been completed against the Audit Scotland Best Value Toolkit for Risk Management and its findings will be presented to the June Audit &amp; Risk Committee, along with an improvement plan.</li> </ul>	3.6
<ul style="list-style-type: none"> <li>• Compliance with NHS Lothian's Risk Appetite is set out in Table 2, which suggests NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4).</li> </ul>	3.7

Jo Bennett  
 Associate Director for Quality Improvement & Safety  
 1 June 2015  
[Jo.bennett@nhslothian.scot.nhs.uk](mailto:Jo.bennett@nhslothian.scot.nhs.uk)

# NHS Lothian

Board Meeting  
24 June 2015

Medical Director

## NHS Lothian Corporate Risk Register

### 1 Purpose of the Report

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

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

### 2 Recommendations

- 2.1 Note that the April 2015 Board approved the changes to the Corporate Risk Register recommended by the Audit & Risk Committee.
- 2.2 Use the updated NHS Lothian Corporate Risk Register; highlights of which are contained in section 3.2 and set out in detail in Appendix 1 to inform assurance requirements.
- 2.3 Reflect on the current position that NHS Lothian remains outwith its Risk Appetite on corporate objectives where low risk appetite has been set.

### 3 Discussion of Key Issues

- 3.1 The Risk Management Steering Group (RMSG) in January 2015 undertook a review of the risks on the Corporate Risk Register to ensure they were fit for purpose and reflected NHS Lothian's risk profile. Individual members were asked to review the risk and grading using a 5x5 matrix within the context of the two following principles:-

- The Corporate Risk Register needs to be focused on specific unmanaged risks that executive management cannot themselves address by their actions
- What decisions does the Board need to take to mitigate the unmanaged risks.

- 3.2 The February 2015 Audit & Risk Committee approved the recommendations, with the exception of Medical Workforce Sustainability prior to approval at the April 2015 Board. Table 1 below sets out the Board approved Corporate Risk Register.

- 3.2.1 There are 10 risks in total; the top 4 risks at Very High 20 are:-

- Healthcare Associated Infection
- Achieving the 4-Hour Emergency Care standard
- Achieving the Delayed Discharge targets at 2 and 4 weeks
- The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.

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

Table 1

Datix ID	Risk Title	Initial Risk Level	Apr-Jun 2014	Jul-Sept 2014	Oct-Dec 2014	Jan-Mar 2015
<a href="#">1076</a>	Healthcare Associated Infection (Standing item on Board Agenda)	High 12	Medium 9	High 16	High 16	↑ High 20
<a href="#">3600</a>	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. (Standing item on Board Agenda)	High 12	High 12	High 12	High 12	↑ High 20
<a href="#">3203</a>	Achieving the 4 hour emergency target (split into two separate risks March 2015 – 3203 & 3726)	High 10	High 10	High 10	High 10	↑ High 20
<a href="#">3726</a>	Achieving the Delayed Discharge targets at 2 and 4 weeks (new risk)	-	-	-	-	High 20
<a href="#">3480</a>	Patient Safety - Delivery of 4 SPSP Workstreams. (Safety Measures in Quality Report)	High 16	High 16	High 16	High 16	High 16
<a href="#">3455</a>	Health & Safety – Management of Violence & Aggression. (Reported at H&S Committee, via Staff Governance Committee Minutes)	Medium 9	High 15	High 15	High 15	High 15
<a href="#">3211</a>	Achievement of National Waiting Times Targets (Standing Board Agenda item under Performance Report)	High 12	High 12	High 12	High 12	↑ High 16
<a href="#">3454</a>	Patient Experience – Management of Complaints and Feedback. (Complaints reporting and Person-Centred Culture Programme reported to Board)	High 12	High 12	High 12	High 12	↑ High 16
<a href="#">3527</a>	Medical Workforce Sustainability	High 16	High 16	High 16	High 16	High 16
<a href="#">3567</a>	Health & Social Care Integration	High 16	High 16	High 16	High 16	↓ Medium 9

3.3 Three risks removed from the Corporate Risk Register are to be reviewed by the Risk Management Steering Group (RMSG):-

- Two at a divisional level with respect to Facilities being for purpose and Road Traffic Management, with the agreement to discuss in April at the RMSG any risk that cannot be managed at divisional level.
- One risk concerning information management across cost, quality and activity, which will be reviewed following a diagnostic piece of work led by Strategic Planning.

- 3.4 A number of emerging risks are being examined by the RMSG in June 2015, for inclusion in the Corporate Risk Register. These include General Practice Workforce Sustainability, Nursing Workforce Sustainability and Compliance with Mandatory Training.
- 3.5 The Audit & Risk Committee have asked for the top four risks to be reviewed by the RMSG as it was the committee's view that not all those risks graded at Very High 20 are the same. This review is in progress.
- 3.6 Review of NHS Lothian Risk Registers

In June 2014, the Audit & Risk Committee approved a review of NHS Lothian's risk management system using the Audit Scotland Best Value Toolkit for Risk Management. The review methodology included a review of documentation and discussions with RMSG members and senior management teams to assess current strategy and practices against Audit Scotland's matrix and identify opportunities for improvement. Discussion sessions were held with a sample of senior/clinical teams and relevant risk registers were reviewed.

- 3.6.1 The review has been completed and the findings have been presented to the March 2015 RMSG and an improvement plan agreed, prior to submission to the June 2015 Audit & Risk Committee.
- 3.6.2 A Clinical Governance internal audit report was presented to the February 2015 Audit & Risk Committee which concluded that the controls NHS Lothian has in place to manage clinical governance are adequate and operating effectively. It recognised that a review of risk registers was taking place as set out above. An Internal Audit management action is to ensure that a routine process for updating divisional risks is part of the review and this action will be reflected in the improvement plan.

- 3.7 Risk Appetite Reporting Framework

NHS Lothian's Risk Appetite Statement is:-

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

The Board agreed in August 2014 to report Lothian's Risk Appetite against the 2013/14 Corporate Objectives at each meeting using the table below.

Table 2

	Current Status	Current Position	Data Report
<b>Corporate Objective 1 – Improving Patient &amp; Staff Safety. Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>Scotland target to reduce acute hospital mortality by 20% (Scotland-14.4%) with a tolerance of 15-20% by Dec 2015 <sup>1</sup></li> </ul>	Green	12.7%	Quality Report (Graphs 7-9)
<ul style="list-style-type: none"> <li>Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015</li> </ul>	Green	99.7%	Patient Safety Programme Annual Report (July)
<ul style="list-style-type: none"> <li>Achieve 184 or fewer SAB by March 2015 with a tolerance of 95% against target. n=193 to 184</li> </ul>	Red	284 (as at Mar 2015)	Quality Report (Graph 12) HAI report on Board Agenda
<ul style="list-style-type: none"> <li>Achieve 262 or fewer C.Diff by March 2015 with a tolerance of 95% against target. n=275-262</li> </ul>	Red	393 (as at Mar 2015)	Quality Report (Graph 11) HAI report on Board Agenda
<ul style="list-style-type: none"> <li>Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015</li> </ul>	Green	20%	Quality Report (Graph 15)
<ul style="list-style-type: none"> <li>Reduce staff harm – to be agreed with executive lead</li> </ul>	Tbc		
<b>Corporate Objective 2 – Improving Patient &amp; Staff Experience. Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>95% of patients would rate their care experience as good/very good, with a tolerance of 93-95%</li> </ul>	Green	98%	In-depth patient surveys, Person Centred Culture paper
<ul style="list-style-type: none"> <li>90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%</li> </ul>	Tbc	Tbc	To be collected
<ul style="list-style-type: none"> <li>Staff absence below 4% with a 5% tolerance (4-4.2%)</li> </ul>	Red	4.8%	Quality Report (Graph 6)
<b>Corporate Objective 3 – Improving the way we deliver Scheduled Care. Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%</li> </ul>	Green	86.1%	Scheduled Care Report
<ul style="list-style-type: none"> <li>95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%</li> </ul>	Green	90.5%	Quality Report (Graph 18)
<b>Corporate Objective 4 – Improving the way we deliver Unscheduled Care. Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%</li> </ul>	Red	94%	Quality Report (Graph 17) Unscheduled Care report on Board Agenda
<ul style="list-style-type: none"> <li>No of patients will wait no more than 14 days to be discharged by April 2015 with a tolerance of 13 to 14 days</li> </ul>	Red	84	Quality Report (Graph 5)
<ul style="list-style-type: none"> <li>No of patients will wait no more than 28 days to be discharged from hospital by April 2015 with a tolerance of 26-28 days</li> </ul>	Red	57	Quality Report (Graph 5)

<sup>1</sup> This is a Scotland-wide target which NHS Lothian will contribute to.

	Current Status	Current Position	Data Report
<ul style="list-style-type: none"> <li>90% of all stroke patients to be admitted to stroke unit on day of admission following a stroke with a tolerance of 85-90%</li> </ul>	Red	73.3%	Quality Report (Graphs 19-21)
<b>Corporate Objective 6 – Protect and Improve Health in Lothian for all. Medium Risk Appetite</b>			
<ul style="list-style-type: none"> <li>To deliver 7,001 quits successful quits at 12 weeks post-quit in the 40% most deprived within board SIMD areas, i.e. the bottom two local SIMD quintiles over the 1 year ending March 2015, with a tolerance of 40-43%</li> </ul>	Red	43%	Performance Report on Board Agenda
<ul style="list-style-type: none"> <li>80% of pregnant women have access to antenatal care by 12<sup>th</sup> week by March 2015, with a tolerance of 70-80%</li> </ul>	Green	84%	Performance Report
<b>Corporate Objective 7 – Ensure the delivery of a sustainable financial framework. Medium Risk Appetite</b>			
<ul style="list-style-type: none"> <li>In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%</li> </ul>	Green	£4,150k underspend at period 12 (inc. unachieved LRP), equating to 2.83%	Period 12 Finance Report Finance report on Board Agenda
<ul style="list-style-type: none"> <li>For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%</li> </ul>	Green	£244k underspend for the year-to-date (inc. unachieved LRP) equating to 0.02%	Period 12 Finance Report

3.7.1 The above reporting would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4).

#### 4 Key Risks

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

#### 5 Risk Register

5.1 Not applicable.

#### 6 Impact on Health Inequalities

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

## **7 Resource Implications**

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

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### **List of Appendices**

Appendix 1: Summary of Corporate Risk Register  
Appendix 2: Corporate Objectives - Rationales for Tolerances

NHS Lothian Corporate Risk Register

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
1076	1:Improving Patient Safety	Healthcare Associated Infection	<p>Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment.</p>	<p>•NHS Lothian has an Infection Prevention &amp; Control Service to provide access to specialist knowledge. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid &amp; East and West Lothian) established to cover both acute and community settings.</p> <p>•The UHS and CHP Infection Prevention and Control Committees are in place and report to the board through LICAC.</p> <p>•IT based system in place to facilitate the IPCN to monitor incidences of HAI within their clinical remits and to monitor for trends and patterns. SPSP have provided a collection of tools to support good practice to minimise potential for HAI risk to patients. IPCNs work collaboratively with clinical teams and bed management to provide advice and guidance on isolation and restriction of patient movements to balance the risk of transmission and impact on patient flow.</p> <p>•IPCNs communicate directly with clinical services, escalating as appropriate. SAB and CDI rates are reported weekly and monthly through IPCT reports which are sent by email and available on intranet. At senior management level there is CMG, Healthcare Governance and board papers. All incidences of SAB &amp; CDI are investigated, clusters of 2 or more have further investigations for links and SBARs are provided to report findings and advise of any recommendations. Systems are in place to escalate investigations. HAI Matrix utilised to identify reporting level HAI-ORT. Communications provide support to manage public release of information as required.</p> <p>•Packages of audits are in place to monitor standards and are currently being updated and linked to the National Standard Infection Control Precautions Chapter.</p> <p>•HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro and the Education Strategy is available on line.</p> <p>•There is a Decontamination Operational Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/15</p> <p>Recommended Risk Grade/Rating increased to High/20</p> <p>Range of evidence to support increase:</p> <ul style="list-style-type: none"> <li>• Not achieving HEAT target for SABs &amp; C.Diff</li> <li>• Benchmarking C.Diff illustrates not seem reduction in comparison to other Boards</li> <li>• Impacts on experience and outcome – LoS</li> <li>• Risk appetite in the Red</li> <li>• Date risk Opened 11/06/2007</li> </ul> <p>December 2014: Risk has been reviewed and remains as High Risk. Based on current trends NHS Lothian is unlikely to achieve either of the HEAT Targets for HAI inspections. Action plan has been updated</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 6	Sarah Ballard-Smith	Healthcare Governance Committee



ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3600	7:Ensure the Delivery of a Sustainable Financial Framework	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	<p>NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target.</p> <p>On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years.</p> <p>The December 2014 Finance Board paper update the Board on the current financial challenge.</p> <p>If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.</p>	<p>The Board has already established a financial governance framework and systems of financial control.</p> <p>Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.</p> <p>NHS Lothian is currently reliant on non-recurring efficiency savings. A detailed Action Plan, attached to this risk, is in place and is regularly reviewed by the Senior Finance Team.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/2015</p> <p>Risk grade/rating increased to High/20</p> <p>Range of evidence to support increase:-</p> <ul style="list-style-type: none"> <li>• Risk appetite in the Red</li> <li>• Reliance on non-recurring strategy</li> <li>• Date risk opened 23/04/2014</li> </ul> <p>January 2015 - Risk Reviewed. Description and Controls updated. Adequacy of control - Action plan is in place and regularly reviewed to mitigate against this risk.</p>	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3203	4: Improve the way we deliver Unscheduled Care	Unscheduled Care: 4 hour Performance	<p>There is a risk that patients are not seen in a timely manner who require emergency care as required by the Emergency Care standard of 98% resulting in sub optimal care experience and outcome.</p>	<p>A range of governance controls are in place for Unscheduled Care notably:</p> <ul style="list-style-type: none"> <li>- Bi monthly Unscheduled Care Board meeting jointly chaired by the Director of Health &amp; Social Care (City of Edinburgh Council) and NHS Lothian's Director for Unscheduled Care – Oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area.</li> <li>- This is supplemented by further governance arrangements including quarterly Formal SMT meetings and fortnightly Informal SMT meetings. Both are chaired by the Director for Unscheduled Care.</li> <li>- The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis.</li> <li>- Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, StJ).</li> <li>- Upward reporting to Acute Hospitals Committee</li> </ul> <p>A number of performance metrics are considered and reviewed, including:</p> <ul style="list-style-type: none"> <li>- 4 hour Emergency Care Standard and performance against trajectory</li> <li>- 8 and 12 hour breaches</li> <li>- Attendance and admissions</li> <li>- Delayed Discharge</li> <li>- Boarding of Patients</li> <li>- Winter Planning</li> <li>- Length of Stay (LOS)</li> <li>- Cancellation of Elective Procedures</li> <li>- Finance</li> </ul> <p>Adherence to national guidance/ recommendations</p> <p>NHS Lothian's strategic Local Unscheduled Care Action Plan (LUCAP) 2</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/15. Controls updated.</p> <p>Increasing pressures on patient flow due to number of delayed discharges continues to hamper performance.</p> <p>Additional winter capacity to be made available (Jan- Mar) to deal with anticipated heightened demand. This includes the opening of beds at Gylemuir House, a joint venture with City of Edinburgh Council</p> <p>LUCAP 2 approved by Scottish Govt with Quarterly update undertaken as at September. Next update due by 23<sup>rd</sup> January 2015.</p> <p>Significant work has been undertaken during 2014 in supporting a range of service redesign initiatives within unscheduled care services. These outputs will inform proposals to be submitted to NHS Lothian Board in February 2015.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Melanie Johnson	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3726	4: Improve the way we deliver Unscheduled Care	Unscheduled Care: Delayed Discharge	<p>There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.</p>	<p>A range of governance arrangements are in place for Unscheduled Care notably:</p> <ul style="list-style-type: none"> <li>The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis.</li> <li>Quarterly Formal SMT meetings and fortnightly Informal SMT meetings. Both are chaired by the Director for Unscheduled Care</li> <li>Acute Hospitals Committee</li> <li>Further weekly briefings to the Scottish Government on performance across Lothian (data analysis from EDISON).</li> </ul> <p>A number of performance metrics are considered and reviewed, including:</p> <ul style="list-style-type: none"> <li>- Attendance and admissions</li> <li>- No. of Delayed Discharges ( by Local Authority Area)</li> <li>- Length of Stay (LOS)</li> <li>- Bed Days Lost</li> <li>-</li> </ul> <p>NHS Lothian strategy to improve unscheduled care performance – Local Unscheduled Care Action Plan (LUCAP) which includes joint working.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/15. Controls updated.</p> <p>The number of Delayed Discharges (DD) continues to cause concern</p> <p>Additional winter capacity has been approved (Jan-Mar) to deal with the anticipated heightened demand. This includes the opening of beds at Gylemuir House, a joint venture with City of Edinburgh Council</p> <p>Action to help tackle DD across NHS Lothian include:</p> <ul style="list-style-type: none"> <li>Creation of Community Clinical Support Workers</li> <li>Hospital to Home' pilot in partnership with a voluntary organisations</li> <li>Rapid Elderly Assessment Team (REACT) service in West Lothian</li> <li>Comprehensive Assessment for Elderly People COMPASS (Edinburgh)</li> <li>Implementation of 'Discharge to Asses' models</li> <li>Discharge Hubs in the Royal Infirmary of Edinburgh, the Western General Hospital and St John's Hospital</li> <li>Orthopaedic Pathway Review</li> <li>Joint Venture with CEC to create additional bed capacity at Gylemuir</li> <li>implementation of the 'Moving On' guidance</li> </ul> <p>New Monthly Reports to Scottish Government outline the action being taken by each of the 4 Local Authorities to tackle increasing delays within the system. This follows the allocation of central monies to support joint Health/ Local Authority proposals to improve overall performance.</p> <p>The controls in place are not effective as illustrated by non compliance with national targets. In response the risk has been regarded to Very High 20</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Melanie Johnson	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3480	1: Improving Patient Safety	Delivery of SPSP Work Programme	There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm	<ul style="list-style-type: none"> <li>The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety.</li> <li>Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response.</li> <li>The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring.</li> <li>Incident Management Policy and Procedure (2011).</li> <li>Quality Improvement Strategy (2011-14) sets out a range of improvement programmes to improve safety and outcomes of care.</li> <li>Quality of care which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit &amp; Risk Committee and HCG Committee when appropriate.</li> <li>Quality Assurance Mechanism proposed to validate self reporting of patient safety data</li> <li>Quarterly visit by HIS to discuss progress actions</li> <li>Adverse Event Improvement Plan in place monitored via HCG</li> <li>Quality Management Group at the Board initiated to strengthen governance, monitor and inform improvement of a range of improvement programmes including Patient Safety Programme.</li> <li>Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly.</li> <li>Single System medicines reconciliation group.</li> </ul>	<p>Updated and reviewed at A&amp;R Committee 17/02/2015</p> <p>Risk grade/rating to remain High/16</p> <p>Risk to be renamed to link to Delivery of SPSP Work Programme to reflect description.</p> <ul style="list-style-type: none"> <li>There is a range of evidence from process and outcome indicators that shows improvements are still required around reliability of safety essentials and outcomes related to priority workstreams, e.g. pressure ulcers.</li> <li>Harm impacts on experience, outcome, LoS, etc</li> <li>Date risk opened 07/05/2013</li> </ul>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Dr David Farquharson	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3211	3: Improve the way we deliver Scheduled Care	Achievement of National Waiting Times Targets	<p>There is a risk of:</p> <p>Lack of management of national waiting times targets for a number of reasons due to lack of core capacity or appropriate use of what is available</p> <p>Overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money.</p> <p>Lack of robust management process and staff capability to deliver consistent management of waiting lists.</p> <p>Risk of adverse publicity relating to failure to meet waiting times targets.</p>	<p>Monthly Access Performance and Government Group meeting chaired by Director of Scheduled Care oversees this area. These are supplemented by weekly scheduled reviews between this Director and Directors of Operations.</p> <p>It considers:</p> <ul style="list-style-type: none"> <li>• Performance against trajectory across a range of measures (including waiting time standards)</li> <li>• Finance</li> <li>• Governance position, in terms of adherence to national guidance and local access policy/SOPs</li> </ul> <p>This meeting reports to the Acute Services Committee with a comprehensive overview provided in September 2014.</p> <p>The approach to recovering the waiting time position is outlined in Delivering for Patients, due to be considered at the Board in February 2014.</p> <p>Papers on CAMHS and psychological therapies presented to the Board in June outlining difficulties in delivering standards of 18 weeks coming into force in December. Further investments were approved.</p> <p>The December 2014 Board meeting heard that the DFP trajectories would not be delivered as specified and additional financial support was required to maintain waits at their current level. A decision on additional support is to be considered in light of updates on the financial forecast for 2014/5.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/2015</p> <p>Risk Grade/Rating increased to High/16</p> <p>Rationale:</p> <ul style="list-style-type: none"> <li>• Data available shows non-compliance with targets and the Board has been asked to make a decision about resource to address the current situation.</li> <li>• Impacts on Experience, Safety and Efficiency.</li> <li>• Date risk opened 02/04/2012</li> </ul> <p>December 2014: Risk Reviewed – Controls and Action Progress updated</p>	Satisfactory, controls adequately designed to manage risk and working as intended	High 16	Low 1	Jim Crombie	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3454	2: Improve Patient and Staff Experience	Management of Complaints and Feedback	<p>There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.</p>	<p>The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care.</p> <ul style="list-style-type: none"> <li>• The Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response.</li> <li>• The Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care.</li> <li>• Delivering Better Care commitments have been agreed and plans are now in place to deliver on the required actions from the HIS Older People's review and the updated vulnerable Patient's Quality Improvement Framework. This activity is reported to the Board through the Executive lead. These plans are informed by inspection reports produced by Healthcare Improvement Scotland, local audit and regular checks i.e. PQI, mock OPAH ,frailty bundle audit and via the Clinical manager ward assurance checklists. The tools in use have been adapted and updated to reflect the person centred agenda.</li> <li>• Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit &amp; Risk Committee and Healthcare Governance Committee</li> <li>• The Delivering Better Care established on 2012 as a resource for staff (primarily nursing) but where appropriate, other disciplines continue to deliver support to clinical areas on the key ambitions of harm reduction work is now on going to streamline programmes of work for 2015/16 working more closely with Clinical Governance and using improvement methodology.</li> <li>• As part of the improving care to vulnerable patient's support manual with detailed information inclusive of a rapid patient essential care check sheet was implemented within acute and community In patient facilities during 2013 and has recently been reviewed and the e-version on all PC's has been updated.</li> <li>• The National Person Centred &amp; Care Collaborative is a key priority for NHS Lothian with the aim of capturing and responding to patient, carer and staff experience and the Quality Improvement Plan was approved by NHS Lothian Board in October 2014. The aim of the collaborative is to ensure all patients receive a positive experience and get the outcome they expect (by Dec 2015). This will be demonstrated in a number of ways which will include a specific measure of 905% achieved. A local collaborative will take place in February 2015 and will link patient and staff experience to develop a 'person centred culture' across our organisation. Following a visit to Northumbria, NHS L are testing their questionnaire in a number of different in-patient areas.</li> <li>• A review and update of "Tell us Ten Things" TTT questionnaire was undertaken during November 2014 to ensure the questions map to the '5 must do with me' elements of the PCHC Collaborative.</li> <li>• Enhanced reporting arrangements will be put in place via the Healthcare Governance Committee and NHS Lothian Board - the first of which will be for the January 2015 HCG Committee.</li> <li>• Funding to support this for 2015/16 has been confirmed by Scot Gov, NB does not cover all costs.</li> </ul> <p><b>Rationale for Adequacy of Controls</b> is through the newly developed quality management group discussions are ongoing.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/2015</p> <p>Risk Grade/Rating increased to High/16 Replace title of risk with 'Management of Complaints and Feedback'</p> <p>Rationale:</p> <ul style="list-style-type: none"> <li>• The aspect of this current risk that is not being managed and requires Board action is the management of complaints and feedback which has been highlighted by the Board.</li> <li>• Review taking place. Once plan in place, this risk will be reviewed.</li> <li>• Acknowledgment that patient experience runs through the vast majority of the corporate risks.</li> <li>• Date risk opened 13/02/2013</li> </ul> <p>December 2014: Risk Reviewed and controls updated.</p> <p>Funding for 2015/16 has been identified to continue elements of improvement work and in conjunction with the DBC hub and Clinical Governance discussions are on going as to how the work of the DBC Hub and the emerging Quality Improvement hub will progress this will include discussions on how funding will be allocated. The vulnerable Patients Quality Improvement Framework has been revisited in light of the OPAC September 14 self assessment, the document has been made more user friendly with a supporting Driver diagram .NHS Lothian are anticipating a HIS Visit in April 2015 with HIS using new scrutiny process ,a workshop to prepare CMT's is to be held in January 2015 and all CMT's have identified a virtual group to progress this work. Feedback from previous patient experience surveys have been fed back to the local teams. NHS Lothian Board have approved the Person Centred Culture QI Plan and a local collaborative will take place in February 2015. The patient Quality Indicator tool (PQI) has been reviewed and now also incorporates Person centred questions. The Jan HCG paper will include reporting of TTT and the in-depth patient experience surveys</p> <p>Adequacy of controls changed to Inadequate following discussion at Risk Management Steering Group.</p>	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Melanie Johnson	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3527	8: Ensure the Delivery of a Sustainable Workforce Framework	Medical Workforce Sustainability	<p>There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff.</p> <p>Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics &amp; Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.</p>	<ul style="list-style-type: none"> <li>•In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk.</li> <li>•For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG.</li> <li>•A report is taken to each Board meeting updating the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. The main challenges have been in Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Radiology and Medicine for the Elderly.</li> <li>•For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures.</li> <li>•A Medical Workforce Group has been established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model.</li> </ul>	<p>Updated and reviewed at A&amp;R Committee 17/02/2015</p> <p>It was agreed to keep this risk on the Corporate Risk Register.</p> <p>January 2015: Risk Reviewed and action updates. Risk Grade/Rating remains as High/16.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Dr David Farquharson	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3455	1: Improving Patient Safety	Management of Violence & Aggression	There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being.	<ul style="list-style-type: none"> <li>• Closed loop Health &amp; safety management system in place.</li> <li>• Robust H&amp;S Committee structure.</li> <li>• H&amp;S policies and procedures in place (attached document).</li> <li>• Competent specialist H&amp;S advice in place. Robust Occupational Health Services. Learning lessons through incident investigation.</li> <li>• Director of Occupational Health &amp; Safety/Occupational Physician delivers an annual report to the NHSL H&amp;S Committee with specific actions within these reports.</li> </ul> <p>ROSPA QSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/2015</p> <p>Risk Grade/Rating remains at High/15 Risk title changed to 'Management of Violence &amp; Aggression'</p> <p>Rationale:</p> <ul style="list-style-type: none"> <li>• This is a very generic risk</li> <li>• The H&amp;S risk which is not being managed at executive level is that of management of violence and aggression. Support by both data and HSE involvement.</li> <li>• Date risk opened 13/02/2013</li> </ul> <p>December 2014: Risk Reviewed and updated.</p> <p>"Risk - Health &amp; Safety ID 3455, has remained at orange as the RMSG previously agreed to include the "threat of prosecution" as a significant risk factor and we were subsequently prosecuted and fined on 2 counts of breach of H&amp;S legislation last year and will most probably be prosecuted in the future following the 2009 WGH fatal traffic accident. We were lucky not to be prosecuted following the SJH Labs ruptured copper pipe incident.</p> <p>In addition, over the previous few years we have received a number of HSE Enforcement Notices due to the NHS Lothian failure to implement closed loop H&amp;S management systems (ie controls are adequately designed but not effectively implemented) as Policies are not implemented or compliance checked, risks are not adequately assessed and controlled at local level by trained / competent local managers, control implementation is not checked and assured by appropriate site inspections, incidents are not investigated to identify immediate and underlying causes then action planned to prevent recurrence etc etc.</p> <p>Until there is robust evidence that interventions are resulting in a reduction of measurable negative outcomes (such as reduced harm incidents reported and lost time due to injury and illness) then this risk must remain at the current rating".</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 15	Medium 6	Alan Boyter	Staff Governance Committee



ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Assurance
3567	11: Improve Integration - Integrated Joint Boards	Health & Social Care Integration	There is a risk that the Board and its Partners fail to submit agreed integration plans that satisfy the Scottish Government requirements to agreed timescales resulting in a failure to meet its legal responsibilities (Public Bodies Joint Working Act)	<ul style="list-style-type: none"> <li>•A leadership group with the NHS Lothian CEO and Chair has been in Edinburgh to oversee the development of that particular integration scheme</li> <li>•Integration of Health and Social Care Plan Lothian Leadership Group</li> <li>•Named leads for the writing of the Integration Schemes in each area</li> <li>•Nominated leads for the development of each key section</li> <li>•Common text produced for development in each Local Authority area</li> <li>•Structured engagement with senior staff in the Health Board and Local Authority in East, Mid and Edinburgh</li> <li>•First set of Regulations published in October. Integration Schemes developed in response.</li> <li>•Plans will be open to consideration by the three governance committees during the consultation.</li> <li>•The Board will adopt the "body corporate" integration model (Section 1(4)(a) of the Act) in all four integration schemes</li> <li>•The Board has agreed the functions that must be delegated as defined in the current version of the draft Regulations</li> <li>•Edinburgh Leadership Group established to oversee the Integration Scheme and establishment of the Integration Joint Board</li> <li>•Executives and officers from West Lothian Council and NHS Lothian working to produce an Integration Scheme agreeable to both organisations</li> <li>•The Board has approved the East and Midlothian Schemes for consultation</li> <li>•The Board will consider the Edinburgh and West Lothian Integration Schemes on January 14th.</li> </ul> <p><b>Rationale for Adequacy of Controls:</b> The Scottish Government have issue the final regulations, guidance and orders in relation to health and social care integration. Integration Schemes drafted and all now expected to be out for consultation by January 15th.</p>	<p>Updated and reviewed by A&amp;R Committee 17/02/2015</p> <p>Risk grade/rating reduced to Medium/9</p> <p>Rationale:</p> <ul style="list-style-type: none"> <li>• Clear understanding of actions to be taken.</li> <li>• Integration schemes progressing within set Scottish Government timelines and guidance.</li> <li>• Date risk opened 16/01/2014</li> </ul> <p>January 2015: Risk Reviewed and Controls Updated.</p> <p>Adequacy of controls is now more adequate than previously reported but there is still potentially a risk that the West Lothian Scheme will not be approved by the Health Board or that the changes required by the Health Board in the Scheme will not be approved by the West Lothian Council. This risk is lower in the other three areas.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Medium 9	Low 3	Alex McMahon	NHS Lothian Board

## **Corporate Objectives – Rationales for Tolerances**

### Corporate Objective 1 - Improving Patient and Staff Safety (Low Risk Appetite)

1. High reliable organisations within Health and outwith Health consider safety improvement a key organisational priority.
2. National indicators and targets for the Patient Safety Programme and Health Protection Scotland are as follows:-
  - Reduce Acute Hospital Mortality by 20% by December 2015 (SPSP)
  - Achieve 95% harm free care by December 2015 (SPSP)
  - To achieve 184 or less SAB by March 2015 (HEAT)
  - To achieve 254 or less CDI by March 2015 (HEAT)
  - Reduce falls with harm by 20% by December 2015 (SPSP)
3. NHS Lothian has determined a low risk appetite to achieving this objective and accordingly the following which equals a set of targets and tolerance ranges are set out below:
  - Reduce Acute Hospital Mortality by 20% but will tolerate 15% by December 2015
  - Achieve 95% harm free care but will tolerate a range of 93-95% by December 2015
  - Will achieve 184 SABS by Mar 2015 but will tolerate not achieving this target by 5%. 184-193 which equates per month to 15-16 cases.
  - Will achieve 254 CDI by March 2015 but will tolerate not achieving this target by 5%. 262-275 which equates per month to 22-23 cases.
  - Reduce falls with harm by 20% by December 2015 but will tolerate a 15-20% reduction
  - Reduction in staff harm to be agreed with executive lead

### Corporate Objective 2 - Improving Patient & Staff Experience (Low Risk Appetite)

1. “High Reliable Organisations” report benchmarks for positive customer/staff feedback at 95%
2. NHSL has determined a low risk appetite for Patient/Staff Experience, compared to Finance.
3. Accordingly, the Board has set a Target of 95% for this measure – this is the level the Board strives to achieve as a minimum
4. The Board is however prepared to “tolerate” a range of 93-95% as acceptable (“green”) for reporting purposes.

### Corporate Objective 3 - Improving the way we deliver Scheduled Care (Low Risk Appetite)

There are national performance targets around the management of scheduled care. The Board has determined a low risk appetite for improving the way we deliver scheduled care. Accordingly, the Board has set the target in line with the national target, but will tolerate a range of 5% below target as acceptable (green) for reporting.

**Corporate Objective 4 - Improving the way we deliver Unscheduled Care (Low Risk Appetite)**

There are national performance targets around the management of unscheduled care. The Board has determined a slightly higher risk appetite for improving the way we deliver unscheduled care. Within the context of national targets, the Board has set the target in line with the national target. It is however prepared to tolerate a range of 5% below the target as acceptable (green) for reporting. Key targets will be reported in the risk appetite reporting table to the Board.

**Corporate Objective 5 - Develop whole system capacity to deliver care closer to home (Medium Risk Appetite)**

This is a new objective directly related to milestones/objectives in the Clinical Strategic Framework and as such its targets are to be agreed.

**Corporate Objective 6 - Protect and Improve Health in Lothian for all (Medium Risk Appetite)**

Improving health of the population is seen as a long-term strategic objective and as such NHS Lothian risk appetite is slightly higher. There are key national targets for Health Improvement, however, NHS Lothian will tolerate a range 10% below target for key indicators reported in the Risk Appetite Reporting Framework.

**Corporate Objective 7 - Ensure the delivery of a sustainable financial framework (Medium Risk Appetite)**

The Board has set a slightly higher risk appetite with respect to delivery of financial balance and Finance have proposed two indicators for financial reporting that are in the reporting framework.

**Corporate Objective 8 - Ensure a Sustainable Workforce Framework (Medium Risk Appetite)**

This objective is a new objective but is key to the Clinical Strategic Framework and as a consequence has a higher risk appetite of medium as previously agreed by the Board in February 2014. There are a number of objectives/targets being developed and they will set the Board target and tolerance range.

Corporate Objectives 9, 10, 11, 12 are in a developmental stage and as such have not been included in the Risk Appetite Reporting Framework to the Board.

Board Meeting  
24 June 2015

Director of Human Resources & Organisational Development

**SUMMARY PAPER - HUMAN RESOURCES AND ORGANISATIONAL STRATEGY: JULY 2015 TO MARCH 2018**

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

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

<ul style="list-style-type: none"><li>• Consistent with Scottish Government Workforce Vision: Everyone Matters</li></ul>	3.3
<ul style="list-style-type: none"><li>• Designed in Partnership with the Trades Unions/Professional Organisations</li></ul>	7.2
<ul style="list-style-type: none"><li>• Approved by the Staff Governance Committee</li></ul>	7.4
<ul style="list-style-type: none"><li>• HR/OD Strategy to July 2015 to March 2018</li></ul>	Appendix 1
<ul style="list-style-type: none"><li>• Action Plan to support delivery of the HR/OD Strategy</li></ul>	Appendix 2

Alan M Boyter  
Director of Human Resources and Organisational Development  
8 June 2015  
[alan.boyter@nhslothian.scot.nhs.uk](mailto:alan.boyter@nhslothian.scot.nhs.uk)

# **NHS Lothian**

Board Meeting  
24 June 2015

Director of Human Resources & Organisational Development

## **HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT STRATEGY: JULY 2015 TO MARCH 2018**

### **1 Purpose of the Report**

- 1.1 The purpose of this report is to allow the Board the opportunity to receive and approve the Human Resources and Organisational Development Strategy.

### **2 Recommendations**

- 2.1 It is recommended that the Board approve the Human Resources and Organisational Development Strategy for the period July 2015 to March 2018.

### **3 Discussion of Key Issues**

- 3.1 Healthcare is delivered through people. NHS Lothian employs approximately 26,000 people across 700 square miles. In the last 10 years NHS Lothian has had an HR/OD Strategy setting out our approach to the management, development and leadership of our most important asset our people.
- 3.2 The extant HR/OD Strategy expired March 2014 however the Board agreed to continue that Strategy until December 2014. The attached strategy sets out the proposed HR/OD Strategy for the period to March 2018.
- 3.3 The format of this strategy has been designed to be shorter, sharper and more focussed than previous iterations. The chapter headings have been chosen to map across to the NHS Scotland 2020 Workforce Vision documentation often referred to as the Everyone Matters: 2020 Workforce Vision. The format is designed to be easy to read and clear in its objectives.
- 3.4 The action plan to support delivery of the strategy is detailed in Appendix 2.

### **4 Key Risks**

- 4.1 The key risk is that the Board does not approve the Strategy and that there is no overall overarching approach to ensuring a healthy organisational culture, a sustainable trained workforce with appropriate capability, working in an integrated manner to deliver high quality services to patients.
- 4.2 Confirming the importance of the effective leadership and management of a large and diverse workforce to support the delivery of the Board's objectives is a primary concern.

## **5 Risk Register**

5.1 Workforce risks are identified as appropriate in the Risk Register. There are no additional risks anticipated as a result of this strategy.

## **6 Impact on Inequality, Including Health Inequalities**

6.1 An impact assessment will be carried out and the results reported through the Staff Governance Committee.

## **7 Involving People**

7.1 Senior HR/OD staff and the Area Clinical Forum were consulted on this strategy.

7.2 The strategy was designed in partnership with the trades unions/professional organisations.

7.3 The strategy as approved by the Lothian Partnership Forum at the November 2014 meeting.

7.4 The strategy was approved by the Staff Governance Committee at the April 2015 meeting.

## **8 Resource Implications**

8.1 There are no resource implications directly attributed to the approval of this strategy.

8.2 Individual work streams ongoing or new in respect of any actions required to support the implementation of this strategy will be subject to the usual financial governance processes and procedures.

Alan M Boyter

Director of Human Resources and Organisational Development

8 June 2015

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## **List of Appendices**

Appendix 1: Human Resources & Organisational Strategy July 2015 - March 2018

Appendix 2: Action Plan

# Human Resources and Organisational Development Strategy June 2015 – March 2018





Welcome and Introduction from  
**Alan Boyter**, Director of Human  
Resources and Organisational  
Development

## Welcome and Introduction

Welcome to the 2015 – 2018 NHS Lothian Human Resources and Organisational Development (HR/OD) Strategy. This is the fourth HR/OD Strategy; the previous strategies covering the periods 2005 – 2008, 2008 – 2011, 2011 – 2014. Much has happened in the life of this healthcare system over recent years. Despite an increase in resources year on year, demand continues to grow and the financial resources do not keep pace with health inflation. For example, in the financial year 2015/16 we anticipate an increase of £29.7m recurring resources. With health inflation and predicted costs of paybill, pharmaceuticals and supplies increasing, as a healthcare system we will need to deliver £40m in efficiency savings in order to live within the resources available to us.

NHS Lothian is one of 22 healthcare systems in NHS Scotland. As such we are committed to delivering the Scottish Government 2020 Healthcare Quality Strategy, of safe, person-centred, effective and efficient care for people. This Human Resources and Organisational Strategy is designed to support the delivery of the Board's overall Clinical Framework. It recognises Scottish Government intentions in relation to the integration of health and social care and is aligned to the Scottish Government's 2020 Workforce Vision entitled "Everyone Matters."

In relation to the Human Resources, Organisational Development, Occupational Health, Health and Safety and Communications teams our vision is to support line managers by providing expert services, systems and advice to enable them to lead, manage and change how we provide services for patients, carers and their families. This HR/OD Strategy is one of two main strategies which support the delivery of the Strategic Plan. The other is the Financial Plan. Given the demography/epidemiology and economic environment, the pace of change, advances in technology, people's expectations of the NHS and Scotland's public health, this strategy sets out our vision for the workforce for the next three years. In relation to previous HR/OD strategies it sets out both continuity and change. This is a smaller and more focused document than in previous years. The cornerstone of employee relations in the NHS in Scotland is to work in partnership with the trades unions/professional organisations and during the life of the strategy we will continue to work with staff-side colleagues to ensure that the partnership ethos is understood by all. This strategy has been subject to consultation and has the support of the Lothian Partnership Forum. Measurement of progress will take place and will be reported to the Board through the Staff Governance Committee.





Our vision is to have a healthy psychologically motivated, organisational culture, with a sustainable and capable workforce. Leadership and management of our people will be effective and conducted in a manner that improves patient and staff experience. Our staff will work in an integrated manner with our partners and in the context of our values. The values were developed following engagement with over 3,000 staff and they were agreed by the Board in July 2013. The values are as follows:

- Care and compassion
- Dignity and respect
- Quality
- Teamwork
- Openness, Honesty and Responsibility.

## Our Promise

The core purpose of HR is to provide specialist knowledge and expertise on HR policies, processes and solutions; this includes giving managers the tools they need to manage their own staff.

To build a workforce who are engaged, motivated and driven to provide excellent patient focused care and working environments.

We will continue to develop our web-based people management system (HR Online) which provides managers and staff with a consistent HR service 24 hours a day 7 days a week. This will be complemented by a new HR Advisory telephone service providing a single telephone number and email address for all HR enquiries. Senior HR professionals will continue to be aligned to sites, services and Health & Social Care Partnerships to work with Senior Management Teams on their Staff Governance Improvement Plans, and implementation of the HR Strategy.

We will seek feedback from our customers and put systems and processes in place to continuously improve what we do, taking cognisance of the clinical, financial and governance frameworks within which we operate.



## Monitoring and Governance

Progress will be monitored locally through the site, service and Health & Social Care Partnership Forums with quarterly reporting to the Lothian Partnership Forum using the staff improvement planning tool.

Six-monthly progress reports will be submitted to the Staff Governance Committee with an annual report to the Board. The Annual Staff Survey, Staff Governance Standard Assessment process, Investors in People and iMatter will also have a role to play in taking stock of progress.

## Framework for Delivery

The HR strategy will be delivered through five priorities for action:

**Healthy Engaging Organisational Culture:** By developing and sustaining a healthy organisational culture we will create the conditions for high quality health and social care through the development and implementation of a motivational strategy.

**Sustainable Workforce:** Our workforce will need to change to match new ways of delivering services and new ways of working. We need to ensure that people with the right skills, in the right numbers are in the right jobs. We also need to promote the health and wellbeing of the existing workforce and prepare them to meet future service needs.

**Capable Workforce:** All staff need to be appropriately trained and have access to learning and development to support the Quality Ambitions 2020 Vision for Health and Social Care and the Board's Strategic Plan.

**Integrated Workforce:** We need to make sure that the workforce is more joined up across primary and secondary care, and with partners across health and social care.

**Effective Leadership and Managers:** Our managers and leaders are part of the workforce and have a key role to play in driving service and culture change. They also need to be valued, supported and developed.

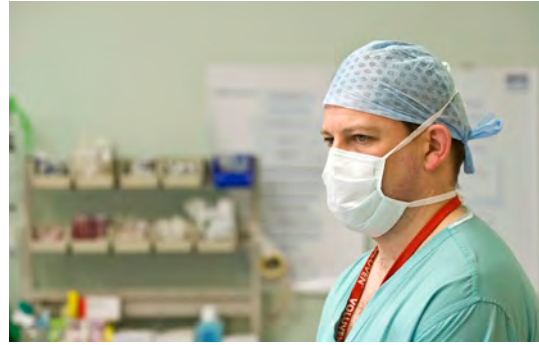
The detailed actions required to support each of the priorities during 2015 – 2018 are summarised in the tables below. The shaded sections relate to commitments set out in 'Everyone Matters: 2020 Workforce Vision' which the Board must comply with and the other actions are locally determined.

**Table 1 Healthy Engaging Organisational Culture**

- We will take action to ensure that staff are clear about the values and behaviours expected of them
- Incorporate behavioural competencies (which reflect our values) within recruitment, development and appraisal processes. Roll out the iMatter Staff Experience Continuous Improvement Model
- Ensure that local feedback and monitoring arrangements (from patients, staff, service users, etc) inform how well the core values are embedded
- Engage and involve staff in decisions that affect them.

- Build and enhance management capability and confidence to deliver an alternative approach to conflict and dispute resolution
- Agree targeted action plans for those areas where staff sickness is over 4%
- Develop a strategy for tackling the health and wellbeing issues associated with an ageing workforce
- Implement the Internal Communications Strategy to ensure staff are well informed and engaged
- Implement the NHS Lothian Equality Outcomes Framework 2013-17, the International Equity Standards programme and the Black and Minority Ethnic Nurses Progression Project
- Continue to work with education providers to ensure that in addition to staff having the technical competence to undertake their role, the vision and values of NHS Lothian are also embedded in their education programme
- Embed Rapid Impact Assessments at all levels in the organisation
- Implement the Health and Safety Strategic Plan
- Implement a revised Health and Safety Manual and Safe Management System
- Design and implement a revised Health and Safety Management System Audit
- Review and refresh the Occupational Health and Safety Service specification
- Commit NHS Lothian to becoming an accredited Living Wage Employer.

We will develop and support a Motivational Strategy in conjunction with NHS Lothian Psychology to ensure that we build and sustain a motivated workforce.



**Table 2 Sustainable Workforce**

- Review our workforce planning arrangements to ensure a joined-up, consistent approach so that all services are included and benefit from the process
- Demonstrate that workforce planning includes a long term perspective and supports new and emerging service delivery models
- Identify workforce issues and use this information to inform local workforce plans
- Put in place measures to provide high quality workforce data and identify a lead officer with responsibility for workforce data
- Ensure that workforce plans include an analysis of future education and training needs and that this is reflected in learning and development strategies
- Implement the good practice principles recommended by Audit Scotland in their 'Early Departures' report to ensure early release schemes are driven by the needs of our workforce plans.

- Ensure Consultant job plans match service demand and support 24/7 delivery. Consider extending the use of job plans to other staff who manage case loads (e.g. Nurse Consultants)
- Review the need for 24/7 staffing by clinical area and develop staffing models that match service demands
- Continue to develop medium to long term sustainable plans to address medical staffing pressures
- Continue to review supplementary staffing utilisation to enhance quality of care and reduce costs
- Consider and explore further developments in regional rationalisation for clinical and non-clinical areas to optimise opportunities for workforce availability and development
- Expand and develop the Band 1-4 workforce in clinical areas creating roles that are both patient-centred and provide a career structure
- Maximise opportunities for youth employment and socially responsible recruitment through academies, modern apprentice schemes, placement schemes and recruitment campaigns, working with voluntary and other public sector partners
- Ensure that succession planning takes account of the age profile and workforce demographics.

**Table 3 Capable Workforce**

- Ensure that appraisers and those being appraised understand the purpose of development reviews/appraisals, their individual and mutual responsibility for ensuring it is meaningful and that conversations review whether behaviours, decisions and actions reflect our shared values
  - Improve the confidence, capability and capacity of everyone involved in leading and practicing quality improvement
  - Provide fair and appropriate access to learning and development for support staff
  - Ensure that our learning and development strategy is developed in partnerships and addresses longer-term learning and development need up to 2020.
- 
- All staff will receive feedback on performance, including behaviours and will have a personal development plan
  - Implement the learning development strategy
  - Work collaboratively with other Health Boards to develop training programmes for small occupational groups, e.g. Oncology, Medical Physics and Perfusion.



## Table 4 Integrated Workforce

- Use the Health and Social Care guidance provided to inform the appointment of Chief Officers and other joint appointments
  - Continue local actions and development work to support integration of primary and secondary care
  - Make better use of existing mechanisms, such as community planning partnerships to identify opportunities to share resources including workforces.
- 
- Develop a joint workforce/organisational plan that aims to have a fully integrated workforce by 2020 for each Health and Social Care Partnership
  - Develop the skills and competencies we require for an integrated workforce (new roles, working together)
  - Develop joint organisational change processes for each Health and Social Care Partnership which meet staff governance standards
  - Explore and maximise opportunities for shared services across NHS Scotland and with other public sector partners.





**Table 5 Effective Leadership and Management**

- Plan to build local leaderships and management capacity and capability as part of our workforce plan to deliver the 2020 vision
  - Ensure that line managers at all levels are clear about their people management responsibilities and are held to account for how they carry out these responsibilities
  - Identify the development, training and support needs of line managers at all levels, particularly in relation to people management and dealing with difficult performance management conversations, and ensure these needs are met
  - Ensure that Heads and Managers at all levels understand and demonstrate the values and behaviours expected of them as well as their responsibilities in relation to the Staff Governance Standard and Quality Ambitions
  - Ensure Leaders and Managers are aware of and abide by national governance arrangements/structures
  - Ensure that the approach to ongoing leadership and management development supports Everyone Matters: 2020 Workforce Vision and Quality Ambitions and reflects the leadership and management policy statement
  - Ensure that managers and leaders identify and focus on the strategic workforce actions needed to deliver Everyone Matters: 2020 Workforce Vision.
- 
- Managers and Leaders will work in partnership with trades union partners and ensure staff are engaged and involved in matters that affect them at work
  - Develop and implement Staff Governance Improvement Plans in all local areas
  - Develop and implement a Leadership Framework.



**HR & OD STRATEGY 2015 - 2018  
ACTION PLAN**

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
<b>HEALTHY ORGANISATIONAL CULTURE</b>								
<b>2020 WORKFORCE VISION PRIORITIES</b>	1. We will take action to ensure that staff are clear about the values and behaviours expected of them.	1.1 Continue the marketing / branding campaign through use of fliers, posters, email signatures etc.	Associate Director of HR (JB)	Head of Education & Employee Development/Head of Leadership & Management Development		✓	✓	✓
		1.2 Continue to deliver a values session at induction and ensure our values are threaded through all education and development for staff				✓	✓	✓
		1.3 Support and encourage NHS Lothian staff to incorporate and embed our values within their roles and services.				✓	✓	✓
	2. Incorporate behavioural competencies (which reflect our values) within recruitment, development and appraisal processes. Rollout the iMatter Staff Experience Continuous Improvement Model.	2.1 Scope, develop and implement values based recruitment.	Associate Director of HR (JB)	Head of Resourcing		✓	✓	✓
		2.2 Review current PDPR training to incorporate values based standards.	Associate Director of HR (JB)	Head of Education & Employee Development		✓		
		2.3 Scope, develop and implement iMatter project plan.	Associate Director of HR (RK)	Head of Medical Workforce Planning		✓		
	3. Ensure that local feedback and monitoring arrangements (from patients, staff, service users etc) inform how well the core values are embedded.	3.1 Utilise staff feedback mechanisms to monitor how values are being embedded.	Associate Director of HR (JB)	Head of Leadership & Management Development		✓	✓	✓
	4. Engage and involve staff in decisions that affect them.	4.1 Through the Workforce Organisational Change Group process gain assurance that both staff and partnership representatives have been involved and engaged in the proposals for change.	Associate Director of HR (JB)	Heads of HR		✓	✓	✓
		4.2 Support Partnership Forums and service				✓	✓	✓



	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
		leads to implement the identified initiatives within local Staff Governance Improvement Plans.						
LOCAL PRIORITIES	5. Build and enhance management capability and confidence to deliver an alternative approach to conflict and dispute resolution.	5.1 Monitor, Evaluate and Review Mediation Service	Associate Director of HR (JB)	Head of Leadership & Management Development / Head of Education and Employee Development		✓	✓	✓
		5.2 Pilot, review and roll out the Courage to Manage Training.				✓	✓	
		5.3 Develop Team / Group Mediation Service.				✓		
	6. Agree targeted action plans for those areas where staff sickness is over 4%.	6.1 Scope and develop an absence management strategy to support line managers i.e. achieve reductions and meet the HEAT standard.	Associate Director of HR (JB)	Heads of HR		✓	✓	✓
	7. Develop a strategy for tackling the health and wellbeing issues associated with an ageing workforce.	7.1 Develop materials and information to support the management of an ageing workforce.	Acting Director of Occupational Health & Safety	HR Policy Group			✓	
	8. Implement the Internal Communications Strategy to ensure staff are well informed and engaged.	8.1 Review, develop and champion practice improvements to increase staff engagement and experience, using tools such as staff survey and iMatter.	Acting Director of Communications	Internal Communications Manager		✓	✓	✓
	9. Implement the NHS Lothian Equality Outcomes Framework 2013-17, the International Equity Standards programme and the Black and Minority Ethnic Nurses Progression Project.	9.1 Implement the NHS Lothian Equality Outcomes Framework 2013-17 as it relates to staffing.	Associate Director of HR (RK)			✓	✓	✓
		9.2 Implement the International Equity Standards programme	CMT			✓	✓	✓
		9.3 Implement the Leading Better Care - Leading Across Difference Programme.	Head of Education & Employee Development			✓	✓	✓
	10. Continue to work with education providers to ensure that in addition to	10.1 Values into Action to be included in commissioning and review of all partnered education	Head of Education & Employee	Deputy Head of Education & Employee		✓	✓	✓

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	staff having the technical competence to undertake their role, the vision and values of NHS Lothian are also embedded in their education programme.		Development	Development				
	11. Embed Rapid Impact Assessments at all levels in the organisation.	11.1 Ensure that all HR policies, processes and projects comply with rapid impact assessment requirements.	Director of Public Health & Health Policy/ Director of Human Resources and Organisational Development			✓	✓	✓
	12. Implement the Health and Safety Strategic Plan.	12.1 NHS Lothian Health & Safety Committee will oversee implementation and monitor progress.	Acting Director of Occupational Health & Safety	NHSL H&S Committee		✓	✓	✓
	13. Implement a revised Health and Safety Manual and Safe Management System.	13.1 NHS Lothian Health & Safety Committee supported by local H&S Committees will monitor and evaluate performance against this.	Acting Director of Occupational Health & Safety	NHSL H&S Committee		✓	✓	✓
	14. Design and implement a revised Health and Safety Management System Audit.	14.1 Scope, plan and deliver a refreshed programme of audits.	Acting Director of Occupational Health & Safety	NHSL H&S Committee		✓	✓	✓
	15. Review and refresh the Occupational Health and Safety Service specification.	15.1 Commission an External Review of the OHSS provision and implement agreed changes to ensure the service provision meets organisational requirements	Director of HR&OD	Acting Director of Occupational Health & Safety		✓	✓	✓
	16. Commit NHS Lothian to becoming an accredited Living Wage Employer.	16.1 Determine what is required to be an accredited employer.	Associate Director of HR (RK)			✓		
<b>SUSTAINABLE WORKFORCE</b>								
<b>2020 WORKFORCE</b>	17. Review our workforce planning arrangements to ensure a joined-up, consistent approach so that all services are	17.1 Through the Efficient Workforce Programme Board ensure our Workforce Plan and Learning and Development Strategy are aligned.	Associate Director of HR (RK)	Head of Workforce Planning / Head of Education & Employee Development		✓		

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	included and benefit from the process.							
	18. Demonstrate that workforce planning includes a long term perspective and supports new and emerging service delivery models including 24/7 and 7 days working.	18.1 Development of the Workforce Plan and associated education plans, which take account of the Workforce 2020 Action Plan and includes the rebalancing of the workforce.	Director of HR &OD	Operational Service Leads / Head of Workforce Planning/Head of Education and Employee Development		✓	✓	
	19. Identify workforce issues and use this information to inform local workforce plans.	19.1 Refresh Medical Workforce Risk assessments and report to the Lothian Medical Workforce Group, SEAT and Board.	Associate Director of HR (RK)	Head of Workforce Planning		✓		
		19.2 Review workforce demographic profile and identify areas of challenge including age profile, recruitment and retention, and gaps.				✓		
		19.3 Develop standardised Workforce Reporting for management teams and local Partnership Forums through the appropriate mechanisms.				✓		
	20. Put in place measures to provide high quality workforce data and identify a lead officer with responsibility for workforce data	20.1 Workforce Planning and the HR Systems team will work jointly to improve data quality and support specific national initiatives.	Associate Director of HR (RK)	Head of Workforce Planning / Head of HR Systems		✓	✓	
		20.2 The HRIS lead will work with the national eESS team to influence amendments to the system, which will support the collection of robust data.	Associate Director of HR (RK)	Head of HR Systems		✓		
	21. Ensure that workforce plans include an analysis of future education and training needs and that this is reflected in learning and development strategies.	As per Priority No. 17	Associate Director of HR (RK)	Head of Workforce Planning / Head of Education & Employee Development		✓		

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	22. Implement the good practice principles recommended by Audit Scotland in their 'Early Departures' report to ensure early release schemes are driven by the needs of our workforce plans.	22.1 Review our current processes to ensure they are robust and meet the Audit Scotland requirements.	Associate Director of HR (RK)			✓	✓	✓
LOCAL PRIORITIES	23. Ensure Consultant job plans match service demand and support 24/7 delivery. Consider extending the use of job plans to other staff who manage case loads (e.g. Nurse Consultants).	23.1 All Career Grade staff to use the electronic job planning software for the 2015/16 round of job planning and evaluate	Associate Director of HR (RK)	Head of Medical Workforce Planning		✓	✓	✓
		23.2 Meet with Service Managers to agree potential use of job planning software for other professional groups.				✓	✓	✓
	24. Review the need for 24/7 staffing by clinical area and develop staffing models that match service demands.	See action no. 18.	Corporate Management Team	Operational Service Leads / Head of Workforce Planning		✓	✓	
	25. Continue to develop medium to long term sustainable plans to address medical staffing pressures.	25.1 Support Clinical Directors to ensure agreed working rotas for Junior Doctors comply with Scottish Government requirements.	Associate Director of HR (RK)	Head of Medical Workforce Planning		✓		
		25.2 Support the Lothian Medical Workforce Group to work with services to achieve sustainable workforce models	Associate Director of HR (RK)	Head of Workforce Planning		✓	✓	✓
		25.3 Support the development of national international recruitment initiatives to enable services to achieve sustainable workforce levels.	Associate Director of HR (JB)	Head of Resourcing		✓	✓	
	26. Continue to review supplementary staffing utilisation to enhance quality of care and reduce	26.1 Co-work with the Associate Director of Nursing to develop workforce trend reporting and feed into the Efficient Workforce Programme Board and Lothian	Associate Director of HR (RK)	Head of Workforce Planning		✓	✓	✓

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	costs.	Medical Workforce Group.						
	27. Consider and explore further developments in regional rationalisation for clinical and non – clinical areas to optimise opportunities for workforce availability and development.	27.1 Work collaboratively with regional partners and HEI/FE to identify opportunities for joint development and commissioning.	Head of Education and Employee Development	Deputy Head of Education and Employee Development		✓	✓	✓
		27.2 Implement Education Frameworks for Bands 1 to 4 and Nursing Bands 1 to 8.				✓	✓	
	28. Expand and develop the Band 1-4 workforce in clinical areas creating roles that are both patient centred and provide a career structure.	28.2 Implement the Band 1 to 4 Education Framework.				✓	✓	
	29. Maximise opportunities for youth employment and social responsible recruitment through academies, modern apprentice schemes, placement schemes and recruitment campaigns, working with voluntary and other public sector partners.	29.1 Support the implementation of employability scheme with the Scottish Prison Service and the Community Pay Back scheme.	Associate Director of HR (JB)	Head of Resourcing		✓		
		29.2 Deliver schemes to support youth employability targets and socially responsible recruitment.	Associate Director of HR (JB)	Head of Resourcing/Head of Education and Employee Development		✓	✓	✓
	30. Ensure that succession planning takes account of the age profile and workforce demographics.	See action no. 19.	Associate Director of HR (RK)	Head of Workforce Planning		✓		
<b>CAPABLE WORKFORCE</b>								
<b>2020 WORKFORCE VISION</b>	31. Ensure that appraisers and those being appraised understand the purpose of development reviews / appraisals, their individual and mutual responsibility for ensuring it is meaningful and that	31.1 Ensuring that we have training and education programmes to support good appraisal and staff feedback in line with our Values.	Head of Education and Employee Development	Deputy Head of Education and Employee Development		✓	✓	

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	conversations review whether behaviours, decisions and actions reflect our shared values.							
	32. Improve the confidence, capability and capacity of everyone involved in leading and practicing quality improvement.	31.2 Co-working with colleagues in Quality Improvement to identify management development needs encompassing iMatters rollout.				✓	✓	✓
	33. Provide fair and appropriate access to learning and development for support staff.	33.1 Implement, monitor and evaluate Learning and Development Strategy						
	34. Ensure that our learning and development strategy is developed in partnerships and addresses longer-term learning and development need up to 2020.					✓	✓	✓
LOCAL PRIORITIES	35. All staff will receive feedback on performance, including behaviours and will have a personal development plan.	35.1 Co-working with services to ensure all staff will receive feedback on performance, including behaviours and will have a personal development plan	Head of Education and Employee Development	Operational Service Leads		✓	✓	✓
	36. Implement the learning development strategy	36.1 Implement, monitor and evaluate Learning and Development Strategy				✓	✓	
	37. Work collaboratively with other Health Boards to develop training programmes for small occupational groups e.g. Oncology, Medical Physics, and Perfusion.	37.1 Continue to contribute to national groups and explore opportunities for a shared service approach.	Head of Education and Employee Development	Deputy Head of Education and Employee Development		✓	✓	✓
<b>INTEGRATED WORKFORCE</b>								
202	38. Use the Health and Social	38.1 Implement the guidance for appointments.	Director of HR &	Associate		✓		

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	Care guidance provided to inform the appointment of Chief Officers and other joint appointments.		OD	Directors of HR				
	39. Continue local actions and development work to support integration of primary and secondary care.	39.1 Support service leads and management teams with the development of OD / integration plans, engaging all stakeholders in the process whilst ensuring that monitoring arrangements are in place to inform progress.				✓	✓	
		39.2 Support Local H&SC Management Teams to identify opportunities for development work to support primary and secondary care integration.				✓	✓	
	40. Make better use of existing mechanisms, such as community planning partnerships to identify opportunities to share resources including workforces.	39.3 Support HSCP Management Teams in the development and delivery of their Strategic Plans and associated engagement with stakeholders				✓	✓	
LOCAL PRIORITIES	41. Develop a joint workforce / organisational plan that aims to have a fully integrated workforce by 2020 for each H & SCP.	41.1 Establish local HR&OD Working groups to develop an HR&OD Plan for each Partnership with relevant workstreams.				✓		
		41.2 Provide technical HR input to the operational aspects of the integration agenda, ensuring managers continue to comply with the staff governance standard.	Director of HR & OD	Associate Directors of HR		✓	✓	
	42. Develop the skills and competencies we require for an integrated workforce (new roles, working together).	See Priority No. 41				✓	✓	✓

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	43. Develop joint organisational change processes for each H & SCP which meet staff governance standards.	43.1 Review all HR Policies and Procedures including Organisational Change for NHS Lothian and the 4 Lothian Councils to identify areas of similarity and difference.				✓		
		43.2 Produce recommendations for a Joint Organisational Change Process for discussion and agreement in relevant groups.				✓		
	44. Explore and maximise opportunities for shared services across NHS Scotland and with other public sector partners	44.1 Continue to support the progression of shared services across NHS Scotland and explore opportunities with other public sector partners.				✓	✓	✓
<b>EFFECTIVE LEADERSHIP AND MANAGERS</b>								
<b>2020 WORKFORCE VISION PRIORITIES</b>	45. Plan to build local leaderships and management capacity and capability as part of our workforce plan to deliver the 2020 vision.	45.1 Refresh Coaching provision to ensure this supports managers and enhances leadership capabilities.	Associate Director of HR (JB)	Head of Leadership & Management Development		✓		
		45.2 Establish a planned approach to attracting and targeting participants on National Leadership Programmes.	Associate Director of HR (JB)	Head of Leadership & Management Development		✓		
		45.3 Build on the established clinical management networks to allow for the dissemination of skills and knowledge.	Head of Education and Employee Development	Deputy Head of Education and Employee Development			✓	
	46. Ensure that line managers at all levels are clear about their people management responsibilities and are held to account for how they carry out these responsibilities.	46.1 Review and refresh our Leadership and Management Training Programmes.	Associate Director of HR (JB)	Head of Education and Employee Development / Head of Leadership & Management Development		✓		✓
		46.2 Deliver 'masterclass' sessions for senior managers to respond to service need.	Associate Director of HR	Heads of HR		✓	✓	✓



	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
			(JB)					
		46.3 Implement Case Management System across NHS Lothian.				✓		
		46.4 Continually review and develop HR Online to support managers.	Associate Director of HR (JB)	OD Consultant – Programme Lead		✓	✓	✓
	47. Identify the development, training and support needs of line managers at all levels, particularly in relation to people management and dealing with difficult performance management conversations, and ensure these needs are met.	See Priority No. 5 Action.	Associate Director of HR (JB)	Head of Leadership & Management Development / Head of Education and Employee Development		✓		✓
	48. Ensure that Heads and Managers at all levels understand and demonstrate the values and behaviours expected of them as well as their responsibilities in relation to the Staff Governance Standard and Quality Ambitions.	See Priority No. 1 Action.	Director of HR&OD	Corporate Management Team		✓	✓	✓
	49. Ensure Leaders and Managers are aware of and abide by national governance arrangements / structures.	HR & OD Director supports the work of the Governance Committees.				✓	✓	✓
	50. Ensure that the approach to ongoing leadership and management development supports Everyone Matters: 2020 Workforce Vision and Quality Ambitions and reflects the leadership and	See Priority No. 5 Action.	Associate Director of HR (JB)	Head of Leadership & Management Development / Head of Education and Employee Development		✓	✓	✓

	PRIORITIES	ACTION	ACCOUNTABILITY		RAG rating	TIMELINE		
			Strategic	Operational		2015/16	2016/17	2017/18
	management policy statement.							
	51. Ensure that managers and leaders identify and focus on the strategic workforce actions needed to deliver Everyone Matters: 2020 Workforce Vision.	Implement the HR & OD Strategy.	Director of HR & OD	Corporate Management Team		✓	✓	✓
LOCAL PRIORITIES	52. Managers and Leaders will work in partnership with trades union partners and ensure staff are engaged and involved in matters that affect them at work.	Continually review the Partnership arrangements and report back to the Lothian Partnership Forum.	Employee Director/ Associate Director of HR (JB)	Local Partnership Forum Co-chairs		✓	✓	✓
	53. Develop and implement Staff Governance Improvement Plans in all local areas.	Support Partnership Forums to develop and implement Staff Governance Improvement Plans in all local areas.	Employee Director/Associate Directors of HR	Heads of HR		✓	✓	✓
	54. Develop and implement a Leadership Development Framework.	See Priority No.45 Action	Associate Director of HR (JB)	Head of Education and Employee Development / Head of Leadership & Management Development		✓	✓	

RAG Description Key (Time Status)	
<b>RED</b>	Key milestones will be or have been delivered outside tolerance to agreed baseline
<b>AMBER</b>	Forecasting that there is a significant risk that key milestones will be delivered outside tolerance on agreed baseline
<b>GREEN</b>	All milestones forecast to be on time or early
<b>WHITE</b>	Task Complete

Board Meeting  
24 June 2015

Chairman

## SCHEDULE OF BOARD AND COMMITTEE MEETINGS FOR 2016

### 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 2016 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 2016.

### 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. 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 2016 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  
14 May 2015  
[peter.reith@nhslothian.scot.nhs.uk](mailto:peter.reith@nhslothian.scot.nhs.uk)

### List of Appendices

Appendix 1: List of dates and deadlines for Board and Committee meetings in 2016  
Appendix 2: Calendar version of dates for Board and Committee meetings in 2016

# 2016

## BOARD AND COMMITTEE DATES AND DEADLINES

The dates of Board and Committee Meetings for 2016 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
3 February 2016	13 January 2016	13 January 2016
6 April 2016	16 March 2016	2 March 2016
22 June 2016*	1 June 2016	4 May 2016
3 August 2016	13 July 2016	20 July 2016
5 October 2016	14 September 2016	7 September 2016
7 December 2016	16 November 2016	2 November 2016

\* 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:
20 January 2016	11 January 2016
9 March 2016	29 February 2016
11 May 2016	29 April 2016
13 July 2016	4 July 2016
14 September 2016	5 September 2016
30 November 2016	21 November 2016

### 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:
27 January 2016	18 January 2016
27 April 2016	18 April 2016
27 July 2016	18 July 2016
26 October 2016	17 October 2016

### 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:
26 January 2016	12 January 2016
29 March 2016	15 March 2016
24 May 2016	10 May 2016
26 July 2016	12 July 2016
27 September 2016	13 September 2016
29 November 2016	15 November 2016

## AUDIT & RISK COMMITTEE

Meets **five** times a year normally on a **Monday** at **9:00 a.m.**

<b>Date of Meetings</b>	<b>Deadline for Papers - close of business on:</b>
29 February 2016	15 February 2016
18 April 2016	4 April 2016
20 June 2016*	6 June 2016
5 September 2016	22 August 2016
5 December 2016	21 November 2016

\* *Annual Accounts Meeting*

## REMUNERATION COMMITTEE

Meets **five** times a year normally on a **Tuesday** at **10:00 a.m.**

<b>Date of Meetings</b>	<b>Deadline for Papers - close of business on:</b>
9 February 2016	1 February 2016
19 April 2016	1 April 2016
19 July 2016	11 July 2016
18 October 2016	10 October 2016
13 December 2016	5 December 2016

## STRATEGIC PLANNING COMMITTEE

Meets six times a year normally on the **second Thursday** of every **second month** from **10:00 a.m. - 12:00 p.m.**

<b>Date of Meetings</b>	<b>Deadline for Papers - close of business on:</b>
11 February 2016	2 February 2016
14 April 2016	5 April 2016
9 June 2016	1 June 2016
11 August 2016	2 August 2016
13 October 2016	4 October 2016
8 December 2016	29 November 2016

## ACUTE HOSPITALS COMMITTEE

Meets four times a year normally on the **first Tuesday** of the month at **2:00 p.m.**

<b>Date of Meetings</b>	<b>Deadline for Papers - close of business on:</b>
1 March 2016	22 February 2016
7 June 2016	30 May 2016
6 September 2016	29 August 2016
6 December 2016	28 November 2016

# Board & Committee Meetings Calendar 2016

January							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
53					1	2	3
1	4	5	6	7	8	9	10
2	11	12	13	14	15	16	17
3	18	19	20	21	22	23	24
4	25	26	27	28	29	30	31

February							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
5	1	2	3	4	5	6	7
6	8	9	10	11	12	13	14
7	15	16	17	18	19	20	21
8	22	23	24	25	26	27	28
9	29						

March							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
9		1	2	3	4	5	6
10	7	8	9	10	11	12	13
11	14	15	16	17	18	19	20
12	21	22	23	24	25	26	27
13	28	29	30	31			

April							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
13					1	2	3
14	4	5	6	7	8	9	10
15		12	13	14	15	16	17
16	18	19	20	21	22	23	24
17	25	26	27	28	29	30	

May							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
17							1
18	2	3	4	5	6	7	8
19	9	10	11	12	13	14	15
20	16	17	18	19	20	21	22
21	23	24	25	26	27	28	29
22	30	31					

June							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
22			1	2	3	4	5
23	6	7	8	9	10	11	12
24	13	14	15	16	17	18	19
25	20	21	22	23	24	25	26
26	27	28	29	30			

July							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
26					1	2	3
27	4	5	6	7	8	9	10
28	11	12	13	14	15	16	17
29	18	19	20	21	22	23	24
30	25	26	27	28	29	30	31

August							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
31	1	2	3	4	5	6	7
32	8	9	10	11	12	13	14
33	15	16	17	18	19	20	21
34	22	23	24	25	26	27	28
35	29	30	31				

September							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
35				1	2	3	4
36	5	6	7	8	9	10	11
37	12	13	14	15	16	17	18
38	19	20	21	22	23	24	25
39	26	27	28	29	30		

October							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
39						1	2
40	3	4	5	6	7	8	9
41	10	11	12	13	14	15	16
42	17	18	19	20	21	22	23
43	24	25	26	27	28	29	30
44	31						

November							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
44		1	2	3	4	5	6
45	7	8	9	10	11	12	13
46	14	15	16	17	18	19	20
47	21	22	23	24	25	26	27
48	28	29	30				

December							
Wk	Mo	Tu	We	Th	Fr	Sa	Su
48				1	2	3	4
49	5	6	7	8	9	10	11
50	12	13	14	15	16	17	18
51	19	20	21	22	23	24	25
52	26	27	28	29	30	31	

## Public Holidays 2016

<b>1 January</b>	New Year's Day	<b>28 March</b>	Easter Monday	<b>26 December</b>	Christmas Day
<b>4 January</b>	New Year	<b>2 May</b>	May Day Holiday	<b>27 December</b>	Boxing Day
<b>25 March</b>	Good Friday	<b>19 September</b>	Autumn Holiday		

Board Meeting	Development Day	Finance & Resources	Audit & Risk	Acute Hospitals
Healthcare Gov	Staff Governance	Remuneration	Strategic Planning	Public Holidays

The draft minutes of the meeting held on Tuesday 7 April are attached.

Key issues discussed included:

- Assurance committee given around self assessment and planned HIS visit to NHS Lothian on 14 April regarding older people in acute care.
- Presentation on progress and management oversight of building work at RIE - clear need to keep changes to a minimum during building phase.
- Discussion of the committee's assurance needs statement and need to take a pragmatic approach, avoid duplication, and relate to terms of reference.
- Discussion of new management arrangements for acute services and committee's role in scrutinising progress and outcomes.
- Updates on scheduled and unscheduled care, covering progress on issues such as Waiting Times, Endoscopy, Redesign of Outpatients, Performance Management Scorecard and Stroke, Delayed Discharge and HAI.
- Assurance given to committee around Waiting List Governance and work done to address this.
- Financial update, year to date overspend across all acute services and requirement to maintain implementation of financial recovery actions.

Key issues on the horizon are:

- Attendance at and increased effectiveness of Committee
- Committee keen to drill down into more specific areas e.g. stroke to gain more assurance
- Outcomes from management restructuring in terms of effectiveness and increased accountability
- Need to maintain pressure on financial management and LRP

Kay Blair  
Chair

## **NHS Lothian**

### **Acute Hospitals Committee**

Minutes of the Meeting of the Acute Hospitals Committee held at 2:00 p.m. on Monday, 2 February 2015 in the Meeting Room 5.4, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mrs K Blair (Chair); Mrs S Ballard-Smith; Mrs A Meiklejohn and Mrs A Mitchell.

**In Attendance:** Ms J Brown (Associate Director, Human Resources); Mr J Crombie (Director of Scheduled Care); Ms M Johnson (Executive Director Nursing, AHPs and Unscheduled Care); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager) and Mr N Wilson (Unscheduled Care Manager).

Apologies for absence were received from Dr D Farquharson, Mr A Joyce and Mr G Walker and Alex McMahon.

#### **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.

#### **47. Scheduled Care Update**

- 47.1 Mr Crombie introduced a previously circulated report giving an overview of issues across scheduled care.
- 47.2 It was noted that an unannounced inspection by the Healthcare Environment Inspectorate at the Western General Hospital had taken place on 18 & 19 November 2014 with a follow up review on 27 November. The inspectors had visited nine wards and initially found poor standards of cleaning of the patient environment and patient equipment. They had also felt there was a lack of risk assessments. On their return visit on 27 November the inspectors noted significant improvement. The report, published on 26 January 2015, identified 8 requirements to be met and 1 recommendation. 3 of the requirements related to hand washing facilities and another to the availability of alcohol gel. The other 4 related to cleanliness of the patient environment, patient equipment, blood spills policy and mattress audits. The recommendation was in reference to single use patient toiletries.
- 47.3 The Committee noted that an immediate action plan had been developed which supported an intense period of activity to sustain the improvement noted by the Inspectorate. There was an ongoing weekly site meeting to ensure that all the actions were completed on time. The action plan published along with the report was also on track for completion within the timescales indicated.
- 47.4 The Committee noted some of the challenges at the Western General Hospital because of the nature of the building and facilities.
- 47.5 It was noted that there had been an outbreak of C-difficile at the Royal Infirmary of Edinburgh which had begun in November 2014 and had involved 14 cases on



5 wards 4 of which were in scheduled care. Two of the patients had died and had c-difficile identified on part 2 of the death certificates. Evidence from other Scottish Boards supported the indication that antimicrobial prescribing, particularly of c-diffogenic antibiotics was closely linked to the prevalence of c-difficile in hospitals and in the community. It had therefore been agreed to change the NHS Lothian empirical antibiotic prescribing policy to specifically reduce the use of antibiotics associated with an increased risk of c-difficile and this policy had been implemented on 2 February 2015.

- 47.6 It was noted that following the South East Scotland Deanery Visit in September 2014, a number of concerns had been raised by trainee doctors in Simpsons Centre for Reproductive Health around rotas, workload and clinical governance. The Deanery had accepted that many of these issues were already being addressed through the maternity services programme workstreams but it had been felt that an external review of the service should be carried out by the Royal College of Obstetrics and Gynaecology and this had happened on 18 & 19 February 2015.
- 47.7 Mr Crombie advised that an oral maxillofacial surgery consultant had been subject to an interim order from the General Medical Council and the General Dental Council requiring supervision by another consultant pending the investigation of a complaint. The General Medical Council had reached a decision and issued a warning to the consultant with their interim order requiring supervision lifted in December 2014. The final decision from the General Dental Council was awaited.
- 47.8 The Committee noted that a National Institute for Clinical Excellence guidance recommending segregation and traceability of instrumentation of patients who may have been exposed to varience CJD from within the food chain and children born after 1 January 1997 who had not had exposure to varience CJD through the food chain of neurosurgical procedures was to be implemented in Scotland by 31 March 2015. The estimated cost of the separate instrumentation was £700k, of which £256k had been made available nationally. Funding had been identified for this shortfall. As a result of this, NHS Lothian's hospitals sterilization and decontamination unit were revising processes to ensure that neurosurgical instrument sets were maintained and the instruments and trays for pre and post 1997 could be clearly identified.
- 47.9 In order to meet the requirements to track and trace trays from the hospital sterilization and decontamination unit to theatres and on return there was a requirement for NHS Lothian to invest in a system for the tracking of instrumentation at a likely cost of £300k. The capital case for this investment was currently being developed.
- 47.10 The Committee noted that a report on complaints would be considered at the April Board meeting.
- 47.11 The Committee noted that the Scottish National Viral Haemorrhagic Fever Test Service was based at the Royal Infirmary of Edinburgh and offered Ebola, Marburg, Crimean-Congo haemorrhagic fever and Lassa fever testing to NHS Scotland in close collaborative partnership with the rare and imported pathogens laboratory at Porton Down, Wiltshire. The service had handled 8 blood samples since it was established at the beginning of December 2014 and all but 1 had been negative. The turnaround times for all samples had been before 4 – 6 hours and due process was followed on all instances with no adverse incidents.

**AB/DF**

- 47.12 Mr Crombie advised the committee that the number of inpatients and day cases beyond time to treatment guarantee in December was 447 and in January was 626. The number of outpatients waiting over 12 weeks in December 2672 and in January 3176.
- 47.13 It was noted that the 18 weeks performance from referral to treatment for December remains stable at 86.3% and that both 31 and 62 day performance against cancer were above 95% across the final quarter as a whole.
- 47.14 An improvement in those difficulties experienced in cystoscopy capacity had reduced the number waiting over 6 weeks for a diagnostic endoscopy at the end of December to 588. However it remained higher than earlier in the year. 68 radiology patients also exceeded this 6 week standard and predominantly were waiting for an ultrasound scan.
- 47.15 The end of December's surveillance endoscopy position saw 805 patients waiting beyond their due date and the numbers delayed for a review colonoscopy had increased whilst a decrease was evident in those overdue a check cystoscopy. 341 adult patients were waiting beyond the standards in place in audiology at the end of December and the forthcoming standard for in vitro fertilisation continued to be met.
- 47.16 The Committee noted that the Scheduled Care Division was reporting a year to date overspend (including slippage against local reinvestment plan targets) of £9,336m after 9 months, equating to a 3% overspend on budget. This position included a £3,853m shortfall against local reinvestment plan targets so that the net overspend against core budgets was £5,482m.
- 47.17 Mr Marriott expanded on the local reinvestment plan performance to December 2014 and it was noted that a shortfall of £1.5m remained in schemes identified against targets.
- 47.18 The Chair thanked Mr Crombie and Mr Marriott for their reports and commented that timelines and timescales on actions were still not included in the report. The Chair also commented that it would be helpful if papers could reference previous decisions on related matters confirming their implementation and outcome.
- 47.19 The Chair commented that her recent personal experience at the Western General Hospital had underlined that whilst staff were stretched the care provided was excellent although the facilities were inadequate. Organisational efficiency and management control could be improved and, in her opinion, the building itself was not considered fit for purpose.
- 47.20 The Committee noted a previously circulated report on the organisational arrangements for the management of NHS Lothian Acute Hospital Services to the Board meeting on 14 January 2015.
- 48.21 The Committee noted that at the January Board meeting, it had been agreed to revise the interim organisational arrangement for the management of acute hospital services in order to consolidate management arrangements for scheduled care, unscheduled care and estates and facilities under a single Chief Officer, Acute Hospital Services post.
- 47.22 This change had been seen as enhancing both the delegation of responsibilities and the interface between acute site and its constituent Integration Joint Board. The reduction in the number of business units managing acute services was also anticipated to deliver a material financial saving through the release of management costs.

- 48.23 The Committee noted that the Board had agreed that the revised management arrangements should be developed in partnership taking into account the need to work closely with the Health & Social Care Partnerships and were also cost effective. The revised management arrangements would be based on a general management model and the establishment of robust professional leadership and governance.
- 48.24 The Chief Officer would be appointed in accordance with NHS Lothian's organisational change policy and procedure. There would be consultation with staff in regard to the proposals for the structures which would be implemented in accordance with agreed policies and procedures. Appointments to posts would be based on performance.
- 48.25 The development plan would be drafted for the new teams and the intention was that the new structure would be implemented by April 2015.
- 48.26 It was noted that once developed and appropriate consultation had been undertaken the proposal would come back to both the Acute Hospitals Committee and the Remuneration Committee for approval. It was also agreed that the Acute Hospital Committee would take an ongoing scrutiny role of the new Acute structure to gain assurance that it was delivering its new objectives,
- 48.27 Mr Crombie left the meeting.

JC

#### **49. Minutes of the Access, Governance and Performance Meetings of 22 August and 7 October 2014**

- 49.1 Mr Wilson introduced the previously circulated minutes of the meetings of the Access, Governance and Performance Committee held on 22 August and 7 October 2014.
- 49.2 It was noted that whilst the current focus was on unscheduled care the role of this committee would evolve. Mr Wilson advised that he was currently concentrating on the statement of assurance needs which would come back to the Acute Hospital committee for approval.
- 49.3 It was noted that the beds in the Golden Jubilee Hospital constituted part of NHS Lothian's core capacity and that any confusion over this matter had now been resolved.

#### **50. Minutes of the Previous Meeting**

- 50.1 The previously circulated minutes of the meeting held on 16 September 2014 were approved as a correct record.

#### **51. Running Action Note**

- 51.1 The Committee noted the previously circulated running action note and received reports on the following items:
- 4.1.1 - it was noted that the report about plans for the re-provision of the Princess Alexandra Eye Pavilion had been submitted into the strategic planning process.

- 4.1.2 - it was noted that the balanced scorecard approach had the potential to evolve into an acute wide product and a more detailed report would be brought to a future meeting of the committee.
- 4.1.6 - It was noted that the strategic plan was currently with the Scottish Government and would be considered by the Board at its meeting on 4 February 2015.

JC

51.2 The Chair commented that it would be important for the Committee to have input to the strategic plans of the Integration Joint Boards.

## 52. Matters Arising

52.1 Readmissions to St John's Hospital at Howden - Ms Johnson introduced a previously circulated report and advised that work on this was currently ongoing and that an update detailing what measures were having the greatest impact would be brought to the meeting of the Committee on 8 June 2015.

MJ

52.2 Assurance Needs Statement - Mr Wilson advised that Mr Payne had produced a template for the statement and he and Mr Payne would be working on this with the involvement of the Committee and the Chair.

NW/AP

52.2.1 The Chair commented that wherever possible duplication with assurance work being undertaken by other Governance Committees should be avoided.

## 53. Unscheduled Care

53.1 Ms Johnson Introduced a previously circulated report giving an update on unscheduled care performance and measurement against agreed national targets.

53.2 The Committee noted that the January performance currently stood at 87% and NHS Lothian was ranked at about the middle of NHS Boards in Scotland. The Western General Hospital continued to experience difficulties and overall the winter had been mild to date with lower levels of infection. Delayed discharges were causing major problems with the staff had worked tremendously hard under difficult circumstances to achieve these results. Staff had been very supportive of different ways of working and the engagement events held had proved to be helpful.

53.3 It was noted that unscheduled care were experiencing the same issues as scheduled care with pressure around nursing costs continuing. The local reinvestment plans for the year ahead were based on redesign of services with a move of beds from Liberton Hospital to the Royal Infirmary of Edinburgh. The management team had spent a lot of time on this but recognised that it had not been as successful as hoped.

53.4 Ms Johnson explained that a healthcare associated infection report at the Western General Hospital would be discussed at the Board but that significant improvements had already been made. The main issue would be the sustainability of the actions and there were some issues about the levels of domestic cleaning. An early trial of how ward teams might be re-modelled was being undertaken.

53.5 Ms Johnson reported that there had been two fires, one at the Western General Hospital in which a patient had died and one at St Johns Hospital. Both fires were currently the subject of investigations but external factors were not thought to be involved.

53.6 It was noted that there had been four suspected cases of Ebola but all had proved negative. The Committee noted that staff were not reluctant to be trained in handling Ebola patients but were anxious about the complexity of the training and some of the equipment. It was noted that 50% of staff had been trained and the key risks had been identified.

#### **54. Acute Hospitals Mid-year Finance Review**

54.1 The Committee noted a previously circulated report on the financial performance of the Divisions of Scheduled and Unscheduled care for the 9 months to the end of December 2014.

54.2 The Committee noted that the Scottish Government had allocated additional funding and the January and February focus of the Finance Department was on the achievement of a balanced financial plan for 2015/16.

54.3 Mr Marriott advised that 2014/15 would be difficult but it should be possible to reach financial balance by 31 March 2015. One of the main problems was with delivery against the Local Reinvestment Plan targets and more work was required to address this.

54.4 It was noted that the move to Integration Joint Boards would introduce greater levels of complexity and 2015/16 was likely to be a challenging year.

54.5 Mr Marriott advised that he would be bring a report to the committee at its June meeting on the financial perspectives and how these would impact on acute services. Mr Marriott also offered to discuss the financial situation individually with any committee members seeking information.

#### **55. Quality of Papers and Debate**

55.1 The Chair commented that there had been a few themes throughout the meeting and that more attention was required to agenda planning. There had been some delays in receiving papers and information was still not included on actions timeframes and outcomes where these were not being met and giving reasons. The Chair asked that the Executive Team address these issues in terms of support to the Committee and focus on outcomes.

#### **56. Standards of Care for Older People**

56.1 Ms Johnson advised that a set piece inspection of NHS Lothian would be undertaken on 14 April and within 4-6 weeks of that there would be an unannounced inspection. An outline paper would be brought to the April meeting.

**MJ**

**57. Date of Next Meeting**

- 57.1 It was noted that the next meeting of the Committee would be held on Tuesday 7 April 2015 at 2:00 p.m. in meeting room 5.4 on the 5<sup>th</sup> Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**DRAFT**

**NHS Lothian**

**Acute Hospitals Committee**

Minutes of the Meeting of the Acute Hospitals Committee held at 2pm on Monday, 7 April 2015 in the Meeting Room 5.4, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mrs K Blair (Chair); Mrs S Ballard-Smith; Dr D Farquharson (from minute 3.9); Mrs A Meiklejohn and Mrs A Mitchell.

**In Attendance:** Ms J Brown (Associate Director, Human Resources); Mr J Crombie (Chief Officer); Dr B Cook (Associate Medical Director); Mr B Currie (Project Director RHSC/DCN); Mr I Graham (Director of Capital Planning and Projects); Mr A Jackson (Associate Director of Strategic Planning); Mrs L Khindria (Associate Director of Human Resources); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager) and Mr N Wilson (Unscheduled Care Manager).

Apologies for absence were received from Ms M Johnson, Mr A Joyce and Mr G Walker.

### **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. Minutes of the Previous Meeting**

1.1 The previously circulated minutes of the meeting held on 2 February 2015 were approved as a correct record subject to an amendment in paragraph 47.19 to read 'Organisational efficiency and management control could be improved and, in her opinion, the building itself was not considered fit for purpose'.

### **2. Running Action Note**

2.1 The Committee noted the previously circulated running action note and the Chief Officer undertook to provide due dates for future versions. **JC**

### **3. Presentation: Royal Infirmary of Edinburgh**

3.1 The Chair welcomed Mr Currie, Project Director for the Royal Hospital for Sick Children and Department of Clinical Neurosciences Development at Little France to the meeting. Mr Crombie explained that the purpose of the presentation was to ensure that members were sighted on activity at the Royal Infirmary of Edinburgh site.

- 3.2 Mr Currie summarised work that had already been undertaken to produce a detailed programme with timescales and it was noted that work had already started on the main site, driving in piles to support the main structure. Traffic had been re-routed and construction vehicles would enter and leave the site from designated access points.
- 3.3 Mr Currie gave a brief summary of the projected stages of the development through 2015 and 2016 to the completion of the major elements of construction in the first quarter of 2017 and the fitting out to handover in July 2017.
- 3.4 The Committee noted that a number of associated works would be carried out in 2015 and 2016 in conjunction with the main construction.
- 3.5 Mr Currie advised that there would be risks associated with a number of the operational transitions there would be an emphasis on maintaining service capacity, providing clearly marked bus stances and routes and maintaining the car parking ratios and numbers. It was noted that with the increase in capacity on the site the options for further support accommodation would be reduced.
- 3.6 Mr Currie reassured the Committee that communications with the interface with the projects, contractors and current services and the public interface for patients and visitors were in hand. Whilst links would be maintained with the site Masterplans and the NHS Lothian strategic plan as well as the Edinburgh Bio-quarter, it was intended to restrict any proposed changes until the completed building had been handed over to NHS Lothian .
- 3.7 The Committee noted that the revised Masterplan for the Edinburgh Bio-quarter included expansion land to the south, new housing developments to the south and University of Edinburgh developments. There was the potential for NHS Lothian to express an interest in land for expansion and the development of changed connectivity with the Royal Infirmary of Edinburgh site.
- 3.8 The Chair thanked Mr Currie for his presentation and asked if there had been much adverse comment from either staff or public on the development.
- 3.8 Mr Currie explained that the biggest issue encountered so far was car parking.
- 3.9 The Chair sought assurances that the risks had been identified and added to the risk register and Mr Crombie advised that this had been done and he would be bringing a report to the next meeting outlining what actions had been taken to ameliorate these risks. **JC**
- 3.10 It was noted that transplant and renal dependency units would be re-provided and a number of high dependency beds would have to be closed although there were other areas of the Royal Infirmary that could be used to provide such beds as a back up.
- 3.11 The Committee also noted the need to contain changes to the plan at least until the building had been handed over as any such changes constituted a risk.
- 3.12 Mr Crombie emphasised that there was a high level of ownership by clinical teams of the project and staff were fully sighted on the potential of the risks. He confirmed that critical path analysis had been carried out and that renal critical care was currently looking good. The change was on target for a May start and current plans did not anticipate any impact on waiting time targets.



3.13 The Chair thanked Mr Currie for the presentation and noted that a report on the risks associated with the project would be coming to the next meeting. It was agreed that a further update should be received by the Committee on the progress of the project at a suitable date. **SG**

#### **4. Old People in Acute Care**

4.1 Mrs Ballard-Smith introduced a previously circulated report giving an update on the changes in the review methodology for Healthcare Improvement Scotland in relation to older people in acute care and on the plans for the announced visit to NHS Lothian on 14 April 2015. This included a summary of the current position in relation to NHS Lothian's self assessment and plans going forward.

4.2 The Committee noted that NHS Lothian was as prepared as it could be for the inspection and Mr Crombie and Mrs Ballard-Smith would report back to the Acute Hospitals Committee and the Healthcare Governance Committee at future meetings.

4.3 It was noted that a work plan addressing the issues raised in the Scottish Public Service Ombudsman reports in connection with a number of complaints about NHS Lothian would be brought to a future meeting. **JC**

4.4 The Committee noted that the process of inspection would commence in NHS Lothian on 14 April 2015, with a planned day of presentations and staff interviews, followed by an unannounced inspection of ward areas within the following 6-8 weeks.

4.5 The overview of NHS Lothian's self assessment in relation to the required outcomes for the formal OPAH scrutiny visits, areas of good practice, improvement in closed areas where requirement for improvement continued was noted. The Committee also noted the development of Local Clinical Management Team Groups to support the delivery of this agenda.

#### **5. Lothian University Hospitals and Support Services**

5.1 Mr Crombie introduced a previously circulated report outlining the revised arrangements for acute services following the Board decision to consolidate management arrangements for scheduled care, unscheduled care and estates and facilities under a single Chief Officer. Each site would be responsible for playing its role in supporting the management of total demand across all 3 sites and to produce mutual aid in support as part of a single NHS Lothian University Hospital system.

5.2 The Board had also agreed that Site Director roles, responsibilities and accountability should be enhanced to include all site based services for unscheduled and scheduled care inpatient services. This would enable Site Directors to focus on local management of all inpatient services across all unscheduled and scheduled care services, local visible management based on each site with specific responsibility for clinical engagement and opportunities for local control for estates and facilities.

5.3 Site Directors would also be focussing on their explicit responsibility to develop relationships with primary, social and community care providers which formed part of the pathway for patients. Site Management Teams would be expected to develop positive collaborative relationships with each of the Integration Joint Boards and to play a full role in shaping the Integration Joint Boards strategic commissioning plans for acute hospital

functions delegated to the Integration Joint Boards and to influence the efficient use of 'set a side' budgets.

- 5.4 The Committee noted that there would be no changes to the Women and Children's Services but the way in which services were delivered locally was being examined. Estates and Facilities would remain under Human Resources & Organisation Development until the site structure had been fully implemented.
- 5.5 It was noted that the new structure would see a move from 9 to 6 business units, improving local management and supporting the delivery of a possible £900k per annum reduction in management costs, subject to the organisational change policy, redeployment and voluntary severance.
- 5.6 Mr Crombie advised that the proposals would be discussed with staff at each site and emphasised that General Managers would have accountability for all local services. He reassured the Committee that staff were sighted on the overall structure and draft governance structures were evolving.
- 5.7 Dr Farquharson confirmed that there was full clinical engagement and clinical leadership work would be maintained.
- 5.8 Mrs Khindria advised the Committee that the proposed structure was not radically different and the previous solution of separating scheduled and unscheduled care had been an interim one. Regular meetings with staff were helping to allay any anxieties and it was now important to deliver on the commitments given.
- 5.9 Mr Crombie advised that West Lothian Council had expressed interest in joint models and he emphasised the need for consistency in approach by Integration Joint Boards.
- 5.10 The Chair commented that it has been a very helpful paper and discussion and emphasised the importance of clinical engagement and leadership, particularly when engaging with the Integration Joint Boards.
- 5.11 It was agreed that an update report should be brought back at an appropriate date. **JC**

## **6. Statement of Assurance Needs**

- 6.1 Mr Wilson introduced a previously circulated draft statement of assurance needs.
- 6.2 The Committee noted the danger of concentrating solely on current issues and the need to ensure that it was covering all the governance issues identified in the terms of reference through its activities.
- 6.3 It was agreed that Mr Wilson would produce an updated statement with appropriate reference to the Committee's Terms of Reference. This would be circulated amongst Committee members for comment before the next meeting. **NW**

## **7. Unscheduled Care Update**

- 7.1 Mr Crombie introduced a previously updated report giving an update on unscheduled care performance and NHS Lothian's measurement against agreed national targets.

- 7.2 The Committee noted that a pan Lothian review of stroke services led by Dr Simon Edgar would be undertaken during 2015 and would form part of the Stroke Pathway Management Groups remit going forward.
- 7.3 It was proposed to establish a small Pan Lothian Group comprising clinical, managerial, patient and partnership representatives to assist Dr Edgar. Outcomes from this work would be reported to the Efficiency and Productivity Group and through the Acute Hospitals Committee to the Strategic Planning Committee.
- 7.4 The Committee noted that as winter ended in March 2015, all additional beds funded by winter or other temporary funding (as well as those opened on an unfunded basis) would need to close and remain closed as funding was not available in the 2015/16 financial plan.
- 7.5 Mr Crombie advised that 22 beds had been transferred to Gylemuir and 55 delayed discharges would be moved to a package of care.
- 7.6 It was noted that some 15% of hospital admissions had been found to be unnecessary and it was accepted that there was a need to build up clinical pharmacy to help address this issue.
- 7.7 Mr Crombie advised that the Royal Infirmary of Edinburgh had been very busy over the previous Easter weekend with 350 patients over-estimate on Easter Monday. In spite of this there had been no breaches of the 12 hour guarantee and performance was between 92-93% with performance on Saturday and Sunday at 95-96%.
- 7.8 The Committee noted that the Healthcare Environment Inspectorate had requested a 16 week update on the action plan developed following the unannounced inspection at the Western General Hospital on 18-19 November and 27 November 2014 to be returned to the inspectorate by 24 March 2015. This was being taken on board.
- 7.9 The Committee agreed to note the NHS Lothian unscheduled care performance and the actions being taken forward to support NHS Lothian's performance outcomes for unscheduled care.

## **8. Scheduled Care Update**

- 8.1 Mr Crombie introduced a previously circulated report providing an overview of the Scheduled Care Division. He advised that as part of the capacity planning process, there was a focus on ensuring efficient use of theatres and future papers to the Committee would include an initial analysis of theatre utilisation data and progress on performance. **JC**
- 8.2 The Committee noted that an external review of NHS Lothian's vascular services was undertaken in February by two leading national figures, both nominated by the Vascular Society and had examined current practices of the vascular unit and reviewed behaviours within the department.
- 8.3 It was noted that the official report had not yet been finalised, however initial feedback had been provided to senior general and clinical managers. A number of changes had already taken place and it was intended that a full action plan would be developed, with a brisk and detailed programme of implementation in place, very quickly after the receipt of the official report.

8.4 It was noted that a review of NHS Lothian services by the Royal College of Obstetrics and Gynaecology in February 2015 had been undertaken and, whilst the official report had not yet been published, the review team had given some verbal feedback which was, on the whole, positive. The team had recognised that there was a significant plan of work underway through the Maternity Programme Board and that there had been a number of improvements to various aspects of NHS Lothian's Obstetrics and Gynaecology Services, including medical staff training. The Committee would be updated on the official findings in due course. **JC**

8.5 It was noted that in the feedback reports on these reviews assurances that any issues identified would be evidenced within the reports.

8.6 The Committee agreed to note the overview on performance and progress within the division.

## **9. Waiting Times Governance**

9.1 Mr Jackson introduced a previously circulated report on waiting times governance since the previous report in September in 2014.

9.2 The Committee noted that it had requested an update on governance every 6 months. In September 2014 the responsibility of waiting lists governance had been transferred to the Director of Strategic Planning, Performance & Information to ensure independence from the operational line was consistent with the expectations of the Scottish Parliament's Public Audit Committee. The work undertaken was overseen by the Access, Performance & Governance Committee, which met monthly and included senior operational representation across Lothian.

9.3 Overall sampling had shown a good level of compliance with standard operating procedures, although some instances had been identified where training and input was required. Where omissions had been identified these were followed up and it had been agreed that this process would now be centralised. This was currently being investigated and the potential to partially automate the process was being considered.

9.4 It was noted that an internal audit of waiting times governance had been undertaken and graded compliance positively at "green". Recommendations had been made to ensure that records of sampling and forensic investigations were completed and retained on the basis for the selection of targeted samples made clear.

9.5 The Committee noted that the report evidenced the work that had been put in to ensuring compliance with the governance requirements and it was agreed that a further report would be received in six months time. **JC**

## **10. Finance Position and Update to Outturn Forecast**

10.1 Mr Marriott introduced a previously circulated report giving an update on the financial performance of the divisions of scheduled and unscheduled care for the 11 months to February 2015.

10.2 It was noted that the year to date overspend across all acute services was £20.3m of which £7.9m was in relation to non delivery of the Local Reinvestment Plan.

- 10.3 The Committee noted that the updated NHS Lothian forecast position presented an operational deficit of £36.7m against which non recurrent resources had been identified to ensure the statutory requirements to breakeven was delivered.
- 10.4 It was noted that the updated forecast position against acute services presented a forecast deficit of £26.4m of which £10.9m was in relation to operational pressures, £6.9m non core expenditure and a further £8.6m was in relation to projected non delivery of local reinvestment plans.
- 10.5 Mr Crombie advised that current LRP schemes were being examined in detail and were stating to deliver results but there were still major challenges.
- 10.6 Mr Marriott confirmed that action would be being taken at an earlier stage after the first quarter if agreed LRP was not being delivered.
- 10.7 The Committee agreed to note the requirement to maintain the implementation of financial recovery actions to mitigate the financial performance.

## **11. Leadership and Engagement for Improvement in NHS Lothian**

- 11.1 Dr Farquharson introduced a previously circulated report giving an update on his earlier report given to the Committee in July in 2014.
- 11.2 The joint paper, produced by the Medical Director and the Chief Officer highlighted a number of significant reports illustrating the importance of strong leadership including the review at Aberdeen Royal Infirmary, the enquiry into the deaths of at least 34 patients caused by an outbreak of clostridium difficile at Vale of Leven Hospital in 2007/08, the independent review into creating an open and honest reporting culture in the NHS, a report produced by Sir Robert Francis QC highlighting the importance of strong leadership and the report of the Morecombe Bay investigation into maternity care.
- 11.3 Dr Farquharson commented that these reports highlighted the problems arising when there was insufficient clinical leadership and advised that a number of clinical development days had already been held for staff.
- 11.4 The Chief Executive had created a Clinical Change Cabinet aimed at engaging and empowering a core group of clinical leaders and opinion formers to champion and help to implement clinical practice and or policy change.
- 11.5 Ms Brown advised the Committee that action was starting to be taken to address the issue of compliance with policies and procedures. The committee noted that there had been a considerable amount of important and necessary multi professional clinical engagement to date and supported the need for strong and highly visible clinical leadership within wards and departments. It was agreed that leaders must engage openly with staff and create an environment of accountability, where clinical staff felt confident to highlight concerns, whilst recognising that they may be required to support in the finding of solutions.
- 11.6 The Committee supported the requirement for continued leadership and engagement whilst identifying new opportunities to engage clinical staff.

11.7 It was agreed that an update report should be submitted in a further 9 months with consideration being given into ways in which it could be evaluated what impact the work was having on performance, values and behaviours. **DF**

## **12. Annual Report of Chair**

12.1 The Committee endorsed the previously circulated annual report of the chair of the Acute Hospitals Committee for the period ending 31 March 2015. Mr Crombie undertook to provide some specific comments directly to the Chair.

## **13. Access and Governance Committee**

13.1 The Committee received the previously circulated minutes of the Access and Governance Committee meeting held on 23 January 2015.

## **14. Quality of Papers in Debate**

14.1 The Chair commented that the quality of the papers submitted to the meeting had been good albeit still with too much detail. She felt that it was important to prioritise areas in which the Committee would require greater detail and have presentations around particular aspects. It was particularly important to avoid duplication with other Governance Committees.

14.2 The Chair commented that the current frequency of meetings every two months was unnecessary and it was agreed to move to quarterly meetings to be held prior to formal Board meetings. **PR**

## **15. Date of Next Meeting**

15.1 It was noted that the next meeting of the Committee would be held on Tuesday 8 June 2015 which would be prior to the Board meeting on 24 June 2015.

The draft minutes of the meeting held on 20 April 2015 are attached.

Key issues discussed included:

- The Committee reviewed the NHS Lothian Corporate Risk Register, which has been updated following approval of proposed changes by the Board at its April meeting. To further ensure that it is sighted on financial risks, the Committee has requested quarterly reports from the Chair of the Finance and Resources Committee.
- The Committee received the Risk Management Annual Report 2014-2015, which provides assurance on the management of risks across NHS Lothian. No concerns were noted.
- The Committee discussed an Internal Audit Progress Report, noting the excellent format of the report and the level of detail conveyed. While performance on targets has not been fully achieved, the Committee received assurance of future improvement.
- The Committee expressed concern about the findings of the internal audit on compliance with policies and procedures. While the audit concluded that there is a comprehensive framework in place that provides staff with guidance about policies and procedures, managers are not able to demonstrate that staff are aware of and complying with all mandatory policies. There is data evidencing continued non-compliance with policies in some areas. Although this data is reported to governance committees, there appears to be a lack of consequences associated with continued non-compliance that may be indicative of a wider cultural issue.

Key issues on the horizon are:

- The Committee has invited the Chair of the Staff Governance Committee to attend its next meeting to discuss how both Committees can exercise more effective oversight on compliance with policies and procedures.

Julie McDowell

Chair/Executive Lead

## **DRAFT**

## **NHS Lothian**

### **Audit & Risk Committee**

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday 20 April 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms J McDowell (in the Chair); Mr M Ash; Dr M Bryce; Cllr C Johnstone.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager ); Ms H Berry (Interim Chief Internal Auditor); Mr A Boyter (Director of Human Resources & Organisational Development); Mrs S Goldsmith (Director of Finance); Mr B Houston (Chairman); Ms D Howard (Head of Financial Control); Mr P Lodge (Audit Scotland); Mr D McConnell (Audit Scotland); Mr C Marriott (Deputy Director of Finance); Ms A Muir (for item 3); Mr D Proudfoot (Deputy Chief Internal Auditor); Professor A Timoney (for item 3) and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr Davison; Cllr D Grant; and Mr A Payne.

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. Members agreed that clarity on what should be declared would be sought from Mr Payne and fed back at the next meeting.

**LB/AP**

- 1 Minutes of the Previous Meeting
  - 1.1 Minutes of the previous meeting held on 19 February 2014 – The Committee approved the circulated minutes as a correct record.
- 2 Matters Arising
  - 2.1 Running Action Note - The Committee accepted the Running Action Note. It was noted that all actions listed were either complete or in progress. There were no items to pick up not covered elsewhere on the agenda and any actions that were now complete could be removed.
3. Homecare Services – March 2015
  - 3.1 Mss Berry introduced the previously circulated report. She noted that the points raised reflected the position at that time and the comprehensive response from management detailed within the report.
  - 3.2 Ms Muir advised the Committee that capacity for homecare was discussed at a national level; she highlighted the ongoing work with NSS to address any capacity issues before the implementation of an homecare agreement within NHS Lothian.



3.3 In response to Dr Bryce's comments regarding the roles and responsibilities of the Healthcare Governance Committee, Ms Muir advised that the matter had previously been fed up to Healthcare Governance Committee through the Area and Drugs and Therapeutics Committee. It was anticipated that an update would be provided to Healthcare governance in the near future.

3.4 The Committee accepted the report on Homecare Services and the information therein.

#### 4 Risk Management

4.1 NHS Lothian Corporate Risk Register – Ms Bennett introduced the previously circulated report that set out NHS Lothian's position with corporate risk to date. She advised that work to incorporate acute risk was ongoing to the organisational change that is current being undergoing. It was anticipated that the acute risks would be incorporated when they were fit for purpose.

4.1.1 Members noted that the review of the risk register was now complete and a report would be brought forward from the Risk Management Steering Group to the next meeting once it had been approved.

4.1.2 Ms Bennett advised the Committee that the Risk Management Steering Group had not raised concerns regarding the lack of consistency across the Community Health Partnership Risk Registers. She noted that risk within the Community Health Partnership section accurately reflected the position the each area of Lothian.

4.1.3 The Committee briefly discussed the need for a further level of narrative that highlighted the consequences of the overarching risk. Members agreed that it would be appropriate to receive further information in the comments column of the report if risk had been mitigated or materialised. Members also acknowledged the benefit of having an appropriate representative from the Sub-Committees of the Board present at future meetings.

4.1.4 Members specifically requested that the Chair of the Finance and Resources Committee provide quarterly reports to the Audit and Risk Committee to ensure that they are sighted on financial risks.

SG

4.1.5 The Committee agreed to accept the report.

4.2 Risk Management Annual Report 2014-15 - Ms Bennett agreed to correct the Risk Management Steering Group lines of reporting within the report

JB

4.2.1 The Committee accepted the previously circulated report as a source of assurance on the risk management across NHS Lothian.

## 5 Internal Audit Reports

5.1 Internal Audit Progress Report April 2015 - Ms Berry summarised the work carried out since February 2015 and it was noted that delivery of the full plan was still scheduled for delivery by June 2015. Presently eleven of the nineteen reports were now complete.

5.1.1 The Committee noted the excellent format of the report and the level of detail conveyed. It discussed the fact that on a number of KPIs performance was classed as red or amber and sought assurance of future improvement. In response to a question, Ms Berry assured the Committee that resources are sufficient in the department and she believed performance would improve.

5.1.2 After a brief discussion members decided that Ms Berry should review the KPIs so that they take into account the new process and bring forward a report to on trends over the period of the year to the June meeting.

**HB**

5.1.3 Members queried the management response in relation to the Bed Management action. Ms Berry agreed to sense check the response and feedback at the June meeting.

5.1.4 The Committee agreed to accept the report.

5.2 Staff Lottery – April 2015 - The Committee accepted the previously circulated report on the Staff Lottery and the information detailed therein.

5.3 Hospital Waste Management – April 2015 - The Committee noted the report on Hospital Waste Management and the information detailed therein.

5.3.1 Members were unable to take assurance from the information provided within the report. Further discussions on this matter would be picked up under the compliance with policies and procedures report.

5.4 Compliance with Policies and Procedures – April 2015 - Ms Berry introduced the report on compliance with policies and procedures. She assured the Committee that overall there was a good framework in place.

5.4.1 Members noted that the Hospital Waste Management was a good example of where there was a good framework in place but adherence to the policy was not reinforced within the hospital. Mr Boyter thought that a solution to this matter would be complex and even with a specific executive lead it would be a significant cultural change.

5.4.2 Committee expressed concern about the audit findings and had an extensive discussion on how to address them, including the potential use of sanctions. The Committee expressed the view that when policies and training are deemed mandatory the failure to comply should not be tolerated. It asked that the Chairman of the Staff Governance Committee be invited to attend the next Audit & Risk

Committee meeting to discuss how the Staff Governance Committee might help in exercising oversight over these issues.

**AB/AJ**

- 5.5. Internal Audit Plan 2014 to 2017 - Ms Berry outlined the areas for focus for 14-17 in the context of the four year plan. The changes to the proposed internal audits were listed in appendix one of the report.
  - 5.5.1 The Committee agreed to accept the internal audit plan for 2014-17
6. Counter Fraud (Assurances)
  - 6.1 CFS Referrals & Operations April 2015 - Mr Proudfoot introduced the summary of CFS referrals and operations as at April 2015. He advised that there were 4 new referrals and 4 operations were currently open.
    - 6.1.1 Mr Proudfoot advised the committee of the issues associated with investigating staff members whom were on sick leave but are working on a self employed basis whilst off sick. Work to address this matter was ongoing with Counter Fraud Services.
    - 6.1.2 The Committee accepted the CFS Referrals & Operations report.
7. External Audit (Assurance)
  - 7.1 NHS Lothian Best Value Toolkit – People Management 2014/15 - Mr Lodge gave an overview of the report on the People Management Best Value Toolkit. He drew the Committee's attention to the 4 key areas of review and the summary detailed there in.
    - 7.1.1 The Committee queried whether the report was consistent with the Internal Audit on Policies & Procedures. The External Auditor explained that the external audit was looking at different things and that the two reports were therefore not inconsistent.
    - 7.1.2 The Committee accepted the report.
  - 7.2 NHS Lothian ~Review Key Internal Controls 2014/15 - Mr McConnell introduced the report that outlines the processes that Audit Scotland places reliance on leading up to the review of the audit of the financial statements. He advised that the controls operated by NHS Lothian were satisfactory.
    - 7.2.1 The Committee agreed to accept the report.
8. Corporate Governance (Assurance/ Decision)
  - 8.1 Accounting Policies - The committee agreed to recommend to the board that the accounting policies as amended in respect of CNORIS be adopted as appropriate for the Board at the present time.

8.2 Evaluation of Co-sourcing and Selection of a Permanent Solution for Internal Audit  
- The Committee noted the process for evaluating the current co-sourcing arrangement, and agreed to determine the Board's permanent solution to secure an adequate and effective internal audit service.

8.2.1 The Committee agreed to accept the report and await further reports on this matter.

## **9. Date of Next Meeting**

9.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 22 June 2015 at 9:00 in Waverley Gate, Edinburgh. Committee members only were asked to attend by 8.45 for the scheduled 15-minute pre-meeting.

The draft minutes of the meeting held on 11 March 2015 are attached.

Key issues discussed included:

- Committee members received follow up reports on business cases in relation to St John's Hospital schemes, and the WGH front door. Further work was requested on the St John's projects and the Committee noted the improvement in performance at the WGH front door noting it was still early days.
- The Committee approved a long outstanding business case for the Central Endoscopy Decontamination Facility for the WGH.
- The Financial Plan for 2015/16 and beyond was considered and recommended for approval to the Board in April. In particular Committee members noted the risks in relation to income assumptions, efficiency savings and the imbalance between recurring and non-recurring expenditure. Committee members requested a clarification of the explicit capacity assumptions in the plan.
- The Committee was provided with a report on the implications on revised European guidance on the classification of government assets in relation to the NPD procurement. This was being taken forward by SFT.
- In terms of Business Cases the Committee approved the following;
  - The addendum to the full Business Case for the RHSC/DCN;
  - An Initial Agreement for Microbiology Automation;
  - Direction of travel for the Edinburgh Bioquarter;
  - An Initial Agreement setting out the redevelopment programme for the St John's Hospital Campus.
- The Committee approved the Property and Asset Plan for 2015/16 and beyond recognising this required management of the over commitment and prioritisation of major Capital projects going forward.

George Walker/Susan Goldsmith  
Chair/Executive Lead

## NHS Lothian

### Finance & Resources Committee

Minutes of the Meeting of the Finance & Resources Committee held at 9:00am on Wednesday 11 March 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

**Present:** Mr G Walker (Chair); Mrs Kay Blair; Dr D Farquharson; Mrs S Goldsmith; Mr B Houston; Ms M Johnson and Mr P Johnston.

**In Attendance:** Ms J Campbell (General Manager, St John's Hospital); Mr B Currie (Project Manager, RHSC/DCN); Mr I Graham (Director of Capital Planning & Projects); Dr A K McCallum (Director of Public Health & Health Policy); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager); Mr C Stirling (Site Director, St John's Hospital) and Mr A Tyrothoulakis (General Manager, Diagnostic Services, Royal Infirmary of Edinburgh).

Apologies for absence were received from Mr T Davison; Councillor R Henderson and Professor J Iredale.

#### 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.

#### 70. Minutes of the Previous Meeting

70.1 The Minutes of the previous meeting held on 21 January 2015 were approved as a correct record.

#### 71. Running Action Note:

71.1 The Committee received the previously circulated Running Action Note detailing outstanding matters arising, together with the action taken and the outcomes.

71.2 Potential Impacts on Financial Governance Around the Integration Process – Mrs Goldsmith advised the Committee that work on developing an overview of the level of resources required for Integration was underway. An early part of this work involved undertaking appropriate due diligence and proposals were being developed as to how this would work. The Chair commented that the due diligence process would need to encompass the appointment of the Chief Officer and Chief Finance Officer. It was noted that whilst there were Chief

Officer designates, no NHS staff had been designated to fulfil the roles of Chief Finance Officer in any of the four Integration Joint Boards. This would require four Section 95 Officers which could have a significant impact on the Finance Senior Management Team structure. It was noted that an update would be brought to the next meeting.

SG

## 72. Matters Arising

72.1 Lessons Learnt from the St John's Hospital Business Case – Mr Graham introduced a previously circulated report summarising progress on the identifications of lessons learnt from the recent sequence of projects undertaken at St John's Hospital and their application to future project work both at St John's and elsewhere. The Committee agreed that a more detailed paper in plain English was required, outlining what had gone wrong with the Business Cases at St John's and why. Mr Stirling advised that the Teams currently undertaking projects would benefit from training from Mr Graham's Team. Mr Graham advised that processes had been put in place to ensure that the lessons learned from these previous Business Cases were implemented. It was agreed that an update report should be brought to the next meeting of the Committee.

IG

72.2 Western General Hospital Front Door Services Development Project – Ms Johnson introduced a previously circulated report giving an update on the progress on the Western General Hospital Front Door Services Development Project. The Committee received an initial summary on benefits realised to date. It was noted that NHS Lothian was performing well above the Scottish average that the moment and the new model at the Western General Hospital was proving to be a most interesting experiment which was providing a wonderful environment for patients. It was noted that overall performance had improved and the Surgical Assessment Unit was beginning to see demand reducing. In the context of winter, a number of changes were still going on and staff had not yet been recruited to some positions so there was capacity for further improvement. The Royal Infirmary of Edinburgh was looking at the St John's Hospital model and the funding for delayed discharges provided by the Scottish Government would be passed directly to East, Mid and West Lothian. The funding for Edinburgh would be used to support the delayed discharge beds at the Royal Victoria Hospital. Funding would only be available to the Council in order to keep Gylemuir open. Mrs Blair expressed concern at reduction of the budget for delayed discharges for 2015/16 by the City of Edinburgh Council. Mr Houston advised that the situation with regard to delayed discharges in Edinburgh was being escalated and he and the City of Edinburgh Council Leader would be meeting with the Cabinet Secretary to discuss the problem. Noting the position in respect of Edinburgh, Mr Johnston commented that the Confederation of Local Authorities would expect monies to be passed directly to the Integration Joint Boards who would be in a more hands-on relationship with the Scottish Government.

### **73. Provision of a Central Endoscopy Decontamination Facility for the Western General Hospital**

73.1 Dr McCallum introduced a previously circulated report and standard Business Case for the provision of a Central Endoscopy Decontamination Facility for the Western General Hospital.

73.1.2 The Committee noted that the original initial agreement had covered the changes and investment needs of both the Royal Infirmary of Edinburgh and the Western General Hospital and it had been agreed at that time that separate standard Business Cases would be developed for each site.

73.1.3 It was noted that there were some issues which could not be resolved ahead of the Business Case submission.

73.1.4 The Committee agreed: to note and approve the standard Business Case; to and note that the latest programme showed the best start date on site was 27 April 2015 which would see the new Decontamination Unit being completed and commissioned into use by May 2016. To note that the overall costs to NHS Lothian were £3.2m all of this remained an estimate at present due to the uncertainty on the final equipment costs; to note that there was an estimated recurring revenue gap of £133,000 and to note that a sum of £58,000 had already been approved by the Lothian Capital Investment Group to help cover contingency arrangements and add to help address the service risk of endoscopy washers failure before the project was complete.

### **74. Financial Position to January 2015**

74.1 Mr Marriott introduced a previously circulated report giving an overview of the financial position to 31 January 2015 and the latest forecast outturn position for the financial year 2014/15.

74.1.2 Mr Marriott advised that significant work had been undertaken by financial staff to bring the financial position into balance and that there would be an impact on the following year's financial position.

74.1.3 Mrs Blair commented that she would be keen to see where there were examples of sustainable local reinvestment plan achievements in the organisation that could be showcased as examples.

74.1.4 Ms Johnson commented that there were a large number of unfunded commitments which could skew the position.

74.1.5 The Committee noted that an in-month underspend of £1,481,000 was reported in January against the revenue of resource limit bringing the year to date position to a £4,75,000 overspend including unachieved local reinvestment plan savings.

74.1.6 It was noted that the local reinvestment plan was reporting an in-month delivery of £1,747,000 against the target of £3,342,000 leading to a shortfall of £1,595,000 in January. For the year to date saved, savings of £20,97,000 had



been achieved against a target of £29,958,000 bringing the year to date shortfall to £9,861,000.

74.1.7 It was noted that a further £1.1m of reserves had been released in the month of January in relation to the £13.2m local reinvestment plan requirement that was put in place to underpin the operational position.

74.1.8 The Committee noted that a further review of all corporately held reserves and available flexibility had been undertaken resulting in a further £9,348,000 being identified to support the financial position, £6,232,000 to date. In addition, based on advice from professional advisers, £5m of backdated rates rebate had been assumed in this current year and was being phased in equally over the last 3 months of the year, with £1,667,000 released in month 10.

74.1.9 The Committee noted that based on a review at month 10, the forecast outturn estimated remained breakeven.

74.1.10 The Chair congratulated all those staff who had worked hard to achieve a financial break even.

## **75. Financial Plan 2015/16 to 2019/20**

75.1 Mrs Goldsmith introduced a previously circulated report giving an update on the financial plan for the period 2015/16 to 2019/20 setting out the movements and values since the last iteration reported to Committee and the risks identified which would impact on the achievement of a balanced position in the following year.

75.1.2 The Committee noted the revised financial plan and in particular the forecast gap between additional income and expenditure of £30m, expected to be recovered via the efficiency savings from the local reinvestment programme.

75.1.3 The Committee noted that there were risks around efficiency and productivity with significant vulnerability around the local reinvestment programme schemes and work was underway on reducing the risk profile.

75.1.4 Mrs Blair commented on the assumptions around the usage of the private sector and asked if the best possible deal had been reached with them.

75.1.5 Mrs Goldsmith advised that there was a reasonably good national deal and it was anticipated that NHS Lothian would step up the amount of in-house capacity although there was a need to be realistic about how much this could achieve.

75.1.6 Mr Houston commented that the latest revisions of the NRAC calculations suggested that there would be an increase in NHS Lothian's allocation and Mrs Goldsmith advised that a report would be brought back on NRAC to a future meeting.

75.1.7 It was noted that the Risk Register had already been updated in respect of the financial plan.

**SG**

75.1.8 The Committee agreed to note the presentation of a balanced financial plan in 2015/16; to note the forecast gap between additional income and expenditure of £30m, expected to be recovered via efficiency savings from the reinvestment programme; to note the changes impacting on the financial gaps since the previous iteration; to note the current assumption for anticipated savings delivery; to note the key risks identified and the imbalance between recurring and non-recurring balance and to recommend the draft financial plan for 2015/16 to 2019/20 for approval, noting the key risks and the associated performance management arrangements, to the Board meeting on 1 April 2015 with a clarification of the explicit capacity assumptions in the plan agreed with the Chair of the Finance & Resources Committee by the Director of Finance.

SG

## **76. The Impact of ESA 2010 on NHS Lothian's NPD and Hub DBFM Programme**

76.1 Mrs Goldsmith spoke to a previously circulated report summarising the implications of the revised European guidance on statistical classification on a non-profit distributing model Hub design build finance and maintain programme as it affected NHS Lothian's projects. The Committee noted that updates to relevant Eurostat technical guidance on national statistical accounts had changed the interpretation of factors that influenced a public or private sector classification for infrastructure projects. This change was effective from August 2014 and had implications for all revenue funded schemes being taken forward by the public sector in Scotland using the Scottish Futures Trust standard form "contracts".

76.1.2 Since the issue emerged, the Scottish Futures Trust had been leading the work to understand the impact on the national programmes and what mitigating measures might be required.

76.1.3 It was noted that the initial focus was on non-profit distributing projects as the contractual governance arrangements of these were less complication. Some minor amendments had been proposed and these had been accepted by Scottish Government Ministers and there was a degree of confidence that these would pass the control test with the Office of National Statistics.

76.1.4 With the public sector having a 40% stake in Hub joint venture companies and management direction of the HubCo business plans by the public sector, the position with Hub DBFM projects was more complex.

76.1.5 Whilst the Scottish Government and Scottish Futures Trust believed that current project arrangements demonstrated consistency with the relevant guidelines, until their process of engagement with the Office of National Statistics had concluded, the risk remained that the off-balance sheets of classification would not be agreed. To mitigate this, the Scottish Government had put a contingency measure in place taking the form of cover of £450m arising through a combination of carry forwards and additional borrowing from HM Treasury.

- 76.1.6 NHS Lothian had a number of NPD and DBFM projects at various stages of governance process.
- 76.1.7 The Committee noted the ongoing work to secure the necessary classification for a Royal Edinburgh Hospital Reprovision and noted that the Scottish Futures Trust was developing other options to ensure that projects could be structured to be off the Government's balance sheet.
- 76.1.8 In respect of the Royal Hospital for Sick Children and Department of Clinical Neurosciences, financial close was achieved on 13 February 2015 and the funding letter received in advance fell short of the level of assurance received for the Royal Edinburgh Hospital Phase I. The Board's legal and financial advisers had confirmed that there was no change to the procurement risk around the project as a result of the contract changes to meet the revised requirements.
- 76.1.9 The next project in the NHS Lothian pipeline due to reach financial close was the Partnership Centre bundle and in light of the discussions with the Office of National Statistics and the assessment of the risk of delay out weighed the risk of progressing NHS Lothian was continuing with the enabling works associated with the three individual projects. The East Lothian and Royal Edinburgh Hospital Phase II and the St John's Hospital boiler replacement projects were being progressed on the assumption that the issue would be concluded positively.
- 76.1.10 The Committee noted the position and agreed that appropriate entries should be made upon the Risk Register.

SG

**77. Royal Hospital for Sick Children and Department of Clinical Neurosciences: Addendum to Full Business Case**

- 77.1 Mr Currie introduced a previously circulated report outlining the changes since the full Business Case was presented to the Committee and the Scottish Government Health & Social Care Directorates in August 2014.
- 77.1.2 Mr Currie advised that the project was nearing conclusion and whilst any major changes could not be made without there being risk of significant cost a process was in place to consider necessary change proposals.
- 77.1.3 The Committee agreed to note that the pre-financial close stage review was completed by Scottish Futures Trust and that the recommendations from that review were being actioned. It was noted that financial close was achieved following changes to the standard form NPD Articles of Association and Project Agreement and agreed the submission of the Addendum to the full Business Case to Lothian NHS Board for approval and onward submission to the Scottish Government Health & Social Care Directorates.

SG

## **78. Microbiology Automation Initial Agreement**

- 78.1 Mr Tyrothoulakis introduced a previously circulated report seeking approval to progress the introduction of automation technology within the microbiology service, as outlined in the initial agreement.
- 78.1.2 Mr Tyrothoulakis explained that this was one of the main projects in the Laboratory Medicine strategy and that the Royal Infirmary of Edinburgh was the only site that could accommodate these services on a single site. The facility would be easily expandable and anticipated net reductions in revenue expenditure would be achieved by reducing staffing levels through natural wastage. 30% of the workforce was aged over 50 and a significant profile was expected of the next few years. In the meantime, any vacancies would be held and it was anticipated that savings could be delivered from start of the project.
- 78.1.3 The Committee noted that a supplementary agreement would be required with Consort but the previously agreed template should make this a much easier process.
- 78.1.4 The Committee noted that whilst this was a pioneering project in Scotland, it would involve the procurement of existing technology and was being undertaken in other parts of the NHS in the United Kingdom.
- 78.1.5 The Committee agreed to support the initial agreement to progress the project to OJEU tender for the required technology and agreed the immediate release of the £300,000 budget to support design costs.

## **79. Edinburgh Bio Quarter and the Royal Infirmary of Edinburgh**

- 79.1 Mrs Goldsmith introduced a previously circulated report inviting the Committee to endorse the direction of travel for further engagement with the Partners in the Edinburgh Bio Quarter and to consider the work underway in relation to the Royal Infirmary of Edinburgh as part of the Efficiency and Productivity Programme.
- 79.1.2 It was noted that the University of Edinburgh was rapidly developing their plans and the University's and NHS Lothian's aspirations dovetailed well. Engagement with Scottish Enterprise was still to happen and a joint venture in the future would be the likely outcome.
- 79.1.3 The Committee agreed to endorse the direction of travel for further engagement with the Partners in the Edinburgh Bio Quarters and noted the work underway in relation to the Royal Infirmary of Edinburgh as part of the Efficiency and Productivity Programme.

## **80. St John's Hospital Campus Redevelopment – Initial Agreement**

- 80.1 Mr Stirling introduced a previously circulated report together with the initial agreement for the St John's Hospital Campus Redevelopment programme. This development would support redesigned patient pathways for

ophthalmology and hand patients through the development of an efficient day surgery unit.

- 80.1.2 Ms Campbell explained that the initial agreement outlined a series of investment proposals that would enhance the functionality, condition and capacity of the site using existing infrastructure and would ensure that the inpatient head and neck surgical specialities had sufficient internal capacity to meet current and projected demand for theatres and beds with associated supporting infrastructure.
- 80.1.3 Mr Johnstone commented that this was a very exciting proposal and that the increased investment in St John's Hospital would be welcomed.
- 80.1.4 The Chair commented that the paper was lacking details about what the options would mean and a greater amount of specificity was required.
- 80.1.5 Mr Stirling advised that it was proposed to proceed with the work on Ward 20 but further service changes would need to be determined by the Board.
- 80.1.6 Mrs Goldsmith confirmed that the other aspects of the report would require to go back to the Corporate Management Team for consideration of the bigger picture.
- 80.1.7 Mr Graham advised that there would also be a need to engage with the planning officers for any changes of use.
- 80.1.8 Mrs Goldsmith advised that a further report on timescales would be required and that it was hoped to submit the proposals to Scottish Government Health & Social Care directorates as soon as possible.
- 80.1.9 The Committee agreed to note and approve the programme initial agreement as an overall programme governing the strategic development of the St John's Hospital campus with an understanding that the individual projects within the programme would require specific approval.
- 80.1.10 The Committee approved the development of the Ward 20 initial agreement of an ophthalmology and plastics day theatre unit as a specific project within the overall St John's Hospital campus redevelopment programme and approved the approach taken by the St John's Hospital master planning group.

## **81. Property and Asset Management Investment Programme 2015/16 to 2019/20**

- 80.1 Mr Graham introduced a previously circulated report giving an update on the property and asset investment programme for 2014/15 and 2015/16.
- 80.1.2 The Committee noted that changes to the Capital Investment Manual were currently out for consultation and might require direct Non Executive Board member engagement.

80.1.3 The Committee agreed to note the achievement of the capital resource limit an associated targets was forecast for 2014/15 and recognised the financial performance to date and the highlighted key risks and issues from the programme of work.

80.1.4 The Committee agreed the proposed investment programme for 2015/16, noting the plans to manage the over-commitment and recognised the requirement to prioritise major infrastructure developments in the context of the strategic plan and other priorities.

80.1.5 The Chair commented that it had been some time since a report had been received on backlog maintenance and Mr Graham undertook to include this in the next report.

**IG**

## **81. Date of Next Meeting**

81.1 It was noted that the next meeting of the Finance & Resources Committee would be held on **Wednesday 13 May 2015 at 9:00am in Meeting Room 7, Waverley Gate, Edinburgh.**

81.1.2 The Committee asked Mrs Goldsmith and Mr Graham to examine the possibility of combining Committee meetings with off-site visits and bring forward proposals for suitable locations.

**SG/IG**

## FINANCE & RESOURCES COMMITTEE

The draft minutes of the meeting held on 13 May 2015 are attached.

Key issues discussed included:

- The conclusion of the lessons learned from the post project evaluation of the St John's Business Case and its application for business cases and future work.
- The Committee received a report on the terms of reference for the data diagnostic review exercise with the explicit aim of understanding and using data to identify opportunities for improvement.
- NHS Lothian's position in relation to NRAC was considered and concern expressed at the mechanisms to fund Boards outwith NRAC. Committee members did however note that NHS Lothian's NRAC share had increased.
- The Committee received an initial progress report on LRP, noting no improvement in the position since the Financial Plan was presented. It also undertook the first of its more detailed scrutiny of Directors portfolios in relation to LRP in the Acute Sector.
- The first stage in the due diligence process for the establishment of IJBs was considered. In particular the Chair emphasised the need to work with Chairs/vice Chairs and Section 95 Officers to improve joint working. Committee members noted the potential impact of the IJBs on NHS Lothian's financial management and planning process.
- In terms of Business Cases the Committee considered and approved the following;
  - The Initial Agreement for the Eye Pavilion, and noting that further work was required on the redesign of the service model;
  - The Standard Business Case to relocate Leith Walk Surgery

Key issues on the horizon are:

- The extent of the financial challenge, LRP delivery and capacity implications
- Further discussion on the output of the Data Diagnostic work
- Due diligence for the establishment of IJBs.

George Walker/Susan Goldsmith  
Chair/Executive Lead

**DRAFT**

**NHS Lothian**

**Finance & Resources Committee**

Minutes of the Meeting of the Finance & Resources Committee held at 9:00am on Wednesday 13 May 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

**Present:** Mr G Walker (Chair); Mrs Kay Blair; Dr D Farquharson; Mrs S Goldsmith and Mr B Houston.

**In Attendance:** Mr A Bone (Business Partner, Scheduled Care); Ms J Campbell (General Manager); Mr J Crombie (Chief Officer); Mr P Gabbittas (Joint Director of Health & Social Care, Edinburgh); Mr I Graham (Director of Capital Planning & Projects); Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information); Mr C Marriott (Deputy Director of Finance) and Mr P Reith (Secretariat Manager).

Apologies for absence were received from Mr T Davison, Professor J Iredale, Ms M Johnson and Mr P Johnston.

**Declaration of Financial and Non-Financial Interest**

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

There were no declarations of interest.

**1. Minutes of the Previous Meeting**

1.1 The minutes of the previous meeting held on 11 March 2015 were approved as a correct record.

**2. Running Action Note**

2.1 The Committee received the previously circulated running action note detailing outstanding matters arising, together with the action taken and the outcomes. Mrs Goldsmith advised that it was hoped that the Scottish Futures Trust was close to a solution on the impact of ESA 2010 on NHS Lothian's NPD and HUB DBFM Programme.

**3. Matters Arising**

3.1 Lessons Learned from the St John's Hospital Business Case – Mr Graham introduced a previously circulated report giving further details of the lessons learned from the recent sequence of projects undertaken at St John's Hospital and their applications to future business cases and project work. The Chair commented that this had been a useful



exercise and that a sensible recommendation had resulted. Mr Graham confirmed that all business cases and projects had a similar evaluation and recommendations routinely came back to the Finance & Resources Committee as part of the process. He advised that the Scottish Government Capital Investment Manual and Governance Processes were changing with a greater emphasis being placed on benefits. Mr Crombie confirmed that site management had been involved in the evaluation of both the site and the strategy. The Committee noted the recommendation from the post project review and that the lessons learnt would be developed and applied to future business cases and projects principally through project management led by Capital Planning and Projects alongside Facilities and Finance.

- 3.2 Finance & Resources Committee Site Visit Schedule – Mr Graham advised the Committee that visits were being proposed to one or more sites in the city centre campus of Chalmers Hospital/ Lauriston/ Princess Alexandra Eye Pavilion for the July meeting and the Royal Infirmary of Edinburgh for the 25 November meeting. Mr Gabbitas suggested that the meeting at a primary care venue such as Wester Hailes Health Center and agreed to discuss this with Mr Graham for a future visit. It was noted that the visits would run from 9am to 10am followed by a 2 hour meeting of the Committee. **IG/PG**
- 3.3 Data Diagnostic – Terms of Reference – Mr Marriott spoke to a previously circulated report advising the Committee of the data diagnostic review exercise which had been commissioned in partnership with the Scottish Government. The Committee noted that Deloitte had been appointed to progress this task following a successful tender exercise. The primary objective of the project was to support NHS Lothian to understand its data and how it could be used in the future to identify opportunities for improvement and make changes to services that would support the achievement of the required financial position. It was intended that this project would be rolled out across Scotland. The Chair expressed some concern about the lack of detail and definition in the project scope. Mr Houston commented that he was happy with the analytical data and agreed that whilst the approach was generic such a project needed to be run by someone from the outside to give an external view. The model being used was a very powerful way of identifying how to get benefits. The Committee noted that Deloitte had been appointed to progress this task and that a project initiation document had been approved by the Project Board and the work had commenced.
- 3.4 NHS Lothian NRAC Parity – Mrs Goldsmith spoke to a previously circulated report giving an update on NHS Lothian's position in relation to NRAC parity. The Committee noted that over recent years the Scottish Government had made a commitment to bring all Health Boards to within 1% of NRAC parity and a number of Health Boards, including NHS Lothian, had received additional funding year on year as part of this commitment. NHS Lothian had received a further £7m of NRAC funding in 2015/16, bringing it to parity. More recently, the NRAC parity model had been refreshed based on the most recent data showing that Lothian's NRAC share had increased from 14.36% to 14.5%. Mrs Goldsmith explained that although NHS Lothian's population show had increased other indicators had gone down as the Lothian population was healthier than the rest of Scotland. As a result, Lothian was under significant pressure compared to Glasgow as a result of other allocations of which Glasgow received a significant share. Mr Houston commented that it was important how Lothian took this debate forward as the current ad-hoc funding model was not an effective way to run the

system. The Committee noted that NHS Lothian's NRAC share had increased, resulting in an anticipated additional £11.889m built into financial planning from 2016/17 onward.

#### **4. Finance and Resources – Annual Report**

4.1 Mrs Goldsmith introduced the previously circulated draft annual report from the Finance & Resources Committee and commented that the number of vacancies on the Committee was leading to difficulties in achieving a quorum.

4.1.1 Mrs Goldsmith drew attention to the role of the Committee in expressing its concern at the deteriorating performance in Local Reinvestment Plan (LRP) delivery, and broader financial performance in relation to both 2014/15 and the financial plan for 2015/16 as well as in the overall development of the property and asset management strategy.

4.1.2 The Committee noted the key issues raised in respect of the effectiveness of the Committee, agreed the Committee had adequate access to resources in order to properly discharge its responsibilities and approved the annual report for 2014/15 for submission to Lothian NHS Board. **SG**

#### **5. Financial Position to March 2015**

5.1 Mr Marriott introduced a previously circulated report giving an overview of the financial position for the year to the end of March 2015. Mr Marriott explained that there were two current concerns about the continuing financial position with a deteriorating prescribing position and concerns about the achievability of the local reinvestment plan.

5.1.1 The Committee congratulated Mr Marriott on his work in achieving financial balance for the year 2014/15 and it was agreed that the letter recognising the work undertaken to achieve this should be sent from the Committee. **SG/GW**

5.1.2 The Committee agreed to note that NHS Lothian had achieved its financial targets for the year 2014/15, subject to external audit review.

#### **6. NHS Lothian 2015/16 Local Reinvestment Plan Update**

6.1 The Committee received a previously circulated report giving an update on the progress made to date in developing LRP plans to meet the 2015/16 target.

6.1.1 Mr Crombie gave a presentation providing an update on the acute services LRP.

6.1.2 The Committee noted that the target was £26m comprising of £15m for the year 2015/16 and £11m carried forward from the year 2014/15. The projected savings were £17m in-year with £10.6m in-year schemes identified with £11.8m recurring. Not identified was £6.4m in-year saving and not included was cost avoidance of £3.1m which had no immediate cash release.

- 6.1.3 The Committee noted that a number of schemes had been identified by the Directorate and an improved governance framework involving the establishment of an acute local reinvestment plan hub had been undertaken.
- 6.1.4 The workstream approach was being adopted procurement, medicines, outpatients and laboratories and revised reporting and forecasting arrangements were in place. The need to maximise support from corporate functions was recognised.
- 6.1.5 Mr Crombie commented that the year, managers had been dealing with too large a target which was unachievable in the environment of increasing demand. Salaries were relatively stable and the main drivers were supplies and equipment.
- 6.1.6 Progress and risk were now being evidenced and work was underway in key areas, although the impact of the reduction in the Edinburgh budget for care home places and home helps created a real danger that delayed discharges would impact on the acute services ability to achieve their targets.
- 6.1.7 The Committee noted that eJob planning was being introduced to assist with workforce management and Mrs Blair commented on the number of agency nurses being used.
- 6.1.8 Mr Crombie advised that if the acute services were staffed up to establishment then far fewer agency staff would be required.
- 6.1.9 The Committee noted that there was a large turnover of staff in ward areas and exit interviews were not always being conducted. A 6 month training programme for Scrub Technicians to assist in theatres was currently underway.
- 6.1.10 The Chair asked how service redesign was progressing and suggested that the Local Reinvestment Plans should be rebadged as efficiency and savings.
- 6.1.11 Mr Crombie advised that ideas from the Utah not-for-profit healthcare provider Intermountain, considered the most efficient health care system in the United States, were being investigated and he felt that these would resonate with clinicians.
- 6.1.12 Mrs Goldsmith commented that a tendency to over test patients also required to be looked at. In addition, some £70m worth of replacement equipment was now required.
- 6.1.13 The Committee agreed to note the recommendations in the report.

## **7. Preparation for the Creation of Integration Joint Boards**

- 7.1 Mrs Goldsmith introduced a previously circulated report giving an update on the ongoing preparations for the creation of the four Lothian Integration Joint Boards during the financial year 2015/16. This reflected the Committee's remit to 'have an interest in the wider integration agenda' as part of its financial governance remit.
- 7.1.1 Mrs Goldsmith emphasised the need for transparency around the NHS part of the budget for Integration Joint Boards and noted that the total overspend for each CHP for 2014/15 was £1,541k for East Lothian, £556k for Midlothian, £7,567k for Edinburgh and £74k for West Lothian.

- 7.1.2 The total funding available for 2015/16 was £92,918m against which additional costs of £122m had been identified.
- 7.1.3 The Committee noted Mrs Goldsmith's concern that Section 95 Officers in the four local authorities would not share financial information in front of each other. It was noted that Edinburgh was currently spending £10m more than the budget for 2015/16.
- 7.1.4 It was noted that Integration Joint Boards would have to run a shadow financial year for 2015/16 and some basic principles would have to be agreed with them.
- 7.1.5 Mrs Blair expressed her grave concern about the relationships at the Section 95 Officer level and how these could be made to work. There was also a need for education and training on the financial aspects at Integration Joint Boards.
- 7.1.6 The Chair commented that he was aware there were a number of suspicions around Section 95 Officers and emphasised it would be necessary to get all Integration Joint Board Chairs, Vice Chairs, Chief Officers and Financial Officers together to resolve the problem.
- 7.1.7 The Committee agreed to note the current work underway to support the creation of the Integration Joint Boards for Edinburgh, East Lothian, Midlothian and West Lothian and the process underway to provide financial assurance to the Committee in future. The Committee noted the potential impact of the Integration Joint Boards on NHS Lothian's financial management and planning processes.

## **8. Property and Asset Management Strategy Update**

- 8.1 Mrs Goldsmith introduced a previously circulated report on the Property and Asset Management Strategy.
  - 8.1.1 The Committee noted that the work was ongoing in updating the NHS Lothian part of the Scottish Governments Scottish Report on Property and Asset Management Strategy.
  - 8.1.2 Mr Graham explained how the various aspects fitted together and advised this would feed into the governance process through business cases. Backlog maintenance was reducing and the report would reflect how this was continuing to be driven down. He commented that it would be more difficult to fund equipment replacement with the diminishing capital available.
  - 8.1.3 The Committee noted the position.

## **9. Princess Alexandra Eye Pavilion Initial Agreement**

- 9.1 Ms Campbell introduced a previously circulated report seeking support for the initial agreement for the proposed redesign and reprovision of the Princess Alexandra Eye Pavilion.

- 9.1.1 The Committee noted that the initial agreement had been through LCIG and the Strategic Planning Committee.
- 9.1.2 Ms Campbell advised that the current building at the Princess Alexandra Eye Pavilion was no longer fit for purpose and had £2,700k of backlog maintenance as well as an increasing demand for services. It was not being proposed to replace the service like for like and services were being redesigned to match the requirements of the 21<sup>st</sup> Century.
- 9.1.3 The Chair commented that the initial agreement could be used as an example of how to incorporate redesign into future business cases.
- 9.1.4 The Committee noted that a number of sites had been considered for the new facility with the preferred way forward being to re-provide the services at the Royal Infirmary of Edinburgh/Edinburgh Bio-quarter Campus and this would provide co-location of services with acute clinical capability and adjacencies with front door services and inpatient services.
- 9.1.5 The Committee noted that whilst there were some concerns with transport for the increasingly old patient population transport links to the Royal Infirmary of Edinburgh were being improved and it was intended to make significantly more use of the community optometry service to provide more treatment locally than was currently done at the Princess Alexandra Eye Pavilion. Mrs Goldsmith commented that the possibility of joining up the build with other builds at the Bio-quarter site would be included in the development of the business case. Work would also be undertaken in engaging with the Scottish Government on the appropriate funding mechanism.
- 9.1.6 The Committee agreed to endorse and approve the approach taken to developing the initial agreement for the proposed redesign and reprovision Princess Alexandra Eye Pavilion subject to the details of the design being clarified in the final business case. The Committee also agreed to approve progress to the development of an outline business case and the associated costs of up to £500k to support this development.

## **10. Leith Walk Surgery Standard Business Case**

- 10.1 Mt Gabbitas introduced a previously circulated standard business case for Leith Walk Surgery and advised that the completion cost of £1,000k would give a £21k per annum revenue saving. To build new premises would cost around £4,000k and the standard business case had been agreed by the Corporate Management Team.
- 10.1.1 The Committee noted that there seemed to be a tendency for bigger premises for existing practices and Mr Gabbitas advised that there was a premises prioritisation in Lothian and a lot of work was being undertaken in this area. Whilst there were moves to increase the number of salaried general practitioners, general practitioners were independent contractors and the process was an evolutionary one.
- 10.1.2 Professor McMahon commented that the move towards salaried general practitioners had been discussed at the Board development day in January and an update report would be coming to the June Board meeting with a number of suggestions. Mrs Goldsmith commented that there were different models of care developing in England

and Professor McMahon advised that the new general practitioners contract would address some of these issues.

10.1.3 Dr Farquharson commented that a recent survey of general practitioners coming out of training had show that most now wanted to be salaried GPs.

10.1.4 The Chair congratulated Mr Gabbitas on the paper and the work undertaken on this project.

10.1.5 Mr Graham reassured the Committee that the Project Team would be addressing the experience and track record of the developer.

10.1.6 The Committee agreed to approve the proposal by Edinburgh Community Health Partnership to re-provide Leith Walk Surgery in fit for purpose accommodation and noted that the business case had been approved by Edinburgh Community Health Partnerships Primary Care Management Group and the Lothian Capital Investment Group.

## **11. Property and Asset Investment Programme 2014/15 Business Case Monitor**

11.1 Mr Graham introduced a previously circulated report giving a detailed overview of the major capital projects.

11.1.2 The Committee agreed to note the progress and performance to date of each of the projects and the associated key risks and issues.

## **12. Spending Review**

12.1 In response to a question from Mrs Blair, Mrs Goldsmith advised that the spending review would be discussed with the Directors of Finance and a report would be brought back to the next meeting of the Committee. **SG**

## **13. Date of Next Meeting**

13.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 8 July 2015 at 10.15am at a venue to be determined in the City Centre Campus, Edinburgh.

The draft minutes of the meeting held on 24 March 2015 are attached.

**1. Key issues discussed included:**

1.1. Patient Story

The meeting was opened with an NHS Lothian commissioned DVD which featured a powerful actual case study of how feedback to the Board regarding standards of care should inform continuous improvement and organisational learning. The 'Power of Apology' was expressed by a relative in a way reports cannot fully convey and the Chief Executive's role in this case was an exemplar of a Person Centred Culture handling patient feedback. I commend sight of the DVD to Board members.

1.2. Person Centred Culture

In item 62.1 the Committee received an encouraging and positive report on Person Centred Culture which outlined the framework, reporting structure and timelines on this key aspect of work which will deliver on the Boards assurance need for clear sight and oversight of patient feedback. The report provided considerable assurance on progress in this area.

1.3. Complaints and Patient Feedback

In item 6.3 the committee received an update on Complaints and Feedback, changes pending and direct links to the Person Centred Culture work. The Committee was reassured that this key aspect of Board work would have direct oversight by the Nurse Director from April 2015.

HCG members remain concerned and have limited assurance regarding the current situation on complaints and feedback and are seeking further assurance regarding defined time lines for progressing the improvements to complaints and feedback.

1.4. Nursing and Midwifery Council – Midwifery

In item 6.4 a comprehensive and positive review of Midwifery services across NHS Lothian was welcomed as assurance that care delivery was of a consistently high standard and that NHS Lothian was well placed for pending changes in regulatory processes in Midwifery nationally.

1.5. Staff Mandatory Training

In item 64.2 on the mandatory training report the Committee was not assured that there were adequate and robust systems and processes in place dealing with data capture of mandatory training in NHS Lothian. The matter is to be taken forward by the Staff Governance Committee.

1.6. Outstanding assurance needs

In the annual retrospective review of Healthcare Governance Committee work it has been noted that we have incomplete assurances in a number of areas. These are Healthcare Associated Infection performance against HEAT targets, management of

complaints and patient feedback, and assurance from Staff Governance that systems and processes are adequate in relation to capturing data on staff mandatory training. In addition, achieving all stroke standards and targets remains a challenge with a revised date to review the progress in this work of November 2015.

Dr Morag Bryce

Chair of the Healthcare Governance Committee

27 April 2015



## NHS Lothian

### Healthcare Governance Committee

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 am on Tuesday 24 March 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

**Present:** Dr M. Bryce, Non-Executive Board Member (chair); Ms S. Allan, Non-Executive Board Member; Ms P. Eccles, Partnership Representative; Ms W. Fairgrieve, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Mr A. Joyce, Employee Director, Non-Executive Board Member; Ms A. Meiklejohn, Chair of the Area Clinical Forum, Non-Executive Board Member; Cllr F. Toner, Non-Executive Board Member; Dr R. Williams, Non-Executive Board Member.

**In Attendance:** Mr A. Boyter, Head of Human Resources; Ms Y. Bronsky, Nursing and Midwifery Council (item 64.1); Ms J. Bennett, Clinical Governance Manager; Ms M. Christie, Head of Health, West Lothian CHCP (on behalf of Mr Forrest); Dr B. Cook, Associate Medical Director; Mr T. Davison, Chief Executive; Dr M. Douglas, Consultant in Public Health Medicine (on behalf of Professor McCallum); Ms J. Gajree, Lead Pharmacist, Controlled Drug Governance Team (observing); Ms M. Johnson, Director of Unscheduled Care; Dr J. McCallum, Associate Medical Director, St John's Hospital (item 60.1); Ms K. McSorley, Bereavement Co-ordinator (item 60.1); Ms B. Pillath, Committee Administrator (minutes); Mr A. Short, Head of Health, Midlothian CHP; Ms L. Tait, Associate Director of Strategic Planning (on behalf of Professor McMahan); Professor A. Timoney, Director of Pharmacy.

**Apologies:** Ms S. Ballard-Smith, Nurse Director; Ms L. Cowie, Chief Nurse, Edinburgh CHP; Dr D. Farquharson, Medical Director; Mr J. Forrest, West Lothian CHCP Manager; Ms M. Fraser, Complaints Manager; Mr B. Houston, Board Chairman; Professor A. McCallum, Director of Public Health and Health Policy; Professor A. McMahan, Director of Strategic Planning; Mr D. Small, Joint Health and Social Care Integration Manager, East Lothian; Mr D. White, Assistant General Manager, Edinburgh CHP.

#### Chair's Welcome and Introductions

*Dr Bryce 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.*

#### 57. Patient Story

- 57.1 A DVD was played showing an interview with a member of the public whose mother was cared for in NHS Lothian before her death, giving her thoughts about what constitutes good care and how her feedback to the Board were managed.
- 57.2 Ms Johnson noted that a number of interviews with patients and relatives had now been recorded for use in staff education.

**58. Committee Cumulative Action Note and Minutes from Previous Meeting (27 January 2015)**

58.1 The updated cumulative action note had been previously circulated.

58.2 The minutes from the meeting held on 27 January 2015 were approved as a correct record subject to one correction at paragraph 50.2.3.

**59. Matters Arising**

59.1 Hospital Electronic Prescribing and Medicines Administration (HEPMA)

59.1.1 In response to concerns raised at the previous meeting that electronic prescribing was not included on the Lothian eHealth Strategy, Professor Timoney reported that following discussion with Professor McMahon and the Director of eHealth assurance was given that the strategy would be updated along with the recently published national eHealth Strategy, which included HEPMA. This would mean that the information gathering stage of the process would begin.

**60. Emerging Issues**

60.1 Death Certification (Scotland) Act 2011

60.1.1 A paper had been previously circulated, and Dr James McCallum gave a presentation. Dr McCallum noted that the advantages of the new system were related to quicker processing and quality improvement and assurance.

60.1.2 Dr Williams was assured that implementation the new requirement was being carried out well, but felt that the system being implemented was not ideal for primary care.

60.1.3 Ms Johnson noted that any delay for families due to the change of system would be difficult, and noted the need for staff understanding of this fundamental change. Dr McCallum noted that a communications strategy was in place and that the undertaking industry was also fully engaged and doing some of their own awareness raising. All FY1s and FY2s would receive training on the new process at induction. The change aimed to result in improvement in accuracy so that delays were not caused by errors.

60.2 Healthcare Environment Inspection, Ellen's Glen, March 2015

60.2.1 Ms Johnson reported that the initial feedback from the recent inspection had been positive. The main issue highlighted was the need for more handwashing sinks to meet the national requirements; an action plan for additional sinks was already in progress. Other areas mentioned were the temperature for washing patient clothing and the pet policy. The hospital was found to be clean and all mattresses checked were intact. The final report had not yet been published.

60.2.2 Ms Johnson advised that there was an ongoing complaint by the family of a patient who died at Ellen's Glen. The complainant had noted an intention to publish the review report once completed.

### 60.3 Acute Structure Changes

60.3.1 Ms Johnson advised that from 1 April 2015 Unscheduled Care would become the responsibility of Mr Jim Crombie, now Chief Officer. This change would be communicated to all staff.

### 60.4 Morecombe Bay Investigation Report

60.4.1 Ms Johnson drew the attention of Committee Members to the recently published report and noted that the Healthcare Improvement Scotland had announced a national review of Maternity Services in Scotland in response to this. A report on NHS Lothian's status would be submitted at the next meeting. **MJ**

### 60.5 Penrose Inquiry

60.5.1 Dr Cook noted that the Penrose Inquiry into Hepatitis C and HIV acquired infection from NHS treatment in Scotland with blood and blood products would be published on 25 March 2015 and that an STV programme would include comments from one family in Lothian.

## 61. **Corporate Risk Register**

61.1 The risk register had been previously circulated. Ms Bennett noted that there had been a significant review of corporate risks which changed the level of responsibility for dealing with some risks. For instance, the Board would now be required to make decisions on complaints and violence and aggression. The new approach was supported by the Audit and Risk Committee and would be submitted to the Board for approval at its meeting on 1 April 2015. It was the view of the Risk Management Steering Group that this was a much clearer way of representing the risks.

61.2 Mr Davison noted that the Local Delivery Plan to be considered by the Board on 1 April 2015 would show the difficulties in reconciling safety and quality, access targets, and finances and how this was related to the risk appetite.

61.3 Ms Eccles noted that the Quality of Patient Experience risk was worded in a way which seemed demoralising for staff. Ms Bennett advised that this would change as the risk would be reconstituted as a risk of complaints, and noted that this should not reflect badly on the large number of very good staff and the amount of positive feedback received. Mr Davison noted that he received as many letters of thanks addressed directly to the Chief Executive as letters of complaint. Ms Johnson noted that methods of capturing compliments would improve as part of the person centred culture work and the complaints team review.

61.4 Ms Allan noted that when delivering a person to person service there was always a risk that this could go wrong.

61.5 Mr Boyter and Ms Johnson agreed that the complaints team was not yet at the stage of starting to record compliments, but this would be considered in the future.

## **62. Person Centred Care**

### **62.1 Person Centred Culture Report**

62.1.1 A paper had been previously circulated which showed some of the data collected since the discussion of data collection methods at the previous meeting. Ms Johnson noted that a Person-Centred Collaborative Day had been held on 6 February 2015, aimed at ward and department level with speakers from around the UK talking about how to make changes and record improvements.

62.1.2 Being part of the 'hello my name is...' project being launched in England was being considered, which encourages members of staff to introduce themselves to patients and relatives.

62.1.3 More work was required in getting patients to participate in questionnaires; of 7,000 discharged patients in the trial area, only 200 completed the questions. The use of volunteers to help with this was being tested.

62.1.4 Ms Bennett noted that person-centred culture in primary care was being made part of the House of Care process.

62.1.5 Ms Meiklejohn felt that it would be useful to have the work highlighted in the report spread to all areas as soon as possible. Ms Johnson agreed but advised that a slower progress was required to ensure that work was done to the highest standard.

62.1.6 Dr Williams felt that work was also required to show how improvements were being made in response to problem areas highlighted by patient feedback. Ms Johnson advised that ways of collecting this information were being considered by the teams on the test sites. Ms Bennett noted that data for individual departments was more important for directing improvements than aggregate data. Dr Douglas suggested that data divided by different patient demographics would also be of use; Ms Bennett agreed that this would be considered at a later stage. Data for boarding patients was already being separated as it was recognised that these patients may have a different hospital experience.

62.1.7 The Committee were positive and supportive about the progress in this area.

### **62.2 Older People in Acute Care Inspections**

62.2.1 A paper giving an update on changes in methodology for the Healthcare Improvement Scotland Older People in Acute Care Inspections had been previously circulated. The inspection team would visit NHS Lothian on 14 April 2015 for presentations and staff interviews, and this would be followed by an unannounced inspection of ward areas within 6-8 weeks. The circulated paper identified the issues raised as part of the self-assessment in preparation for the inspections.

- 62.2.2 Ms Johnson advised that the format of regular internal inspections was being reviewed with the aim of making the escalation policy clearer so that any issues would be picked up and acted on immediately before being picked up during external inspections.
- 62.2.3 Dr Bryce noted that assurance would be sought on how learning from Scottish Public Services Ombudsman reports had improved services. Ms Johnson advised that SPSO reports were sent to individual teams to act on and improvements were made, but that organisational learning could be improved.
- 62.2.4 Mr Davison noted that the first integrated inspection by Healthcare Improvement Scotland and the Care Inspectorate was expected to take place in East Lothian in 2015. The report from this would come to this Committee. Ms Christie noted that a pilot of the new inspection had already taken place in West Lothian, which was helpful.

### 62.3 Customer Relations and Feedback Team Report – Quarter 3

- 62.3.1 A paper had been previously circulated. Mr Boyter advised that work was in progress on increasing the capacity and experience of the Complaints Team. It was noted that sickness absence in this team was high due to long term structural issues.
- 62.3.2 Dorothy Armstrong, commissioned to review the service and make recommendations, had submitted her report to the Board for discussion on 1 April 2015. This review included a number of interviews with staff, and there had been four consultation days for staff with 135 attendees in total, all of whom were generally supportive of the change in direction. A number of staff had also noted willingness to be involved in this work. Staff in the complaints service had also been consulted; their feedback identified their recognition that the current system was not working and their agreement with the recommendations made. Mr Boyter was meeting with the team regularly to address any concerns.
- 62.3.3 As complaints work and service improvement was part of the Person-Centred Culture work of the Board, the responsibility for the service would now be with the Nurse Director; the Director of Human Resources would assist with the action plan.
- 62.3.4 Dr Bryce noted that a national direction on complaints was emerging with a commitment from the Scottish Government to improve feedback and handling of complaints.

### 62.4 Integrated Impact Assessment Tool

- 62.4.1 The paper and tool had been previously circulated. Dr Douglas noted that the purpose of the tool was to use the same impact assessment for Board and Council to prevent conflict and repetition of work. The tool both met the legal requirements, and helped with the implementation of new policies by facilitating policy writers taking into account impacts.
- 62.4.2 The tool would be adopted in NHS Lothian and East and Midlothian Council for all policies and by City of Edinburgh Council for integrated policies. West Lothian

Council had not yet indicated its intention to use the tool but it was expected that the same approach would be taken.

- 62.4.3 The Equality and Diversity Lead post no longer existed, so that service areas needed to consider these areas individually. It was proposed that that a person was identified to lead on this in each service area. In response to a question from Ms Christie, Dr Douglas advised that training would be provided to ensure that the tool was applied consistently, and that there would be random quality assurance checks to ensure the tool had been applied appropriately.
- 62.4.4 Ms Allan felt that in an organisation the size of NHS Lothian with different types of interactions, not having an equality lead was a governance risk. Mr Boyter advised that decision not to replace the post was based on financial resources. Ruth Kelly had now taken on the role of equality lead for staff, in addition to her other roles, but equality for the population was not part of her remit; this fell under Public Health. Dr Williams felt that a lack of adequate support and this area could cause a delay in important policies being implemented. Dr Bryce noted the need to consider how requirements could be met without this post.
- 62.4.5 Ms Gormley noted that the remit of the Mutuality and Equality Committee had also been absorbed into other Committees, meaning that governance and capacity for equality had been removed at the same time.
- 62.4.6 Dr Williams noted that it was a possibility that additional funding would be allocated to the new Health and Social Care Partnerships and that this may be an area they would consider investing in. Dr Bryce agreed to write to them highlighting the issues. **MB**
- 62.4.7 Members supported the recommendations made in the paper.

## **63. Safe Care**

### **63.1 Scottish Patient Safety Programme Review of Falls and Pressure Ulcers**

- 63.1.1 A paper had been previously circulated. Ms Bennett reported that falls had been recorded since 2010 and that there had been a 20% reduction in falls with harm since that date. The Scottish Patient Safety Programme target was to reduce falls with harm by a further 20% from that baseline. Falls remained one of the three most frequent adverse events, and had a serious effect on patients and relatives as well as an estimated additional cost to NHS Lothian of £50,000 per fall with fracture due to increased length of stay and increased need for medication, rehabilitation and care at home. There was also an impact on staff.
- 63.1.2 Improvements were being made locally at two test wards at the Royal Infirmary where the context of falls were being considered, noting the effects of agitation, lighting levels, equipment, and other causes. This made it clearer what interventions would be required.
- 63.1.3 Ms Bennett noted that reducing the incident of pressure ulcers in healthcare was a challenge throughout the UK and internationally. The reliability of assessment had

increased, but responses to assessment needed to be more consistent, with a team based approach.

- 63.1.4 Front line staff had indicated that to consider improvement programmes together rather than separately would be more efficient as for instance infection control, falls, sepsis and pressure ulcers were all related and any changes made could affect more than one of these areas.
- 63.1.5 It was noted that nurse staffing levels had an effect on both of these areas. Ms Johnson noted that review was ongoing in areas of shortage, and ways of improving staffing levels were being considered.
- 63.1.6 Access to appropriate mattresses and equipment was also relevant. Ms Johnson advised that a group was looking at the current bed contract which included pressure relieving equipment, with the aim of improving access.
- 63.1.6 There was discussion on the role of Healthcare Improvement Scotland in setting targets for reduction of pressure ulcers when there was no knowledge on effective ways to do this. Ms Bennett advised that HIS had been asked to carry out an evidence review, but in the absence of this Lothian had started doing this work. A national review would be more efficient than each Board doing this individually. Ms Johnson agreed to raise this with the new Chief Nursing Officer and report back at the next meeting. **MJ**
- 63.1.7 Members commended the robust review outlined in the paper and supported the approach for improvement.

## 63.2 Healthcare Associated Infection Update

- 63.2.1 A paper had been previously circulated. Ms Johnson reported that as expected, NHS Lothian had not met the HEAT target for reduction of *Clostridium difficile* Infection or *Staphylococcus aureus* Bacteraemia. This was disappointing as these infections had an adverse effect on patients, staff and finances; a significant amount of work was still to be done.
- 63.2.2 Ms Johnson noted that the paper now included new charts designed by Dr Liz Bream. These had been accepted by clinicians, who would be included in their distribution.
- 63.2.3 The revised antimicrobial prescribing policy had been launched, and no significant adverse events had been reported so far. There had been an increase in use of gentamicin, and the next few months would show whether the new policy was having any effect on *Clostridium difficile* Infection.
- 63.2.4 NHS Lothian was currently using actichlor plus for routine cleaning, but Health Protection Scotland had advised that this was not evidence based; they recommended use of detergent for routine cleaning, and actichlor plus of enhanced cleaning or cleaning of spillages. Following these recommendations would make cleaning easier for staff and detergent had the advantage of being cheaper and did not degrade equipment. This was currently being trialled.

63.2.5 Members agreed that the change of format in the paper was helpful, and supported the recommendations outlined in the paper.

### 63.3 Public Protection Update

63.3.1 A paper had been previously circulated. Ms Johnson noted that inter-agency referrals in Edinburgh could not be sustained due to medical workforce issues, so had been centralised. This was working well as a temporary measure but needed to be reviewed and further options considered. The shortage of Paediatricians continued.

63.3.2 Ms Johnson reported that the Serious Offender Liaison Service (SOLS) run between NHS Lothian and Policy Scotland would not continue to cover violent offenders in its remit. Funding had been found in Lothian to cover this remit for another year as this was important to support staff dealing with this group of patients. This was an interim arrangement but would be reviewed and different options would be considered.

63.3.3 The Significant Case Review being undertaken jointly between Fife and Edinburgh following the death of a three year old child in January 2014 had been concluded and the report would be submitted to the Committee for information at the next meeting.

**MJ**

### 63.4 Improving Management of Adverse Events

63.4.1 A paper had been previously circulated. Ms Bennett noted that the report set out compliance against the national requirement to close investigations into significant adverse events within 66 days. This requirement was not currently being met. In some cases the delay was the time taken for government sign off, in others the time taken to carry out reviews locally. The Clinical Governance Team were working with areas with large backlogs of reviews to complete; these were areas with high numbers of complex cases.

63.4.2 It was important that managers see the reports from reviews in their own areas so that learning could be included in local action plans; the sign off process for reviews was being worked on in each area but this was complicated by organisational change, which altered the sign off routes. More work was required in this area.

63.4.3 Dr Bryce noted that the paper improved understanding of why cases had not been closed and gave assurance that work was in progress to improve this. Members supported the actions recommended in the paper.

### 63.5 Mental Welfare Commission Report, Midlothian Community Hospital

63.5.1 The report and a covering paper had been previously circulated. Mr Short reported that there had been an unannounced visit from the Mental Welfare Commission to Glenlee Ward, Midlothian Community Hospital which had highlighted concerns with personalised care planning, activities for patients, and the broader ward environment. A short life working group had been convened to take forward the recommendations made, and a group including representation from public protection had begun and audit considering guardianship and the provision for



adults with incapacity. There was also a link with pharmacy regarding arrangements for covert medication.

- 63.5.2 Sustainability checks had been put in place for key improvements which would be reported to the Mental Welfare Commission. The Commission was also expected to revisit the area to check progress in approximately May 2015.
- 63.5.3 Mr Short noted that staff in the ward were disappointed with the outcome of the visit but were considering the recommendations with enthusiasm and optimism, and there was good leadership which was building on good practice in other areas of the hospital.
- 63.5.4 Dr Bryce felt reassured that the approach outlined in the paper for meeting the recommendations was robust, but would like to know what internal systems were in place that should have flagged up these problems earlier, and whether other similar areas were being checked to ensure they did not share some of these problems.
- 63.5.5 In response to a question from Ms Allan, Mr Short explained that covert medication was the process which allowed patients to receive the medication they needed. This process was used for essential medication only, there were very strict restrictions on use, and any use would be discussed by the consultant and relatives of the patient. The concerns raised were around paperwork and recording.

#### 63.6 Electronic Document Transfer (EDT) Implementation

- 63.6.1 A paper had been previously circulated which outlined an incident where there was a software failure which meant that test results were not being received by relevant clinicians, and the risk associated with the introduction of this software which had been piloted in a small number of practices before implementation. Although the failure had caused potential for harm to patients, no actual harm was caused. It was recognised that more testing was required before future rollouts of new software, and more checks once implemented. In general the system introduced allowed much more efficient communication of reports with GPs.
- 63.6.2 Dr Williams noted that there was a significant potential for harm with this failure and would like not a 'period of monitoring' of new systems as recommended in the report, but ongoing monitoring to ensure any problems were identified and resolved. Ms Tait agreed to ask the author of the paper to consider this.
- 63.6.3 Taking into account this change, Members supported the recommendations made in the paper.

#### 63.7 Destruction of Patient Records Following Scanning

- 63.7.1 A paper had been previously circulated. Members supported the second option outlined, which allowed destruction of paper copies of patient records once they had been scanned and were held electronically and felt that for the reasons set out in the paper this would not be a high risk.

### 64. **Effective Care**

## 64.1 Nursing and Midwifery Council Annual Report

64.1.1 The report had been previously circulated along with an NHS Lothian briefing paper. Ms Bronsky, Local Supervising Authority Midwifery Officer, Nursing and Midwifery Council gave a presentation.

64.1.2 Dr Bryce noted that assurance was given by the new method of looking at the evidence to ensure standards were being met. In response to a question about the planned discontinuation of statutory supervision, Ms Bronsky advised that this process generally worked well but that it was felt resources could be better used elsewhere. It had also been found in the Morecombe Bay Investigation that statutory supervision had failed in that instance, which indicated that it may not be robust in all areas.

## 64.2 Mandatory Staff Training Recording Improvement Plan

64.2.1 A paper had been previously circulated. Mr Boyter advised that this was the first forum at which the data in the paper had been reported; although this was the remit of the Staff Governance Committee, it had not yet been discussed there due to the timings of the meetings. It was believed that the data still showed significant under reporting of training that had been completed due to a number of factors discussed previously, and due to a backlog in recording data onto the system.

64.2.2 The data did not yet include classroom based training; this was the preferred method of training in areas such as facilities where staff did not always have the literacy and numeracy skills or IT access and skills to complete computer based training. Information about attendance at these training sessions was collected locally but not recorded on the central system.

64.2.4 Mr Boyter noted that in addition to work on better recording of mandatory training compliance, the mandatory training system needed to be reviewed by the Corporate Management Team, including what was included as 'mandatory' for each staff group according to seniority and how to measure competence.

64.2.5 Dr Bryce felt that due to the limitations of the data given it did not yet give assurance that NHS Lothian met the requirement that all staff were adequately trained, but that it represented a good start for making further improvements which would be discussed further by the Staff Governance Committee.

64.2.6 Ms Johnson suggested that a breakdown of the data into individual areas could help target improvement in compliance. Mr Boyter confirmed that the current dataset would allow this.

## 64.3 Quality Report

64.3.1 The report had been previously circulated. Ms Bennett highlighted the drop in complaints figures from prisons, which was due to local resolution work taking place.

64.3.2 Ms Johnson noted that a presentation on Stroke Care was scheduled for the next meeting in May, but suggested that this be postponed as the review of

performance was ongoing and the update would be of more use once the action plan had been progressed further. This was agreed. **BP**

- 64.3.3 Regarding the apparent increase in staff sickness shown in the report, Mr Boyter advised that the rate fluctuated seasonally and that it remained within tolerance levels and the general trend was not increasing. He also noted that when broken down into individual areas the sickness rates could reflect other problems. There was a commitment from Partnership and Human Resources to identify and resolve these issues.

## **65. Committee Effectiveness**

### **65.1 Clinical Governance Internal Audit Report**

- 65.1.1 The report had been previously circulated. Ms Bennett noted that overall the audit had found good processes in place, but wanted to see a couple of improvements which were laid out in the paper. There were no concerns about completing these actions within the timescale allocated.

### **65.2 Healthcare Governance Committee Assurance Need Report**

- 65.2.1 The report had been previously circulated. Ms Bennett noted that the issues raised in the report reflect the responses from Committee Members for use in the Annual Report. There needed to be discussion about whether assurance risks were reflected in the Committee Terms of Reference. It was agreed that Members would contribute views on the issues raised in the report electronically and this would be discussed at the next meeting. **BP/JB**

## **66. Exception Reporting Only**

### **66.1 Clinical Policy and Documentation Group Annual Report**

- 66.1.1 Dr Williams noted that the Area Drug and Therapeutics Committee had previously raised concerns about clinical policy and felt that the annual report did not give the assurance required. Ms Johnson agreed to discuss this outwith the meeting.

### **66.2 Members noted the following items for information:**

- 66.2.1 Controlled Drugs Accountable Officer Annual Report 2013-14;
- 66.2.2 Healthcare Environment Inspection Report, Western General Hospital;
- 66.2.3 SCAN Colorectal Cancer Audit Report;
- 66.2.4 Incident Report on Nursing Homes Influenza Outbreak;
- 66.2.5 Catering Strategy and Supporting Documents.

## **67. Other Minutes: Exception Reporting**

### **67.1 Members noted the minutes from the following meetings for information:**

- 67.1.1 Area Drug and Therapeutics Committee, 6 February 2015;
- 67.1.2 Clinical Management Group, 9 December 2014, 13 January 2015;
- 67.1.3 Health and Safety Committee, 27 January 2015;

- 67.1.4 Public Protection Action Group, 25 February 2015;
- 67.1.5 Divisional Dental Committee, 12 February 2015;
- 67.1.6 Organ Donation Sub-Group, 5 February 2015;
- 67.1.7 Clinical Policy and Documentation Group, 24 September 2014.

**68. Date of Next Meeting**

- 68.1 The next meeting of the Healthcare Governance Committee would take place at **9.00 am on Tuesday 26 May 2015 in Meeting Room 7, Second Floor, Waverley Gate.**
  
- 68.2 Further meetings in 2015 would take place on the following dates:
  - 28 July 2015;
  - 22 September 2015;
  - 24 November 2015.

## STAFF GOVERNANCE COMMITTEE

The draft minutes of the meeting held on 29 October 2014 are attached.

Key issues discussed included:

- Progress with Health and Social Care Integration and in particular the workforce issues:
- Values into Action – presentation on progress to date with roll out across the service.
- Communications Strategy – update on the progress with implementation.
- PVG Progress Report against the October 2015 deadline.
- Corporate Risk Register – clarity on the risks associated with the Staff Governance Committee and how these will be reported on an ongoing basis.

Key issues on the horizon are:

- The roll out of imatter across NHS Lothian and in particular the two pilot areas of Public Health and Royal Edinburgh Hospital.
- The results of the Staff Survey.
- Mandatory training and current position across NHS Lothian.
- PVG to ensure progress is maintained and the deadline of October 2015 is met.

Alex Joyce

Chair-Staff Governance Committee

## NHS Lothian

### Staff Governance Committee

Note of an inquorate meeting of the Staff Governance Committee held at 9.30am on Wednesday 29 October 2014 in the meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mr A Joyce (Chair); Councillor D Grant; Mr S McLauchlan; Mrs A Meiklejohn and Mrs A Mitchell.

**In Attendance:** Dr C Kalman; Mrs R Kelly; Mrs L Khindria; Professor A McMahon and Mr P Reith.

Apologies for Absence were received from Mr A Boyter, Dr D Farquharson, Ms M Johnson, Mr B Houston, Mr L Turner and Mr G Warner.

The Chair advised the meeting that as only five members of the committee were present the meeting was inquorate and it was agreed that the meeting should proceed informally with any recommendations submitted to the next quorate meeting for homologation.

#### 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.

#### 30. Minutes of the Previous Meeting

30.1 The previously circulated minutes of the Staff Governance Committee meeting held on 30 July 2014 were accepted as a correct record.

#### 31. Matters Arising

31.1 NHS Scotland Staff Experience – Mrs Kelly advised the meeting that iMatter would be a valuable tool with which to gain information on the staff experience. The 2020 Workforce Vision envisaged all Boards rolling out iMatter by 2017. It was noted that clarification on how widely iMatter required to be rolled out was being sought. In the first instance it would be piloted in two areas in NHS Lothian – Public Health and the Royal Edinburgh Hospital. An action plan was being drawn up and training and awareness raising would also be carried out. The outcome would be an employee engagement score and iMatter would be rolled out to other areas after the pilot had been concluded and evaluated. Mrs Kelly advised that she would bring further updates to future meetings.

RK

- 31.1.1 Mrs Meiklejohn asked how much feedback would go to the Scottish Government and Mrs Khindria advised that the only feedback would be on general progress and no actual data would be revealed.
- 31.1.2 In response to a question from Mrs Mitchell as to whether the surveys would be electronic or paper based, Mrs Khindria advised that the system was electronic and ways were being examined of ensuring that access to technology would be available to all staff as it was important to ensure that the survey was owned by the service.
- 31.1.3 The chair advised that the staff side had been split on this matter especially on the issue of having both i-Matters and the staff survey.
- 31.1.4 The meeting noted the position.
32. Staff Survey 2014 Update – Mrs Kelly advised the meeting that the staff survey had ended on 6 October with a 35% return rate for NHS Scotland as a whole and NHS Lothian's response being 36%. Lothian had the most significant increase with the Edinburgh Community Health Partnership reaching 70% and the Midlothian Community Health Partnership reaching 57%. 10,000 paper copies had been distributed but only 1200 had been completed and returned. The results would be available in December and a presentation would be given to the January meeting of the Lothian Partnership Forum followed by the Staff Governance Committee and the Board Development Day. Details would be provided to Board members as soon as possible.
- 32.1 The meeting noted the position.
33. Staff Counselling – Mrs Kelly advised that a full report on bullying and harassment would be brought to the January meeting as competing priorities had prevented the information being pulled together in time for the agenda for the present meeting.
- 33.1 The meeting noted the position.
- 34. Integration of Health and Social Care – Delegating of Health Functions**
- 34.1 Professor McMahon spoke to a previously circulated report giving an update on the process and progress to respond to the Public Bodies (Joint Working) (Scotland) Act and describing the emerging plan for governance for healthcare staff and how NHS Lothian corporate functions would need to review how they were organised to support the 4 Integration Joint Boards.
- 34.1.1 Professor McMahon emphasised that a number of details of the final scheme had yet to be agreed nationally and guidance would be issued in due course. Key among these were numbers of members on Integration Joint Boards and NHS Board and Local Authority representation. Consultation on the guidance would be undertaken over a six week period and in the meantime both Shadow Boards and Local Health (and Care) Partnerships would continue to operate in tandem.

Legislation to replace the Community Health (and Care) Partnerships and establish Integration Joint Boards would be required.

- 34.1.2 It was noted that Integration Joint Boards would not be employers of staff other than The Chief Officer and the Finance Officer.
- 34.1.3 The meeting noted that acute care was currently being examined and details of the consultation would be finalised when the new system was introduced. The chair advised that a circular from the staff side had been issued and it was noted that the timescale was such that final implementation of the legislation might not take place until after the next elections to the Scottish Parliament in 2016.
- 34.1.4 Councillor Grant asked if there had been any discussions with other NHS Boards to see what they were doing and Mrs Khindria advised that some other Boards had been contacted.
- 34.1.5 Professor McMahon advised there were still a number of issues to be clarified and a draft integration scheme would be considered at the December Board meeting.
- 34.1.6 Councillor Grant advised that East Lothian Council was currently consulting on its integration scheme would be considered at the council meeting on 16 December.
- 34.1.7 The meeting noted the position.

## **35. The Values into Action**

- 35.1 Mrs Khindria gave a presentation on the progress of Values into Action. A particular challenge was embedding those values across all 24,000 employees.
  - 35.1.1 Using a number of enablers, a branding strategy would be implemented on an incremental basis starting in a few pilot areas at St Johns Hospital and the Western General Hospital.
  - 35.1.2 In recruitment and selection, a values session was being provided and over 400 staff had already been through this. Problems were being encountered in recruiting staff to run the recruitment service and local reinvestment plan savings made in this area in previous years had caused difficulties. Additional staff were now being recruited.
  - 35.1.3 The next big issue would be clinical engagement as in recent years there had been a significant rebalancing of staff with fewer management and administrative staff and more clinical staff.
  - 35.1.4 There was, however, a high turnover of staff and the model used in Humberside was being studied to see if there were any lessons to be learned for Lothian.
  - 35.1.5 Areas of the service which generated more complaints were being identified and studied to ascertain where and what the problems were. Information was also being sought on areas which had been assessed as a high risk.



35.1.6 Mr Wilson advised that the recent Celebrating Success Awards had been successful but emphasised the need to ensure that these efforts were not simply seen as a branding exercise.

35.1.7 The meeting noted the position.

## **36. Partnership Information Network Policy Implementation**

36.1 Mrs Kelly introduced a previously circulated report giving an update on recent correspondence from the Scottish Government regarding Partnership Information Network Policy Implementation and the requirement for all NHS Boards to provide them with an update on the current position with the implementation of these policies.

36.1.1 The return submitted by NHS Lothian was circulated and it was noted that all NHS Boards were required to implement the minimum standards in the policies. Currently there were four outstanding policies to be implemented; facilities arrangements, management of employee capability, safer pre and post employment checks and secondment. Whilst the implementation of these policies was currently outstanding, there were already local NHS Lothian policies in each of these areas based on an earlier version of the Partnership Information Network Policies. The Human Resources Policy Group was progressing the work required to have these final Partnership Information Network Policies fully implemented.

36.1.2 It was noted that there was uncertainty about the application of these policies to Integration Joint Boards and guidance was still awaited.

36.1.3 The meeting noted the position.

## **37. Communications Strategy Progress Report**

37.1 Mr Wilson introduced a previously circulated report giving an update on the progress of the NHS Lothian Communications Strategy 2014/16.

37.1.1 Mr Wilson explained that there had been major changes in the Communications Department and instead of being structured along 'folio' lines with officers taking responsibility for different areas of the organisation, this had now changed to three disciplines of internal communications, external communications and print and new media. The strategy was now well on track for the implementation of the rest of the actions.

37.1.2 Councillor Grant asked about agreements with local authorities and Mr Wilson advised that he had spoken to the Human Resources Division in each local authority in Lothian and an agreement was being discussed which might lead to the inclusion of communications staff for the Integration Joint Boards in future.

37.1.3 The meeting noted the position.

## **38. Protection of Vulnerable Groups Progress Report**

- 38.1 Mrs Kelly introduced a previously circulated report giving an update on the Prevention of Vulnerable Groups Scheme and the progress with implementation of the retrospective checking within NHS Lothian.
- 38.1.1 The meeting noted that to-date 8612 forms had been returned from Disclosure Scotland compare to 7670 at the end of June 2014.
- 38.1.2 It was noted that in order to speed up the process of the checks and to try to get back on target a number of actions had been put in place in the past few months.
- 38.1.3 Where progress in an area had been slow, face to face meetings had been taking place to raise awareness and to resolve any issues or difficulties with the process. Members of the Prevention of Vulnerable Groups Team had attended the Medical Directors meeting, Allied Health Professions Directors meeting, Chief Nurse meeting, Director of Scheduled Care meeting and a similar meeting was going to take place with Unscheduled Care.
- 38.1.4 Work had been ongoing with the Communications Team to develop a communications campaign aimed at raising further awareness and reminded staff and managers of their individual responsibilities. This would include the use of Team Brief, site specific newsletters, the development of an intranet banner with links to HR online, the development of a message that could appear in payslips as well as messages via the NHS Lothian Twitter feed and Facebook. These would all begin to appear from November 2014 onwards.
- 38.1.5 In addition, the materials on HR online had been reviewed and refreshed with additional guidance on how to complete the forms and frequently asked questions on the process.
- 38.1.6 Additional temporary resources within the Human Resources Team had been recruited to help process the completed applications once they had been received from service areas and to liaise with the service areas and answer queries they might have about the completion of the forms.
- 38.1.7 It was noted that where forms were incomplete or required clarification, Disclosure Scotland now had a policy of destroying the form if a query was not responded to within 20 days.
- 38.1.8 Mrs Mitchell asked about the rate of return in Edinburgh and Mr McLauchlan advised that for the Royal Edinburgh and Associated Services he could confirm that all senior nurses had been briefed and were aware of the need for forms to be completed and returned urgently.
- 38.1.9 Mrs Kelly undertook to ask the Prevention of Vulnerable Group Teams for details of areas where the return rate was lagging.
- 38.1.10 Mr McLauchlan commented that with very few exceptions, the majority of issues being brought to NHS Lothian's attention by Disclosure Scotland were minor traffic offenses such as speeding.
- 38.1.11 The meeting noted the position.

### **39. Internal Audit Report – Recruitment**

39.1 Mrs Kelly spoke to a previously circulated report from Internal Audit on recruitment.

39.1.1 The meeting noted that the Internal Audit Team had recently undertaken an audit on recruitment as part of their 2014/15 audit plan. The objective of the audit was to evaluate the adequacy and effectiveness of internal controls over the recruitment processes. The audit focussed on specific risks that staff were recruited for posts that were not necessary, staff who were recruited were not suitable to full the vacancies and delays occurring in the recruitment process.

39.1.2 The overall opinion had been that improvement was required although in terms of staff being recruited for posts that were not necessary and delays occurring in the recruitment process, the opinion was that satisfactory controls were in place.

39.1.3 Mrs Kelly advised the meeting that the main problem was that the information held on the HR system 'Empower' needed to be culled more frequently but the team that managed the old Empower system was currently involved in moving data across to the new HR system and did not have the resource to undertake this work at present but it would be achieved by 31 March 2015.

39.1.4 The meeting noted the position.

### **40. NHS Lothian Corporate Risk Register – Risks for the Staff Governance Committee**

40.1 Mrs Kelly introduced a previously circulated report setting out the risks contained within NHS Lothian's corporate risk register that were attributed to the Staff Governance Committee in terms of assurance and for consideration to be given to the level of risk associated with each of these risks.

40.1.1 The existing 4 risks of workforce supply pressures in conjunction with activity pressures resulting in service sustainability risks; corporate prosecution under the Health and Safety at Work etc Act 1974 under the Corporate Homicide Act if staff or visitors were harmed; the risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian's sites and the risk that management capacity, particularly in the acute sector and at Executive level would impact on developing and implementing robust plans to delivery key strategic objectives.

40.1.2 These risks had all been recently updated with the current position and recommendation made about the level of risk that should be attached to each of the issues.

40.1.3 Two further risks were proposed to be added one for equal pay claims and one for the protection of vulnerable groups retrospective checking.

40.1.4 In relation to the equal pay claims, this was previously on the corporate risk register but at a meeting of the Risk Management Steering Group in November 2013 it was agreed that this risk should be removed from corporate risk register

and added to the human resources risk register. The rationale for this decision was not clear given that the equal pay claims that had been submitted were from all parts of the service and would be a risk for many of the service if these were not defended successfully.

40.1.5 The second issue to be considered for inclusion in the corporate risk register was the retrospective checking for the protection of vulnerable adults. This would be a risk for many areas of the service of the service if there were staff who were unable to work beyond the target date October 2015 and it was considered that it was appropriate that this issue should be added to the corporate risk register.

40.1.6 The meeting noted the risks on the corporate risk register that had been attributed to the Staff Governance Committee in terms of assurance and recommended that the update section for each of these risks for feedback to the Audit Committee be agreed. The meeting agreed to recommend that the proposal that the additional risks associated with the protection of vulnerable groups and equal pay be added to the corporate risk register.

#### **41. Mandatory Education in Training**

41.1 The meeting noted the previously circulated report giving an update on issues relating to statutory and mandatory training and education.

41.1.1 The meeting noted that the Healthcare Governance Committee had expressed a number of concerns about the mandatory education and training programme and the difficulty in evidencing the number of staff who had completed this training.

41.1.2 Mrs Kelly advised that there were a disparate number of paper and electronic records which could not easily all be interrogated.

41.1.3 The Chair agreed to discuss the issues with the programme lead for Safety and Compliance Education and the Chair of the Audit and Risk Committee and advise the Staff Governance Committee of the outcome of these at the next meeting. **AJ**

#### **42. Statement of Assurance Update**

42.1 Mrs Kelly advised the committee that she had discussed the statement of assurance needs with Mr Payne and would be looking at making changes to the table contained in the committee's assurance statement.

#### **43. Health and Safety Committee**

43.1 The meeting noted the previously circulated minutes of the Health and Safety Committee of 29 July 2014.

**44. Lothian Partnership Forum**

- 44.1 The meeting noted the previously circulated minutes of the meeting of the Lothian Partnership Forum held on 8 July 2014.

**45. Local Negotiating Committee**

- 45.1 The meeting noted the previously circulated minutes of the Local Negotiating Committee meeting held on 30 June 2014.

**46. Workforce Organisational Change Group**

- 46.1 The meeting noted the previously circulated minutes of the meetings of the Workforce Organisational Change Group held on 14 July and 18 August 2014.

**47. Date of Next Meeting**

- 47.1 It was noted that the next meeting of the Staff Governance Committee would be held on 11 February 2015 and not 28 January 2015 as originally agreed.

## **STAFF GOVERNANCE COMMITTEE**

The draft minutes of the meeting held on 11 February 2015 are attached.

Key issues discussed included:

- Staff Survey Results – a presentation was received on the results of the survey.
- Medical Revalidation – a report was received on the plans for the roll out of medical revalidation.
- PVG Progress report against the October 2015 deadline.

Key issues on the horizon are:

- Mandatory training and concerns at the level of compliance and report to come to the April 2015 meeting.
- Completion of the Staff Governance Standard Monitoring Framework for 2014/15.
- Preparation of the Staff Governance Annual Report for 2014/15.

Alex Joyce

Chair-Staff Governance Committee

## **NHS Lothian**

### **Staff Governance Committee**

Minutes of the Meeting of the Staff Governance Committee held at 9.30am on Wednesday 11 February 2015 in Meeting Room 7, Second Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mr A. Joyce (chair); Mr A. Boyter; Dr D. Farquharson; Councillor D. Grant; Mr B. Houston; Mr S. McLauchlan; Mrs A. Mitchell.

**In Attendance:** Mrs R. Kelly; Mrs B. Pillath (minutes); Mr S. Wilson.

**Apologies:** Ms S. Ballard-Smith; Mrs A Meiklejohn; Mr L. Turner.

### **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.

### **30. Minutes of the Previous Meeting (29 October 2014)**

- 30.1 The previously circulated minutes of the inquorate Staff Governance Committee meeting held on 29 October 2014 were approved as a correct record and the actions homologated.
- 30.2 Mr Joyce noted that as the Membership of the Committee had been reduced, the quorum had also been reduced by the Board.

### **31. Staff Survey Results**

- 31.1 Mrs Kelly gave a presentation giving the results of the 2014 staff survey. The response rate had improved and the responses given to almost all questions were more positive than in 2013. Ms Kelly advised that a further breakdown by area of work and department would be available in the near future.
- 31.2 It was thought that the increased response rate was due to a combination of factors including encouragement by Partnership Representatives of staff to complete the survey, an easier to use survey and effort to raise awareness by the Communications team. A weekly report on responses submitted per service during the survey time had allowed targeted prompting of service areas to encourage their teams to complete the survey, and a competitive atmosphere had been created.
- 31.3 A telephone option had also been available, and had had a good uptake. This could be promoted further in the next survey, particularly in Facilities areas where computer access was limited.
- 31.4 Mr Boyter felt that although the response rate had increased, it was still less than the desired 50% and he would hope that there could be a further increase in

future years. Mrs Kelly noted that the further breakdown of the responses by department would allow further targeting of raising awareness.

31.5 Mrs Mitchell asked how the survey results would be fed back to staff and what actions would be taken to improve staff experience based on the results received, so that an improvement could be shown in the results of the next survey. Mrs Kelly advised that the results would be used to inform the Staff Governance Action Plan to make changes in problem areas. The department breakdown would be important for informing local Staff Governance Improvement Plans. This data would also show which departments had particularly good results in certain areas and could be used for sharing and learning between departments.

31.6 High level comparators with other Boards were also available and would be used to share learning and consider new ideas if other Boards had had positive responses in particular areas.

## **32. Matters Arising**

### **32.1 Statistics on Bullying**

32.1.1 A paper had been previously circulated. Mr Joyce noted that number of cases of bullying investigated did not reflect the high percentage of staff who noted bullying in the staff survey. It was thought that most cases of bullying were never reported. Mrs Mitchell suggested that more in depth data would be useful, but Mrs Kelly noted that the current system used did not allow any further breakdown in recording.

3.1.2 Mr Boyter noted that the statistics showed most bullying to be peer to peer rather than hierarchical as was often thought; this was still contrary to the values of the organisation and needed to be dealt with.

3.1.3 Mr Boyter noted that an individual reporting bullying would be asked if they wanted to resolve the problem informally; if they agreed and a formal complaint was not then lodged, it was taken that the problem had been resolved.

3.1.4 Mr Boyter advised that training of mediators for resolving issues was being undertaken, with the aim of having 30 members of staff trained in this area. Mrs Mitchell suggested that training was also needed for all staff on what constituted bullying, as often bullying did not realise the effect their actions had on other people. Mr Wilson and Mr Joyce also felt that some staff interpreted some appropriate actions of their managers as bullying and training could help here. Mrs Kelly noted that there was a clear definition of bullying in the policy, but agreed that more work could be done to raise awareness, and that this could be part of the Staff Governance Action Plan.

### **32.2 Mandatory Training Update**

32.2.1 Mr Boyter advised that it was now possible to combine data on staff training from eLearning and LearnPro, which covered all the mandatory training areas. A report on statistics would be submitted to the Healthcare Governance Committee in March 2015 and to the next Staff Governance Committee in April 2015.

**AB**



### **33. Healthcare Improvement Scotland; Report on Medical Revalidation Progress 2013/14**

33.1 Dr Farquharson spoke to the previously circulated paper and explained that he was responsible for the revalidation of all doctors appraised in NHS Lothian, apart from trainee doctors who worked in more than one Health Board. At the end of the three year programme in April 2016 all doctors would have been revalidated by the General Medical Council.

33.2 Dr Farquharson advised that he could recommend a doctor for revalidation, defer revalidation, or report a doctor for non-engagement. The deferral rate in Lothian so far was 5%. This covered doctors on maternity, sick, or other leave as well as doctors who had not completed their paperwork in time. If deferred for more than one year, the General Medical Council would make further enquiries as to the reason so it was important to encourage doctors to complete paperwork in time. Doctors who were not revalidated would be unable to practice.

33.3 Being responsible officer for revalidation required administrative work and chasing for paperwork. The British Medical Association had not allowed Boards to mandate the use of the electronic system available for transmission and a number of doctors had chosen to submit it in paper copy.

33.4 Dr Farquharson was responsible for revalidation of doctors employed by the staff bank, but not of retired doctors or doctors working solely in private healthcare or for the University. Private providers and universities had their own responsible officers for revalidation of their staff.

33.5 Mr Joyce noted that a programme for revalidation of nursing staff by the Nursing and Midwifery Council was expected to start at the end of 2015. Each registered nurse would be expected to complete five pieces of reflective work every three years which would be marked by trained members of staff. A pilot of the new programme was currently ongoing in NHS Tayside. At 11,000 nurses, nursing revalidation would be a greater challenge than medical revalidation due to the greater size of the nursing workforce. It was also noted that the timescale for completion was ambitious. Mr Joyce agreed to ask Ms Johnson to give an update on plans at the next meeting. AJ

33.6 Mr Boyter noted that the programme could have business continuity implications if a large number of nurses were not revalidated due to failure to submit paperwork, as they would then be unable to practice. This had occasionally been the case when nurses had failed to meet the current registration requirements.

### **34. Protection of Vulnerable Groups – Progress Report**

34.1 Speaking to the previously circulated paper, Mrs Kelly advised that progress on ensuring all relevant staff had membership of the PVG scheme had improved and that more than 9,000 forms had been returned to date. According to information submitted by line managers on which of their staff required a PVG check, it was expected that 2,000 more staff needed to submit their forms by the deadline of October 2015. All members of staff newly employed were required to join the scheme before confirmation of their position. From the forms returned so far, only two members of staff had required disciplinary action due to failure to disclose previous convictions.

- 34.2 Work was being done to raise of awareness of what the new requirements were, and to ensure that all staff requiring to submit forms had been informed. Areas with lower response rates were being asked why, and what they would be doing to ensure all their staff met the requirements. Mr Joyce noted that it was important that bank staff had also joined the scheme especially during the current ban on use of agency staff
- 34.3 Staff members requiring to be part of the PVG scheme to do their job would be unable to practice after October 2015 if they had not received their disclosure certificates. Staff in this position would be considered on an individual basis in terms of any work they could carry out, and arrangements for pay.
- 34.4 It was noted that there was a slow response rate for receiving disclosure certificates following submission of forms. This was due to the large volume of forms being processed by the PVG schemes before the October deadline.
- 34.5 If a staff member who was part of the PVG scheme were to subsequently be convicted of an offence which was notifiable to the employer, they would have a duty to inform the employer, and the Board would also be notified by the Court.

**35. Staff Governance Standard Monitoring Framework; Arrangements for 2014/15**

- 35.1 A paper had been previously circulated. Mrs Kelly advised that the areas identified in the monitoring framework for the Committee would be included in local action plans. The completed Framework would be submitted to the next meeting for approval.

**RK**

- 35.2 Mrs Kelly also noted that areas of good practice identified from the previous years' monitoring had also been shared and a summary had been published online to share with other Boards.

**36. NHS Lothian Corporate Risk Register; Risks for the Staff Governance Committee**

- 36.1 An extract from the Risk Register and covering paper had been previously circulated. Four items were under the responsibility of the Staff Governance Committee. There had been no change to the risks or the levels of risk since the previous meeting.
- 36.2 Mrs Mitchell felt that there was a lack of assurance in the summary of actions for risk number 3455 regarding the risk of NHS Lothian being prosecuted under Health and Safety regulations that adequate steps were being taken to mitigate this risk. Mr Boyter advised that for the first time in seven years, there were currently no outstanding prosecutions against NHS Lothian. There were also no outstanding improvement notices from the Health and Safety Executive. Four new posts in the Health and Safety Team had recently been agreed to ensure that the team was robust. This risk was a standing item on the Risk Management Steering Group which constantly reviewed risks to ensure that relevant actions were being taken. Mrs Mitchell suggested that some of this activity be demonstrated on the risk register summary to provide assurance. Mr Boyter agreed to discuss this with Jo Bennett, Clinical Governance Manager.

**37. Staff Governance Annual Report to the Board; Governance Statement**

- 37.1 Mrs Kelly advised that the Members' questionnaire would be circulated in the next few weeks and used to inform the Staff Governance Committee Annual Report which would be submitted to the Committee for approval at the meeting in April 2015, and to the Board by the end of May 2015 as required. **RK**

**38. Health and Safety Committee Annual Report**

- 38.1 Mr Boyter advised that due to the dynamic workload of the Health and Safety Committee there were some areas of the Annual Report previously circulated where updates were now required. The paper would be as up to date as possible before submission to the Board and it was likely that electronic approval by the Health and Safety Committee would be necessary as the areas updated in the report would have been previously discussed there.
- 38.2 Taking into account these comments, the Committee approved the report.

**39. NHS Scotland Human Resources Shared Services; Compelling Case for Change**

- 39.1 Mr Boyter advised that Shared Services for Human Resources was one of a number of workstreams being considered for sharing of corporate services across NHS Scotland. The previously circulated paper laid out the reasons why a change to shared services in Human Resources would be beneficial.
- 39.2 There had been discussion on ways of dividing human resources services across Scotland with the suggestion that a single service would not be efficient due to the different requirements of the different areas of Scotland. One possibility was for there to be three regional Human Resources departments with three directors covering Scotland. The final decision would be made by the Cabinet Secretary.
- 39.3 Councillor Grant noted that local government was also being encouraged to share services and that this was likely to be an increasing trend in public services, but that it had to be clear from the business case that shared services would increase effectiveness and efficiency of the service. Some lessons had been learned from the development of Police Scotland as a single police force.

**40. Staff Governance Committee Statement of Assurance Need**

- 40.1 Mrs Kelly advised that all Boar Committees were required to have a statement of assurance need which looked at all the elements of information considered by the Committee, what assurance was given in terms of the Committee's remit, and areas where further assurance was needed. This statement would be part of the Committee annual report.

**41. Items for Information**

Members noted the following items for information:

- 41.1 Minutes of the Health and Safety Committee, 21 October 2014;  
41.2 Minutes of the Lothian Partnership Forum of 11 November 2014;

41.3 Minutes of the Workforce Organisational Change Group, 20 January 2015.

**42. Next Meeting**

42.1 The next meeting of the Staff Governance Committee would take place at **9.30** on **Wednesday 29 April 2015** in **Meeting Room 7, Second Floor, Waverley Gate**.

42.2 Further meetings in 2015 would take place on the following dates:  
- 29 July 2015;  
- 28 October 2015.

## **STAFF GOVERNANCE COMMITTEE**

The draft minutes of the meeting held on 29 April 2015 are attached.

Key issues discussed included:

- Presentation was received on HR On-line and how this has greatly improved the availability of policies and procedures to managers and staff.
- Reports on the Staff Governance Committee Annual Report, Staff Survey Action Plan 2014/15 and the Monitoring Framework return.
- Mandatory training and the current position with compliance and action plan for improvement.
- Equality Outcome Framework 2013/17 progress report.
- Presentation on Nursing and Midwifery Revalidation.
- PVG Report
- Presentation on the content of the HR and OD Strategy for June 2015 to March 2018.

Key issues on the horizon are:

- PVG and ensuring compliance by October 2015.
- Mandatory training compliance.

Alex Joyce

Chair-Staff Governance Committee

## **DRAFT**

## **NHS Lothian**

### **STAFF GOVERNANCE COMMITTEE**

Note of a meeting of the Staff Governance Committee held at 9.30am on Wednesday 29 April 2015 in the meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mr A Joyce (Chair); Councillor D Grant; Ms M Johnson; Mr S McLauchlan; Mrs A Meiklejohn and Mrs A Mitchell.

**In Attendance:** Ms J Brown; Mrs R Kelly; Ms M Lorimer; Ms M Mak and Mr P Reith.

Apologies for Absence were received from Mr A Boyter, Dr D Farquharson, Mr B Houston, Mr P Johnston, Mr L Turner and Mr G Warner.

#### **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.

#### **1. Minutes of the Previous Meeting**

1.1 The previously circulated minutes of the Staff Governance Committee meeting held on 11 February 2015 were approved as a correct record subject to the inclusion of Mrs A Meiklejohn in the list of apologies.

#### **2. Presentation on HR On-line**

2.1 Ms Brown, Ms Lorimer and Ms Mak gave a presentation on HR On-line the new HR advisory service.

2.2 The Committee noted that 1 key driver in the development of this was the National Shared Project and the intent was to future proof the service.

2.3 The previous system had involved named contacts with a number of different teams and this was being moved towards the contact centre with a number of centres of expertise. The self help tool, known as HR On-line had been developed and Ms Lorimer gave a demonstration of the information that could readily be accessed by staff.

2.4 It was noted that the project had already had 1.7m pages viewed and over 600 sessions with staff had been conducted. Representatives from other NHS Boards were visiting Lothian to see how the system worked as it could easily be implemented elsewhere.

- 2.5 Mrs Mitchell commented that the demonstration had been very impressive and congratulated the staff involved in its development.
- 2.6 Ms Lorimer advised that National Services Scotland and the Golden Jubilee had somewhat similar systems and Ms Brown advised that NHS Lothian was the first Board to have this system in place.
- 2.7 The Committee noted that each team was setting up quality control groups to review the information provided and that very good positive feedback was being received.
- 2.8 Mrs Meiklejohn sought assurances on access to network PCs by staff and Ms Lorimer advised that leaflets were being distributed to staff advising of the existence of HR On-line and explaining how it could be accessed.
- 2.9 Ms Johnson commented that there had been a very positive response to the system from frontline staff and work was underway to see how they new e-roster system could be linked in. It was noted that the new HR system and a replacement for e-KSF would also be coming in the future.
- 2.10 Councillor Grant asked if there had been any discussions with Shadow Integration Joint Boards and Ms Brown advised that discussions had been held with the 4 local authorities to compare HR policies and map out the differences between them so that relevant staff could access each others policies.
- 2.11 Mrs Kelly commented that it would be helpful to be able to ascertain where policies were unclear so that any issues could be clarified.
- 2.12 The Chairman thanked Ms Brown, Ms Lorimer and Ms Mak for an interesting presentation.

### **3. Staff Governance Committee Annual Report 2014/15**

- 3.1 The Committee noted the previously circulated annual report of the Chair of the Staff Governance Committee.
- 3.2 The Chair advised that he had touched on the committees remit in discussions with the Board Chairman and was looking to see how the committee could be more dynamic. He reminded the committee that much of the detailed work was carried out at the Lothian Partnership Forum meetings and he felt that it would be beneficial for Non Executive Board members to attend the Lothian Partnership Forum to see how the system worked.
- 3.3 The Committee noted that it was intended that the Staff Governance Committee would work more closely with the Audit and Risk Committee and Healthcare Governance Committee to ensure that whilst all aspects of governance were considered, duplication was avoided.
- 3.4 Mrs Meiklejohn asked about mandatory training which was an issue which had been brought up at the Healthcare Governance Committee.

3.5 Mrs Kelly advised that work on this was ongoing but the format of the annual report was determined by the Scottish Government and mandatory training did not fit in with their criteria. Mrs Kelly undertook to add a sentence to the report that the committee had looked at the issue of mandatory training to see if it was a risk. **RK**

3.6 Subject to this amendment, the Committee agreed to approve the annual report of the Chair of the Staff Governance Committee for inclusion in the Boards annual report and accounts.

#### **4. Staff Survey Action Plan 2014/15 Final Progress Report**

4.1 Mrs Kelly introduced the previously circulated final report of the Staff Governance Action Plan for 2014/15.

4.2 Mrs Mitchell commented that a traffic light system would be helpful and Mrs Kelly advised that she would bring back a report on this. **RK**

4.3 Mrs Meiklejohn raised the issue of the current involvement with Investors in People and the forthcoming i-Matters pilot.

4.4 Mrs Kelly advised that once the pilot had been in operation the position would be reviewed and the plan would be updated.

4.5 The Committee agreed to approve the NHS Lothian Staff Governance Action Plan for 2014/15.

#### **5. Staff Governance Standard – Scottish Government National Annual Monitoring Return 2014/15**

5.1 Mrs Kelly introduced a previously circulated report together with the draft Staff Governance Standard Scottish Government National Annual Monitoring Return 2014/15 for discussion prior to its submission to the Scottish Government by 8 May 2015.

5.2 The Committee noted that whilst this was a working progress it required to be submitted to the Scottish Government by 8 May and evidence from some local partnership forums was still awaited.

5.3 Ms Johnson commented that the section on gender based violence was being dealt with through the Healthcare Governance Committee and this work would help with identifying good practice.

5.4 Mrs Kelly advised the committee that NHS Lothian's partnership representation was very good and that further information on the progress was held locally. She undertook to obtain some details of progress on i-Matters for the next meeting. **RK**

5.5 The Committee agreed to approve the monitoring return for submission to the Scottish Government.



## **6. Mandatory Education and Training.**

- 6.1 Mrs Kelly introduced a previously circulated report giving an update on issues relating to statutory and mandatory training and education.
- 6.2 The Committee noted that the Patient Safety / Experience Action Group was examining the current criteria. It was necessary to examine each of the mandatory groups to get views on the appropriateness of mandatory training for those staff groups to ensure that the number of target staff were not over stated. A number of training modules as required for all staff were only really applicable to clinical staff.
- 6.3 Ms Johnson commented that it had been a struggle for a number of years to get quality data on mandatory training. There were resource implications for staff released for training and much of the online training was uninspiring. The delivery basis of training needed to be appropriate to the staff group.
- 6.4 The Chair undertook to ask the Chair of the Healthcare Governance Committee what input that committee expected from the Staff Governance Committee and Mrs Kelly undertook to prepare a report. **RK**
- 6.5 The Committee agreed to noted the contents of the report and endorse the recommendations and policies submitted for consideration.

## **7. Equality Outcome Framework 2013/17 – Update**

- 7.1 Mrs Kelly introduced a previously circulated report giving an update on progress against the agreed equality outcome framework 2017/17 and seeking approval of the tabled equal pay statement and mainstreaming report which was required in law to be published by the end of April 2015.
- 7.2 The Committee noted that the report showed the action output and gave an update on progress. The committee noted that a review was being undertaken on how the equality service was provided.
- 7.3 Mrs Kelly explained that the gender pay gap shown in the NHS Lothian Equal Pay Statement related to pay progression. An increasing number of newer consultants were female and more of the longer serving consultants were male and were therefore higher up the pay progression scale.
- 7.4 It was agreed that Mrs Kelly would add as paragraph to the report putting this gap into context. She would also check if numbers quoted of less than 5 could constitute a breach of security of personal data. **RK**
- 7.5 The Committee noted the progress made towards achieving the agreed outcomes from April 2013 to April 2014 and the key achievements: approve the equal pay statement for publication (subject to the inclusion of the amendment) and approve the mainstreaming report for publication.

## **8. Nursing and Midwifery Council Revalidation**

- 8.1 Ms Johnson introduced a previously circulated report on the new revalidation requirements that nurses and midwives had to meet when renewing their registration every 3 years with the Nursing and Midwifery Council.
- 8.2 The Committee noted that the revalidation process would give greater confidence to the public, employers and fellow professionals that nurses and midwives were up to date with their practice. Implementation of revalidation was planned for 31 December 2015 across the United Kingdom and would replace the current post registration education in practice 3 yearly renewal and the notification of practice form.
- 8.3 The Committee noted that the revalidation process required registrants to complete the identified number of practice and continuing professional development hours, collect and review feedback, discuss practice related feedback with reflection and discussion, complete the process with third party confirmation and confirm that they had professional indemnity.
- 8.4 The Committee noted that the revalidation process was a risk for the organisation as it was dependant on individual nurses having their appraisals and getting the necessary confirmation. If a nurse was not revalidated they could not re-register and could no longer work as a nurse. NHS Lothian had around 11,000 nurses.
- 8.5 Ms Johnson advised that there were test sites throughout the United Kingdom and undertook to bring back an action plan and timescale to the committee. **MJ**
- 8.6 The Chair commented that the danger period would be May to June 2016 and Ms Johnson emphasised that a priority task would be to identify staff who were in the target group.
- 8.7 Mrs Meiklejohn commented that the inclusion of Fiona Ireland on the Working Group would be helpful and Ms Johnson advised that while this would depend on workload, Ms Ireland would be involved. It was also noted that fulltime staff representatives as well as Non Executives and Senior Managers would be involved.
- 8.8 The Committee noted the introduction of revalidation for nurses and midwife as the mechanism where by they maintained their registration and noted the creation of a Core Group to oversee revalidation implementation in NHS Lothian, to raise awareness of the revalidation process and support staff and confirmers through the process.

## **9. Protection of Vulnerable Groups Progress Report**

- 9.1 Mrs Kelly introduced a previously circulated report giving an update on the Protection of Vulnerable Groups Scheme and the progress with implementation of the retrospective checking within NHS Lothian.
- 9.2 The Committee noted that 1300 remaining checks had to be processed by the end of October 2015.

- 9.3 It was noted that a number of areas were outstanding and managers had been notified. Staff who had not yet returned their forms were being contacted and a report was going to the Corporate Management Team.
- 9.4 The Chair commented that he was aware that a number of doctors had not yet returned their forms and that this was being taken up.
- 9.5 Mrs Kelly advised that a risk assessment was being undertaken by each area.
- 9.6 The Committee noted that the Corporate Management Team paper would be recommending that appropriate entry be placed on the risk register.
- 9.7 The Committee agreed to note the current progress with Protection Vulnerable Groups retrospective checking.

## **10. Review of NHS Lothian Corporate Risk Register**

- 10.1 The Committee noted a previously circulated report setting out changes to the NHS Lothian Corporate Risk Register, approved by the February 2015 Audit & Risk Committee, prior to final Board approval.
- 10.2 It was noted that all the recommendations set out in the paper were approved by the Audit and Risk Committee and that all the recommendations for removal of risks for NHS Lothian's Corporate Risk Register were approved with the exception of the Medical Workforce Sustainability which would remain on the corporate risk register. The Committee agreed to note the amended corporate risk register.

## **11. NHS Lothian Corporate Risk Register – Risks for the Staff Governance Committee**

- 11.1 Mrs Kelly introduced a previously circulated report setting out the risks contained within NHS Lothian's Corporate Risk Register that were attributed to the Staff Governance Committee.
- 11.2 The Committee noted that 4 risks had been attributed to the Staff Governance Committee and the appendices to the reports gave an update on the position.
- 11.3 Ms Johnson commented that a significant risk not existed in respect of the health visitor workforce and Mrs Kelly undertook to put together a report to the Risk Management Steering Group. **RK**
- 11.4 Councillor Grant commented that this would also be an issue for Integration Joint Boards.
- 11.5 The Committee agreed to note the risks on the corporate risk register that had been attributed to the Staff Governance Committee in terms of assurance.

**12. Human Resources and Organisational Development Strategy: June 2015 – March 2018**

12.1 Mrs Kelly introduced a previously circulated report together with the Human Resources and Organisational Development Strategy for the period June 2015 – March 2018.

12.2 The Committee agreed to support the Human Resources and Organisational Development Strategy for the period June 2015 to March 2018 with the inclusion of a reference to Person Centred Culture. Mrs Kelly advised that an action plan would be brought to the July meeting of the Staff Governance Committee. **RK**

**13. Compliance with policies and Procedures**

13.1 The Committee noted a previously circulated report together with an internal audit report on compliance with policies and procedures.

13.2 Mrs Kelly advised the committee that a working group was being set up to evaluate how compliance with policies should be monitored. Membership of the working group would comprise of Mrs Kelly, Mr A Payne, Mrs J MacDowell, Mr Alex Joyce and Ms M Park. The committee expressed the view that in terms of responsibility, the issue of compliance with policies and procedures was not so much a Staff Governance issue and should lie with the Audit and Risk Committee. **RK**

**14. Statement of Assurance Needs Update**

14.1 The Committee noted the previously circulated statement of assurance need and, whilst accepting the conclusions as per the risk management operational procedure, agreed to query with the Healthcare Governance Committee the categorisation of adequate but in effective which seemed contradictory. Mrs Kelly and Mr Joyce would come back to the Committee with a paper. **RK/AJ**

**15. Items for Information**

15.1 Members noted the following items for information.

15.2 Minutes of the Health and Safety Committee of 27 January 2015.

15.3 Minutes of the Lothian Partnership Forum of 10 March 2015.

15.4 Minutes of the Workforce Organisational Change Group of 23 February and 23 March 2015.

**16. Date of Next Meeting**

16.1 It was noted that the next meeting of the Committee would be held on 29 July 2015 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

## STRATEGIC PLANNING COMMITTEE

The draft minutes of the meeting held on 12 March 2015 are attached.

Key issues discussed included:

- Progress with the development of plans for primary care capacity, capability and infrastructure development
- Strategic Planning Committee Revised Role and Remit was presented to the Committee and supported for recommendation the April Board
- NHS Lothian Transport and Access Committee's role, remit and work was discussed and it was proposed that a review of NHS Lothian transport strategy to be taken forward
- Neurological Improvement Plan final version presented and work plan supported
- Draft paper on Improving Older People's Care in Edinburgh
- Ritson Clinic Service Design and Option Appraisal Progress Update was presented and recommendations agreed
- NHS Lothian Strategic Planning Landscape: graphic for information

Key issues on the horizon are:

- A full report on primary and community care to be considered prior to the Board in June.
- Review of the NHS Lothian transport strategy to be undertaken by Director of Finance, Director of Human Resources and Organisational Development.
- Updated report on Improving Older People's Care in Edinburgh
- National Specialist Public Health Review –report progress

Brian Houston/Alex McMahon

Chair/Executive Lead

## **NHS Lothian**

### **Strategic Planning Committee**

Minutes of the Strategic Planning Committee Meeting held at 10am on Thursday 12 March 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mr B Houston (Chair); Mr A Boyter; Mr J Crombie (from 11:00am); Ms P Eccles; Dr D Farquharson; Mrs S Goldsmith; Ms M Johnson; Mr A Joyce; Professor A McCallum; Mrs A Mitchell; Mr D A Small; Ms L Tait and Dr R Williams.

**In Attendance:** Dr J Hopton (for Item 104); Ms R Laskowski (for Item 106); Ms M Simpson (for Item 109) and Mr D Weir.

Apologies for absence were received from Mrs S Ballard-Smith, Mrs K Blair, Mr T Davison, Professor J Iredale, Professor A McMahon, Mrs A Meiklejohn, Mr G Walker, Mr P Gabbitas and Mrs E McHugh.

#### **99. Declaration of Financial and Non Financial Interest**

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

#### **100. Chairman's Opening Remarks**

100.1 The Chairman commented again on the depleted attendance at the current and recent meetings and advised issues around membership would be addressed as part of the discussion under the "Strategic Planning Committee Revised Role and Remit".

#### **101. Minutes of the Previous Meeting held on 12 February 2015**

101.1 The Minutes of the previous meeting held on 12 February 2015 were approved as a correct record.

#### **102. Matters Arising**

102.1 Update on Primary and Community Care Issues – The Committee were reminded that this issue had been discussed in detail at the January Board Development session and thereafter at the Primary Care Forward Group. It was noted that Mr Small had also attended the GP Sub-Committee to discuss issues in further detail. Following discussion agreement in principle had been reached to set aside £1m in the financial plan to address Primary Care priorities.

- 102.2 It was reported that at the Primary Care Forward Group a number of quick wins that could be enacted in the current year had been identified. A further meeting would be held the following day to work up the detail of these proposals. It was noted however in the more medium to longer term that the management of frail older people at home and in care home was a key issue that would require to be addressed and in that regard Dr Morton and the GP Sub-Committee had agreed to write down their views on what future service provision might look like to include links with community nursing in order to determine what other staff groups in addition to General Practitioners could support patients in nursing homes in order to ensure proper end of life and palliative care. The Committee noted that this workstream would require a joined up vision and it was hoped that the work being led by Dr Morton would start to address this issue.
- 102.3 The Committee noted that a fuller report would be submitted to the Board meeting in June although the actions around any identified quick wins would progress in advance of the Board meeting.
- 102.4 The Committee noted that a review of community work would require to develop as the above proposals emerged and that this would link into Item 6 on the agenda "Improving Older People's Care in Edinburgh". It was noted whilst the subsequent paper would focus on buildings there was also a need to ensure appropriate sustainable links into patient pathways.
- 102.5 The Committee were advised that in addition to the £1m that had been identified in the financial plan for Primary Care issues which it was hoped would be reimbursed by the Scottish Government Health Department that funding had also been identified in the capital plan. A prioritised list of proposals had been developed in order to create physical capacity. There was an issue about the availability of sites in Edinburgh in order to develop GP capacity and there was a need for another meeting to be held in order to sketch out in more detail the capital priority list.
- 102.6 The Committee were advised that the response to the strategy had been discussed at the GP Sub-Committee meeting held earlier in the week where it had been agreed that there would be a need to set aside funding to take forward the strategy although the fundamental problem still remained around capacity in Primary Care with particular focus on the following 3 areas:-
- There were insufficient numbers of GPs - there was potential to support this by increasing community nursing and other functions
  - GP premises were also an issue as were care of the elderly visitors and supported accommodation
  - IT and redesign of services were also a key issue
- 102.7 The GP response had supported the direction of travel whilst recognising that there were number of issues that needed to be addressed quickly. It was noted in order to drive this agenda forward that a meeting would be held the following day with representatives of the GP community and management in order to see if a solution could be achieved for the quick fix issues. Thereafter following that discussions would be required around the timescale for addressing the fundamental issue about frail older people. It was noted that a follow up debate had been arranged for June.

- 102.8 The Committee were assured that in the financial plan and local delivery plan that issues were being covered in respect of Primary Care capacity and the inclusion of an appropriate risk analysis although it was recognised that the funding stream for Primary Care was separate and came directly from the Scottish Government Health Department with there still being some residual issues around this to be finalised. It was agreed that the risk of additional Primary Care funding not being received from the Scottish Government should be recognised as a sensitivity within the financial plan.
- 102.9 The Committee further noted that representatives of General Practitioners and E-health had met and a list of issues had been identified that again required to progress quickly. It was noted that Dr John Steyn would attend the Primary Care Forward Group in order to progress priorities.
- 102.10 The Strategic Planning Committee noted the update report.

### **103. Strategic Planning Committee Revised Role and Remit**

- 103.1 The Chairman reminded colleagues that at the previous meeting discussion had ensued around the role and remit of the Strategic Planning Committee partly stimulated by comments by Mrs Mitchell and the wide acceptance of the need to look at the continuing validity and role of the Committee moving forward. The reduced attendance at the meeting had been recognised with there having been wide discussion at the previous meeting around the relationship and frequency of the meeting and the need to play into the developing Integration agenda.
- 103.2 The revised remit and membership paper was presented to the Committee with the key changes from the extant position being highlighted along with links with the NHS Lothian strategic planning implementation process and appropriate links with integration and the Integration Joint Board's strategic plan. It was proposed that the Strategic Planning Committee would receive and consider the detail of the Integration Joint Board's strategic plans and how these matched the NHS Lothian strategic plan. It was proposed that Integration Joint Board's would have a member on the Strategic Planning Committee and that there would also require to be links with the Acute Hospital's Committee. It was noted that if the revised role and remit were agreed by the Strategic Planning Committee then this would required to be formally adopted by the Board at its meeting on 1 April.
- 103.3 Detailed discussion ensued around the process for IJBs nominating and deciding representation on the Strategic Planning Committee; the need for the terms of reference to be able to deliver assurance of the quality and alignment of respective strategic plans; appropriate linkages with IJBs and community planning functions without creating an additional bureaucracy; the need for Primary Care clinicians to be represented in the membership to address nuances in care between the acute sector and potential impacts on Primary Care in taking proposals forward (this was where IJB representation in the membership of the SPC would be crucial).
- 103.4 The Committee considered Joint Director input into the future arrangements with it being recognised that most agenda items would be of relevance to them. A possible scenario would be that IJB representation could consist of either the Chair / Vice Chair of the IJB and an Executive member who by definition would be



the Joint Director although this would need to be agreed in consultation with respective IJBs. It was felt this was one way of ensuring Primary Care due diligence was addressed.

- 103.5 The Employee Director agreed the changes to the remit and membership of the committee on the proviso that Partnership Leads had seats on strategic planning groups within the IJB's. It was noted that this was already the case in Midlothian and there was an expectation that this should also be the case in the other 3 IJB's.
- 103.6 Mrs Mitchell commented that it was important in terms of nuances to remember that the Strategic Planning Committee was owned by NHS Lothian and there was a need to ensure the mechanism remained in place to have oversight and ultimate control of the overarching NHS Lothian strategic plan. It would be important this responsibility was not subsumed by subordinate arrangements. A form of words would be prepared that reflected this position in the paper being presented to the Board.
- 103.7 The point was made that the Committee could be one of the Board Committees specifically consulted upon in respect of IJBs strategic plans. It was agreed this was a sensible way forward and would enable all of the individual IJB plans to be seen together.
- 103.8 The Chairman pointed out that part of the terms of reference of the Committee needed to reflect that part of its function was to manage the process and progress of what was a dynamic strategic plan.
- 103.9 The Committee agreed that the revised terms of reference and membership should be amended to reflect debate at the meeting and be submitted to the April Board meeting for approval. The future schedule of meetings was agreed. **LT**

#### **104. NHS Lothian Transport and Access Committee**

- 104.1 The Committee received an update on the role, remit and work of the NHS Lothian Transport and Access Committee which had been meeting for between 5 and 6 years and was currently chaired by Mr P Johnston. It was noted that the Transport and Access Committee had been established as part of the response to the previous service redesign exercise. It was noted that currently there was no natural flow of business to the Committee with many managers being unaware of its existence.
- 104.2 The point was made that NHS Lothian was a transport provider and had governance responsibilities some of which were addressed by the NHS Lothian Health & Safety Committee. The Chairman commented that he was uncomfortable about subsuming the responsibilities of the NHS Lothian Transport and Access Committee into the Strategic Planning Committee arrangements as he felt that the governance requirements could be addressed by a different mechanism.
- 104.3 It was noted when the Strategic Planning Committee was considering business cases that implications of transport, support and access issues should be considered as one of the criteria. It was not felt that there was a need for a

separate committee to cover all aspects of the business and it was noted that there was significant work undertaken around transport and access through the Health & Safety Committee and liaison with the Scottish Ambulance Service and the Transport Hub in the acute service. In addition a master planning exercise was being undertaken on various sites which looked at transport as part of site development.

104.4 The point was made that the existing Transport and Access Committee appeared to be more operational than strategic and that if business cases coming forward to the Strategic Planning Committee included a transport component then there would be no need to commission a separate Board committee. The Chairman reflected on previous discussions he had held with the Chair of the Transport and Access Committee where it had been agreed to enhance its role although to some extent this had been overtaken by the creation of the Acute Hospitals Committee. It would also be important to recognise the impact and responsibility of IJBs in transport and access arrangements moving forward.

104.5 The point was made that transport arrangements in NHS Lothian were significant with large sums of money being expended. The view was expressed that there was not currently an adequate transport strategy in place. The Committee were reminded that transport arrangements were key to supporting patient care and that this needed to be addressed at an appropriately high level. The Chairman commented that his initial inclination in discussions with the Chair of the Transport and Access Committee had been to have it reporting into the Healthcare Governance Committee but he reiterated that this position had possibly changed given the reshaped agenda around the IJBs and the creation of the Acute Hospitals Committee.

104.6 The Committee agreed that there was a need for a fundamental review of transport with there being a need to identify a sponsor to look at transport in its widest sense given the significance of this workstream. Thereafter it would be important to determine where the outcome of the review report would be considered with links being required at least to the Finance and Resources Committee and the Efficiency and Productivity Group because of governance and capital governance links. It was noted that any review mechanism would require to redefine the membership of any successor committee.

104.7 The Committee agreed that the review process should be coordinated and co-lead by the Director of Finance and the Director of Human Resources and Organisational Development and would include existing committee members who would have a valuable contribution to make to the review process. **SG/AB**

## **105. Neurological Improvement Plan**

105.1 The Chairman welcomed Ms Rona Laskowski to the meeting.

105.2 The Committee noted that neurological care was a multi-stakeholder process and that much of what was in the paper would already be familiar to members of the Committee from previous reports. It was noted that the Scottish Government were keen for a consistency of approach in neurological care and that the Leadership Group would be the key focus for driving forward any progress. The Leadership Group had met twice and the clinical lead for the project had been appointed. It

was noted that there would be significant user involvement as the plans evolved with the objective being to create sustainable clinical pathways. The Committee were advised that Parkinson's Disease had the most advanced pathway and the intention was to learn from processes in this area whilst creating a clinical pathway for headache sufferers.

- 105.3 The Committee were also asked to agree to making the Neurological Care Improvement Plan a public document as this would exemplify commitment in the public domain. The SPC agreed this was an appropriate way forward.
- 105.4 The Committee noted that the proposal fitted well with the strategic plan and that there were experts within the system who could produce an exemplar public facing document. It would be important to ensure that the voices of people with rare conditions were included in the process. Links with imaging work, innovation, investment/ disinvestment, and income opportunities also needed to be reflected.
- 105.5 The Committee noted from a GP perspective that the proposals were long overdue and welcome and aligned with the quality strategy. The question was posed however about how the proposals would link with IJBs. It was noted that the Leadership Group were considering the role of IJBs and that an ongoing proposition was to use the "House of Care" model to engage relevant stakeholders. This would develop the integral relationship between the hospital and IJBs and if the model was formally adopted this would allow the IJB leadership link to be formally discussed. It was noted that currently a senior member of the City of Edinburgh Council served on the Leadership Group with work underway to have this arrangements reflected by other Local Authorities.
- 105.6 The Committee noted that whilst the public document that had been agreed would be focussed on a bespoke group of patients that the message would however be powerful and could be used nationally as an exemplar of how these issues were best taken forward.
- 105.7 The Committee agreed the recommendations contained in the circulated paper.

## **106. Improving Older People's Care in Edinburgh**

- 106.1 The Committee noted that this was a very early draft of a paper being pulled together to bring to the attention of members a number of ongoing workstreams. It was noted that the proposals detailed in the paper had emerged out of ongoing joint work with the City of Edinburgh Council in respect of improvements in patient flow in order to reduce delayed discharges and increase capacity in home care settings and nursing homes as well as to make financial savings. It was noted that work had been underway for sometime with colleagues from the City of Edinburgh Council in order to get system-wide capacity plans in place.
- 106.2 The Committee noted that the circulated paper was helpful in that it set out work and propositions underway in respect of each of the major sites. It was noted that the paper was dynamic and currently did not include issues around the Astley Ainslie Hospital which had only recently evolved. The attention of the Committee was drawn to the list of options detailed in Page 10 of the report with it being noted that there were issues around the pace and scale of what could be undertaken in respect of the safety of patients and staff. The key driver moving

forward was the desire to move off some NHS sites like the Royal Victoria Hospital and Liberton where much of the capacity was being used to support the delayed discharge agenda for patients who should not be in hospital in any event and whose rehabilitation should be dealt with closer to home. It was noted that currently the focus was on buildings rather than pathways of care and that was what was currently driving admissions.

- 106.3 The Committee were reminded that jointly with the City of Edinburgh Council that Gylemuir was open and provided 30 beds which were being successfully used to facilitate the move of patients out of hospital into community care. It was noted however that the finances to operate the facility would run out towards the end of April and there was therefore a need to agree whether to continue funding or close the facility. In any event there was a need to close delayed discharge wards at the Royal Victoria Hospital as funding ended for those beds at the end of March 2015. In addition a national review of inpatient continuing care (IPCC) beds was underway and this could be part of the solution to fund the Gylemuir facility in the future. The need to vacate the Liberton site was stressed as this was part of an LRP scheme and would also release some funding for the Gylemuir facility. It was noted that the whole process of vacating sites was hugely complicated and it would be important to ensure that the patient journey was correct. It was noted that the point of bringing the current paper to the Committee was to ensure they had sight of the complexity of the issues with it being noted that a more formal proposition would be brought forward to the next meeting.
- 106.4 The point was made that until recently the challenge had been that the system had been dealing with separate business cases that were not yet joined up. In the Royal Infirmary of Edinburgh assessment beds were being taken forward as part of the Royal Hospital for Sick Children / Department of Clinical Neurosciences capital project and would come with a price tag. Discussions had been held at Executive Director level about linkages and opportunities around the Midlothian Community Hospital.
- 106.5 The Committee were advised that there was a need for significant focus to vacate at least one site with this being tied to capacity within the City of Edinburgh Council and Gylemuir. The consensus opinion was that the favoured option would be to vacate Liberton as it was a poor site with limited opportunities to undertake improvements. This would release recurrent revenue of £14m which could be used to assist service provision elsewhere including Gylemuir. It was noted however that further work was needed to include consideration around IPCC and delayed discharge beds to release funding to Gylemuir whilst work continued around the Liberton proposal. It was hoped that funding issues around Gylemuir would be agreed in the next week. It was noted that to produce a financial analysis of all the options would be challenging.
- 106.6 The Committee agreed to note the paper at this point and to receive and update at its next meeting. Some members of the Committee felt that Gylemuir was the anchor moving forward as it potentially had capacity to take 120 patients although only 30 beds were currently being used with another 30 having been refurbished but not commissioned. The Gylemuir lease only had 18 months remaining with the potential to extend this by another year. This timescale would fit with the City of Edinburgh Council's plans to open their own facility. This approach would also allow the Royal Victoria Hospital model to be tested. It was stressed however that the plan would need to allow the closure of the Royal Victoria Hospital and not to

reopen it except in extreme circumstances. The suggestion was also made that an alternative anchor point was the community and whether there was sufficient capacity available within that environment.

106.7 The Committee agreed to receive an update report at its next meeting.

**MJ**

## **107. Ritson Clinic Service Design and Option Appraisal Progress Update**

107.1 The Chairman welcomed Ms Marie Simpson to the meeting.

107.2 The Committee noted that the purpose of the report was to seek approval to proceed with an option appraisal for the Ritson Clinic. The Clinic provided a service for Lothian residents who required inpatient alcohol and or drug related treatment and support as part of their recovery. The Committee noted that a lot of work had been undertaken to assess the care pathway and had included Stakeholder engagement. National guidance and evidence from experts had also been taken into account in order to determine how to improve the outcome from these care pathways which were currently not particularly successful. It was felt however that outcomes in future could be enhanced with the input of service users from the outset and this engagement had been undertaken. Clinicians were onboard with the proposals and the next step forward was to progress to option appraisal status.

107.3 The Committee agreed to proceed with an option appraisal for the Ritson Clinic as detailed in the paper.

107.4 The issue was raised about the timing of the option appraisal given that the current building where the service was situated was scheduled to be demolished as part of the Royal Edinburgh Hospital Reprovision and that therefore any proposals would require to be concluded by the commencement of Phase II work otherwise a contingency plan would required. The Committee noted that a temporary decant had been considered.

107.5 The point was raised about whether NHS Lothian used private providers for this service and if so it was suggested that there might be opportunities for savings to be made. The Committee received an explanation of the various funding streams for patient alcohol and or drug related treatment services as well as potential areas of savings. It was noted however that savings from the private provider would be minimal.

107.6 The point was made that patients who attended the Ritson Clinic were in poorer mental and physical health than those who joined the LEAP (Lothians and Edinburgh Abstinence Programme) and might never achieve a life free of alcohol or drug misuse. The Ritson Clinic gave them a period of clarity in their life and allowed appropriate support to be provided. Links with Primary Care would be important when developing the new model as would consideration around potentially refining patient selection. The Committee were advised that the outcomes and expectations of the Ritson Clinic patients would be embedded as part of the wider model. It was noted that currently support workers were unable to attend the Ritson Clinic and this was unfortunate as people felt that continuity of care was important in achieving the best possible outcome.

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

## **108. NHS Lothian Strategic Planning Landscape**

108.1 The Committee received a tabled copy of a strategic map which attempted to capture links with national strategies, NHS Lothian strategies and propositions and how these linked into the NHS Lothian Strategic Plan 2014-2014. It was noted that this was an iterative document and would be amended to reflect the changing landscape.

108.2 The Committee agreed this was a valuable document which highlighted the intensity of the agenda and all of the issues that required to be addressed. It was noted the other document that needed to sit alongside this would be one which detailed the structure and process of the plans.

108.3 The circulated document was noted and it was agreed that it would be distributed electronically to members of the Committee.

**LT**

## **109. Any Other Competent Business**

### **109.1 National Specialist Public Health Review**

109.1.1 The Committee were advised that an engagement letter had been issued from the Scottish Government Health Department and that a draft response was being prepared. The Director of Public Health and Health Policy advised she would be happy to undertake the response to the review and to report further on progress at the June meeting of the Committee.

**AKM**

## **110. Date and Time of Next Meeting**

110.1 The Committee agreed to move to a revised schedule of meetings as follows:-

9 April 2015  
11 June 2015  
13 August 2015  
8 October 2015  
10 December 2015

110.2 It was agreed to attempt to use the new membership as discussed earlier with it being important to contact IJB colleagues and confirm arrangements following the April Board meeting.

**LT**

## **NHS Lothian**

### **Strategic Planning Committee**

The draft minutes of the meeting held on 9 April 2015 are attached.

Key issues discussed included:

- Redesign, Modernisation and Integration of Learning Disability Services towards supporting people with learning disabilities, in both hospital and community settings.
- Redesign and Re-provision of the Princess Alexandra Eye Pavilion
- Improving Older People's Care in Edinburgh – 2015/2016

Key issues on the horizon are:

- Process for Strategic Plan Updates and workplan in 2015/16
- More detailed plans to be submitted to the Committee in relation to Improving Older People's Care in Edinburgh
- Update on plans for developing primary care in Lothian

Brian Houston/Alex McMahon

Chair/Executive Lead

**DRAFT**

**NHS Lothian**

**Strategic Planning Committee**

Minutes of the Strategic Planning Committee Meeting held at 10am on Thursday 9 April 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mr B Houston (Chair); Mr M Ash; Mr A Joyce; Mrs A Meiklejohn and Councillor F Toner.

**In Attendance:** Mr A Boyter; Ms J Campbell; Mr J Crombie; Mr T Davison; Dr D Farquharson; Ms M Johnson; Ms R Laskowski; Mr A McCreadie; Professor A McMahon; Ms D Milne; Mr P Reith and Mrs L Tait.

Apologies for absence were received from Mrs K Blair, Professor J Iredale and Mr G Walker.

**1. Declaration of Financial and Non Financial Interest**

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

**2. Minutes of the Previous Meeting held in 12 March 2015**

2.1 The minutes of the previous meeting held in 12 March 2015 were approved as a correct record.

**3. Matters Arising**

3.1 There were no matters arising from the previous minutes.

**4. Learning Disability Services: Redesign, Modernisation and Integration**

4.1 Ms Laskowski introduced a previously circulated report seeking support for the continued progress towards transformational change in the model of care supporting people with learning disabilities, in both hospital and community settings.

4.2 The Committee noted that the Strategic Plan Programme Board had received an initial report on 23 June 2014 outlining the overarching strategic ambition for the redesign, modernisation and integration of learning disabilities services. The learning disability services had been tasked to continue to secure progress in:



addressing discharge options for those patients with delayed discharge status; the national benchmarking of inpatient models of service and further financial analysis and interrogation of the proposed models of care to reduce forecast costs.

- 4.3 It was noted that the report responded to these tasks and provided an updated progress to date on the changing model of care, strategic developments underway to modernise the service and the financial plan for the programme.
- 4.4 The Committee noted that, following the establishment of a Lothian Learning Disability Collaboration which had reviewed and tested the planned local capacity, this had been stepped down to 38 patients and there was high confidence that this model of care would be appropriate.
- 4.5 It was noted that at the time of the previous report a difference of £4m had been identified between current spend and forecast requirement. Appropriate resource transfers had been identified in the financial plan and the revenue requirement was now broadly in line with the current spend. Ms Laskowski advised that the clinical brief and associated work force planning was still to be undertaken with the Royal Edinburgh Hospital Project Team and there might yet be variation to the final figure.
- 4.6 The Committee noted that currently £2m of UNPACS funding was allocated for out of area care and since the forecast model of care would remove the need for these placements it was proposed that these funds should be transferred from UNPACS to learning disability services.
- 4.7 The Committee expressed some concerns over clinical governance issues as the NHS resource would be transferring to the individual Integration Joint Boards. Because of the small size of the relevant specialisms in Lothian there would be a need for collaboration between all the Integration Joint Boards. Ms Laskowski commented that the local authorities had all contributed to the development of the modernisation, redesign and integration plan via the Lothian learning disability Collaboration. In order to avoid multiple lines of reporting, agreement was being sought for a professional management line, streamlined through the Collaboration.
- 4.8 Mr Ash commented that whilst he was supportive of the proposals it would be important to get support from all Shadow Integration Joint Boards and proposed including a recommendation that endorsement be sought formally from the Integration Joint Boards and Community Health and Care Partnerships.
- 4.9 Ms Laskowski advised that a paper seeking the endorsement of the proposed model would be submitted to all four Integration Joint Boards and / Community Health and Care Partnerships.
- 4.10 The Committee agreed to support the model of care and the focus on successful community lives for people with learning disability in Lothian; to support the overarching programme of a whole system change to deliver the range of services required; to support the onward reporting to the Integration Joint Boards to seek approval of the proposed model of care and to support the onward reporting to the Finance & Resources Committee to seek approval of the financial plan for learning disability services.

**AMcM**

## **5. Redesign and Reprovision of the Princess Alexandra Eye Pavilion**

- 5.1 Ms Campbell introduced a previously circulated report introducing the initial agreement for the redesign and reprovision of the Princess Alexandra Eye Pavilion and providing a specific focus on the redesign elements of service and how these aligned to NHS Lothian's strategic aims.
- 5.2 The Committee noted that the Lothian Acute Ophthalmology Services were currently provided on two main sites, the Princess Alexandra Eye Pavilion and St John's Hospital. Whilst both sites provided outpatient, day case and clean room services with inpatient services and an acute referral centre, the eye emergency service was provided only at the Princess Alexandra Eye Pavilion.
- 5.3 It was noted that the Princess Alexandra Eye Pavilion building, which was opened in 1969, was no longer fit for purpose and did not support efficient patient flows or provide the necessary space for service development and expansion. The building currently required in excess of £2.7m of significant to high risk items of back log maintenance to be addressed.
- 5.4 Members noted that three options had been considered; the reprovision of the Princess Alexandra Eye Pavilion to the Lauriston Building, the reprovision of the Princess Alexandra Eye Pavilion to the Royal Infirmary of Edinburgh / Bioquarter Campus and an alternative new build in Edinburgh city centre. The preferred option was the re-location of the Princess Alexandra Eye Pavilion services to the Royal Infirmary of Edinburgh Bio-quarter site.
- 5.5 Councillor Toner asked if changes would be made to the services at St John's Hospital and asked if it would not be possible to relocate Princess Alexandra Eye Pavilion to St John's.
- 5.6 Mr Crombie advised that increased capacity at Ward 20 would be going ahead expanding the current service at St Johns Hospital. However, the site did not meet the accessibility and access requirements of a patient group with significantly higher numbers of elderly and disabled patients.
- 5.7 It was noted that with the conclusion of Royal Hospital for Sick Children and Department of Clinical Neurosciences Project there would be no more available space at the Royal Infirmary of Edinburgh site at Little France. However, the relocation of the Princess Alexandra Eye Pavilion to the adjacent Bio-quarter site could possibly serve a wider patient population than simply NHS Lothian.
- 5.8 It was commented that this could also relieve pressure on General Practitioners and Ms Campbell advised that, whilst specific discussions had not been held with General Practitioners, the national plan was intended to move such care from General Practitioners to community optometrists.
- 5.9 The Committee agreed to note the progress to date in relation to the redesign of ophthalmology services and the strategic direction of further redesign that would explore modern technologies and infrastructures that would minimise patient attendance within secondary care unless clinically necessary. This would extend to enhancing the service's relationships with Primary Care, Community Optometrists and NHS24 with respect to a holistic approach to the delivery of

care. Redesign principles would ensure care was delivered at the right place, right time and by the right person.

## **6. Improving Older Peoples Care in Edinburgh – 2015/2016**

- 6.1 Professor McMahon reminded members that the previously circulated paper had been discussed at the Board meeting on 1 April and set out the work being done and the process in respect of the proposal to improve care arrangements for older people in Edinburgh through a number of related developments detailed within the paper. The twin objectives of the project were to improve the quality of care for older people and to deliver models of care which were financially sustainable.
- 6.2 Professor McMahon advised that Mr Crombie and Mr Gabbitas would be taking these proposals forward and the Strategic Planning Committee would be monitoring progress. Discussions were being held with the Edinburgh Leadership Group and further reports would come back to the Board.
- 6.3 Mr Crombie confirmed that the aspiration was to allow for overview by the Strategic Planning Committee of these projects and he emphasised the need for good project management.
- 6.4 Mr Davison commented that in order to access any bridging funding from the Scottish Government there would need to be clarity about the purpose and term of such funding.
- 6.5 Mr Ash commented that a number of East Lothian patients would be affected by the proposals and Mr Davison advised that all 4 Integration Joint Boards would need to be involved. Where there were cohorted patients and beds were being closed the money would follow the patients. Ways in which smaller numbers of scattered patients could be moved to community care and demand on acute services reduced slightly would also be examined.
- 6.6 The Committee agreed to accept the report in anticipation of more detailed plans being forthcoming.

**AMcM**

## **7. Process for Strategic Plan Update 2015/16 and Future Agenda Items**

- 7.1 Professor McMahon advised the Committee that he was working with Mrs Tait on a programme of strategic plan updates and future agenda items.
- 7.2 Mr Ash raised the issue of representation on the Committee and the Chair reminded members that the Board had recently agreed amended terms of reference for the Strategic Planning Committee which now consisted of 8 Non Executive Board members including himself as Chair, the Non Executive Chair or Vice Chair (which ever was the Non Executive Lothian NHS Board member on each of the 4 Integration Joint Boards) together with the Chair of the Acute Hospitals Committee, the Employee Director and the University of Edinburgh Stakeholder member.

- 7.3 Mr Davison commented on the need for an organic approach as, whilst each council had only one Integration Joint Board Lothian NHS Board had four Integration Joint Boards and overall responsibility.
- 7.4 Mr Ash commented that there should be some linkage between the Strategic Planning Committee and the Integration Joint Boards Joint Planning Committees.
- 7.5 The Committee agreed that Professor McMahon and Mrs Tait should bring back a programme to the next meeting including proposals as to the tracking of progress against the Local Delivery Plans and the Corporate Objectives. **AMcM/LT**

## **8. Date of Next Meeting**

- 8.1 It was noted that as the frequency of meetings had moved from monthly to bi-monthly, the next meeting of the Strategic Planning Committee would be held on Thursday 11 June 2015 at 10am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

The draft minutes of the meeting held on 30 October 2014 are attached.

Key issues discussed included:

- East Lothian Community Hospital - Cabinet Secretary has agreed the Initial Agreement. Detailed planning has commenced on phasing of Roodlands Site development. Two phases are being looked at.
- East Lothian Health Improvement Alliance - Update the ELCHP Sub Committee on the East Lothian Inequalities Strategy and Action Plan and the work of the East Lothian Health Improvement Alliance. This is a joint framework tackling good quality housing, availability of jobs, education and learning opportunities, access to services and social status. To date two sessions have been delivered.
- Delayed discharges – Figures reported for September and October 2014. September highest figure in recent months.

Key issues on the horizon are:

- Delayed Discharges – Committee to receive reports on further steps being taken at next meeting.

Mike Ash  
Chair/Executive Lead

## NHS Lothian East Lothian Community Health Partnership

Minute of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday, 30<sup>th</sup> October 2014, in Council Chamber, Town House, Haddington

<b>Present:</b>	Michael Ash in the chair (MA) Gill Colston, PPF Representative (GC)
	Councillor Donald Grant, East Lothian Council (DG) David Heaney, Interim Head of Adult Wellbeing (DH)
	Alison MacDonald, Head of Health for East Lothian (AXM)
	Ann McCarthy, PPF Representative (AMcC) Fiona Mitchell, Director of Operations, NHS Lothian (FM) Sue Muir, Senior Health Promotion Specialist (SM) David Small, Director of Health & Social Care (DAS)
	Sian Tucker, Acting Clinical Director, LUCS (ST) Andrew Tweedy, Carers of East Lothian (AT)
<b>Apologies:</b>	Moyra Burns, Health Promotion (MB) Judith Gaskell, Head of Human Resources (JG) David King, Head of Finance (DK) Angela Leitch, Chief Executive, East Lothian Council (AL) Murray Leys, Head of Adult Wellbeing Carol Lumsden, Integration and Transformation Manager (CL) Alison McNeillage, Primary Care Contracts Manager (AMcN) Thomas Miller, Lead Site Staff Rep. (TM) Sharon Saunders, Head of Children's Wellbeing (SS) Dr Amy Small, EL GP Representative (AS) Jon Turvill, Clinical Director (JT)
<b>In Attendance:</b>	Barbara Gilbert, PA (minutes)
<b>1.0 Welcome</b>	
<b>1.1 Update on Health &amp; Social Care Partnership</b>	Perennial item. Please refer to Director's report. MA stated looking at date in May 2015 to go live therefore there will be a role for continuing this group. Children's Health Service being looked at regarding integration.
<b>2.0 Minutes of Previous Meeting held on 28.08.14</b>	Agreed as an accurate record.
<b>3.0 Action Note Previous Meeting</b>	Shadow Strategic Planning Group met on 27.11.14 when Carol Lumsden done a presentation on the Draft Strategic Plan. Progress is being made however noted there are vacancies in this group and MA requested carers be informed of the next meeting on 19.01.15. CHP would like engagement with this forum (this item to be noted as an action) and DG intimated he will talk to Carol Lumsden regarding this. Joint People's Older Planning Group – discussion has taken place at

Management Team, CL will process daft and DH will convene a meeting of representatives to discuss this paper. In turn this should be feedback to SSPG. AT will bring this item up when he attends later. DH reported the legislative position has changed and we have to make sure new arrangements are met. AM stated this has been lengthy process therefore members are a bit disillusioned. MA promised to implement improved communication. Prestonpans Initial Agreement – this is in the hands of Finance Resources Committee at the present time.

#### **4.0 Matters Arising**

##### **4.1 East Lothian Community Hospital**

DAS reported papers will come back here depending on outline case, which will probably take place in the spring of 2015. Initial agreement has been agreed by the Cabinet Secretary and we are now involved with more detailed discussions. Detailing thinking has commenced on phasing of Roodlands site, if this is preferred option. Phasing is quite complicated looking like two phases, 1<sup>st</sup> phase around south site which may be demolished first and then temporary accommodation sited. Ambulance Service is interested and work is being finalised with GP Practices. DAS to enquire as to the date of the next Stakeholder's meeting for GC and AMcC. MA would like to offer Partnership Forum for more detailed briefing and Partnership Forum advised to get back to MA. GC enquired if architects appointed to which reply was made Keppie are involved. MA requested he be consulted with regards to groups who have a particular interest in this item.

**ACTION: DAS**

#### **5.0 Items for Decision**

##### **5.1 East Lothian Health Improvement Alliance**

Purpose of report is to update the ELCHP Sub Committee on the East Lothian Inequalities Strategy and Action Plan and the work of the East Lothian Health Improvement Alliance. Following stakeholders event in September 2013 instruction was endorsed to write a paper. Noted this is a joint framework tackling good quality housing, availability of jobs, education and learning opportunities, access to services and social status. To date two sessions have been delivered; a successful workshop with councillors. Action plan is set over next two years therefore East Lothian Health Improvement Alliance are asking for support to drive this forward. DH noted that life expectancy is quite striking depending on which area you live in. Very reassuring that partnership approach agencies. SM stated she has worked with groups in these areas and any action plans that come out assessments will be done. MA reported that RPP will be receiving a report on this item and this will be put on agenda for their next meeting. Margaret Douglas has been invited to this group. AT commented at here is a lot of discussion regarding health and equalities however the issue is around caring role and paid employment and made a plea that this could be looked at in slightly broader remit taking into account. MA stated social economic circumstances is a characteristic and is one of many features and we are looking towards strategic objectives to reduce inequality. MA welcomes this intervention and AT stated he would be happy to be

involved. SM asked how we are supporting carers so there is some small work going on and AT was invited to attend Health Alliance. Discussion took place how IJB include this and it may well be that situation arises where RPP does not exist. Emphasised that it is important that CL puts forward correct outlines in Strategic Plan. Noted that some projects have been lost however there are still projects still funded by Health Alliance and papers will be brought to this group showing what has been developed and it should be noted there are structures. MA thanked SM for her informative report.

## **6.0 Items for Discussion**

### **6.1 LUCS Review**

MA commented on lengthy report and requested ST to point out one or two key features. DAS reported that the CHP for East Lothian is required to log any East Lothian issues and they key issues are change of hours and lone working. Currently there are five bases for LUCS, WGH, RIE, St John's, Roodlands and Midlothian Community Hospital however challenges have been experienced over the past eighteen months therefore an external review has taken place. ST reported LUCS are experiencing significant difficulties in recruiting and training GPs to fill OOH shifts. Medical and nursing staff sickness is having a significant impact on rota management and attracting other doctors to cover shift. Nearly 20% of staff have sickness higher than 4% which must be addressed in the Service Improvement Plan. IT system called Rotamaster is not used elsewhere in NHS Lothian but is used nationally by the majority of OOHs therefore recommendation has been made for a review of this system. Recommendations have been made for Roodlands and MCH to close at 2200 instead of 2400 i.e. with Monday to Friday opening from 1800 to 2200 hours. Both Roodlands and MCH should close at 2200 on Saturday, Sunday and Public Holidays i.e. open from 0800 to 2200 hours. One car, driver and doctor should cover these two geographical areas with support from car based at RIE when necessary and each base should have a receptionist and doctor as core staffing. Consideration should be made for substituting a Band 5 registered nurse for the receptionist at each site to support, record, manage and assess patient prior to doctor consultation. Home visits are a key and core component of OOH services delivered by GPs and this should continue until alternatives are demonstrated safe and effective and efficient. ST reported this has been approved by the Management Team, Clinical Directors Group and GP Forums however concerns have been raised by Midlothian. MA queried in terms of the change of hours is there any suggestion that this would cost less. ST replied this is not necessarily taking skills from doctors however they may be reluctant to work alone at the base which would boost nursing central bases. DG queried if the reduction of hours is due to lack of use but ST commented on figures i.e. average attendance between 11am to midnight drops to 0.5% however service is busier at weekends. DG enquired if figures are in public domain however ST explained there is one year's data which has to be circulated with minutes. And it was agreed that ST would forward this to BG. MA reported that as hosting service we need to comment on East Lothian and final report will be delivered to CHP and CMT. Reported that change of hours most sensitive. Sub Committee is



supporting this process however change in hours are noted and noted the point ST made about general logistics. ST will talk to logistics and reassure people regarding impact. The next report will come back to Sub Committee in either January or next meeting and MA explained this needs to fit in with board schedule. MA requested Partnership Forum and carers to get feedback for this item. MA reported this as a useful discussion and appreciates ST coming to meetings and the correct approach is evidence led.

**ACTION: DAS / ST**

## **7.0 Performance Reports**

### **7.1 Joint Director's Report**

DAS reported slight delay on papers around the Initial Engagement on the Strategic Plan for IJB which are commencing in November however CL is starting engagement process. Planning is still underway for the Scheme of Integration to be submitted to the Council and NHS Board in December 2014 for agreement to consult. Consultation processing the Strategic Plan will take place over January and February 2015. The intention is that IJB cannot deliver functions until Strategic Plan is formally consulted on. NHSL and ELC will then delegate budgets possibly in May 2015 and IJB will direct NHSL and ELC to provide services based on the Strategic Plan again possibly in May 2015. MA suggested carers need to be geared up immediately after Xmas regarding the consultation on Draft Strategic Commissioning Plan and we may have to have a debate which is very important. DAS spoke to a diagram of the East Lothian model of Joint Management Arrangements. We will put in place some joint management arrangements but not part of IJB responsibilities.

MA reported a clear distinction between board of IJB and the organisations that deliver service. There are two separate roles, one of influencing board and they are as individuals and drawn from stakeholders and in addition there will be specific issues i.e. bidding out of national pot. Same people will be working in a more directive way, DAS is looking at bringing together management structures and related services and manage as one service keeping the same terms and conditions. DG hopefully consultation will bring this out and noted this is a huge job. AMacD reported Unison in Lothian met with managers in Dublin recently and they are creating one body and Unison appeared to be quite impressed. MA stated he has a slightly different view and only a limited amount to try and achieve things and we are some way from looking at single contract. DH reported Crookston is a good example of bringing two organisations together and encouraged by bringing staff together.

### **7.2 Head of Health Update**

AMacD highlighted note that Crookston intermediate care beds are up and running and there are 20 people waiting on care homes or packages of care. There has been good joint working with regular updates and patients receiving high level of rehabilitation. AMacD stated any members of Sub Committee are welcome to visit Crookston and please get in touch with Barbara and this will be organised. DG enquired if anybody had declined to which AMacD replied a couple of people have declined who have been used to existing staff and they do not want to move and other issue is how

we portray unit in proficient manner. MA stated he looks forward to receiving further reports in the future.

Hospital to Home has service in East Lothian which has been extended increasing to 6 care assistants and a Band 6 and then looking to extend further.

Discussion took place on Capital Projects updating on various initial agreements.

Mental Health Service event was held on 1<sup>st</sup> September 2014 to start disaggregating the service between East Lothian and Midlothian.

Children's Service work is ongoing to identify where best this service will sit and event being held tomorrow (31.10.14). Difficult to recruit trained health visitors however this is a national concern and work is ongoing in East Lothian to move staff to different areas. GC enquired what does Hospital to Home offer. AMacD replied a very small number of staff are involved and bridge gap therefore we are doubling staff to look at more people with complex difficulties.

**ACTION: AMacD / BG**

### **7.3 Staff Governance Report**

AMacD reported an issue with long term sickness absence however concentrated work is being undertaken with JG, relevant Nurse Manager and increased sessions with Occupational Nurse. It is a concern we have an ageing workforce and there is a significant illness over some staff. TM is very supportive in working with managers.

### **7.4 Prison Healthcare Report**

AMacD produced quarterly update. Psychology service to be increased with variety of funding and this has been identified as deficit over number of years. At present there are nine applicants for this post.

Mental Health Services have recruitment in process for Senior Charge Nurse at HMP Addiewell. Mental Health Team at HMP Saughton has been shortlisted for a Mental Health Award at the Daily Record Scottish Health Awards which is being held on 6<sup>th</sup> November 2014.

New structure at National Meetings is being introduced and the first meeting was held this morning.

Plans are well underway for new woman's unit at HMP Edinburgh including a mother and baby unit which is due to open in December 2016. AMacD reported SM does some good work around this.

MA reported the enclosed two appendixes are for information.

DG suggested worthwhile to have visits.

DAS stated this will not be a delegated function to IJB and probably will be included in the Healthcare Governance Committee and report direct to Health Board.

### **7.5 Clinical Director's Report**

AMacD reported in the absence of JT that Tranent Practice started last week covering Crookston which is going well. Eskbridge Practice continues to cover six of the seven care homes in the Musselburgh area. We continue to be concerned about the shortage of Care of the Elderly in Roodlands and two vacant posts will be advertised imminently. DAS reported these will be joint appointments with Royal Infirmary and will have extended rota.

### **7.6 Finance Report/Financial Plan 2014/15**

AMacD updated on the financial position in the absence of David King. At the end of month 6 there is an overspend of £697,000 and noted that prescribing is still a significant issue. There has been some LRP auctioned since month 5 however there remains a significantly large element of LRP to be auctioned before the end of the financial year. Managers to be involved at end of each month to show up LRP position. Operational pressures – significant financial pressures from Roodlands regarding the use of a locum consultant to support the geriatric services and some staff within the prison service are in the process of being moved from this budget to other budgets which has created additional staffing pressures with a concomitant cost. MA stated it would be interesting to see when IJB comes into effect how LRP is dealt with. MA reported there is a report being issued today by the Auditor General Scotland, Caroline Gardener, which is an update of NHS and instructed everybody to look at Page 1 which demonstrates the first time that money within health is going down, which is a 1.1% decrease and this is full of statistics which will result in a direct effect which we are interested in.

### **7.7 Delayed Discharges**

We said we would have a separate report on this. DAS gave a quick update on number side which tracks two years therefore helpful to see trends. In September the number of delayed discharges was 43 which has been the highest figure for a number of years. In October the figure came down to 30 and we are expecting November will show a further improvement again. Considering increasing capacity of Crookston again. DH reported recruitment fair is taking place at Queen Margaret University on 31.10.14 and 14 expressions of interest have been received. This event is being held at Bleachingfield again next week which is an area that has been hard to recruit historically. DH stated that Tyneholm Stables had a number of adult protection concerns lately so working closely with them and a recent review showed phased admission i.e. one a fortnight however we need to see improvements are maintained. Lammermuir have a voluntary suspension introduced by provider and again we are working closely with them and hopeful by next month improvement measures can be sustained. DAS reported as we are coming into winter January may be a high point for delayed discharges so we need to our best to keep this under control. MA stated we will identify in a one page item the concerns and this to be kept on agenda as a separate item.

**ACTION: DAS / BG**

### **8.0 Public Partnership Forum Report**

GC reported one paper is in draft however there may be some amendments. Meeting planned for 10 February 2014 and MA stated he would happy to attend any meeting as conscious that we are going through changing times. Keith can link into this meeting.

### **9.0 Carer's Forum Report**

AT welcomed the fact that they are involved in discussions regarding the content of the Strategic Plan which relates to carers. Agreed carer support to be added to the Strategic Plan.

Today's event was very positive however the need for evidence to be included which is critically important i.e. issue of multi morbidity and how does this get

pulled into process. MA stated he is aware of the fact and everybody will have a view however we need to be clear we are seeking everybody's input.

**10.0 AOCB**

None

**Dates of Future Meetings**

8<sup>th</sup> January 2015

1400 – 1600

Esk Room 1, Brunton Hall, Musselburgh

5<sup>th</sup> March 2015

1400 – 1600

Esk Room 1, Brunton Hall, Musselburgh

## **EAST LOTHIAN COMMUNITY HEALTH PARTNERSHIP – SUB COMMITTEE**

The draft minutes of the meeting held on 5 March 2015 are attached.

Key issues discussed included:

- East Lothian Community Hospital – Capita have been requested to do re-modelling of bed numbers. Engagement sessions will take place in April and the Outline Business Case will be delivered in the middle of 2015. Work is also underway on options for decant capacity to allow site development.
- LUCS Review – Will come to April 2015 meeting.
- Delayed discharges – Mix of reasons for delays are changing, overall picture is improving. . A Delayed Discharge Workshop is being held on 6<sup>th</sup> March 2015. A Delayed Discharge Taskforce Meeting has been established weekly on a Thursday with the Chief Executives attending once monthly.

Key issues on the horizon are:

- Delayed Discharges – Committee to receive reports on further steps being taken at next meeting. A two week target to be achieved by 1<sup>st</sup> April 2015.
- LUCS review to April meeting.

Mike Ash  
Chair/Executive Lead

## **NHS Lothian    East Lothian Community Health Partnership**

Minute of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday, 5<sup>TH</sup> March 2015, in Esk Room 1, Brunton Hall, Musselburgh (1400 to 1600)

**Present:** Michael Ash in the chair (MA)  
Meriel Deans, Public Involvement and Community Worker  
Councillor Donald Grant, East Lothian Council (DG)  
David King, Head of Finance (DK)  
Alison MacDonald, Head of Health for East Lothian (AXM)  
Ann McCarthy, PPF Representative (AMcC)  
Sue Muir, Senior Health Promotion Specialist (SM)  
Dr Amy Small, EL GP Representative (AS)  
David Small, Director of Health & Social Care (DAS)  
Jon Turvill, Clinical Director (JT)  
Gill Wilson, PPF Representative (GC)

**Apologies:** Moyra Burns, Health Promotion (MB)  
David Heaney, Head of Resources, ELC  
Judith Gaskell, Head of Human Resources (JG)  
Fiona Mitchell, Director of Operations, NHS Lothian (FM)  
Sian Tucker, Clinical Director LUCS (ST)  
Andrew Tweedy, Carers of East Lothian(AT)

**In Attendance:** Barbara Gilbert, PA (minutes)  
Manx Neill (Shadowing Barbara Gilbert)

### **1.0 Welcome**

#### **1.1 Update on Health & Social Care Partnership**

MA reported that NHS Lothian had approved the Scheme of Integration on 4<sup>th</sup> March 2015. The Council will consider it on 10<sup>th</sup> March 2015

DAS reported that £1.76m per annum for the Integrated Care Fund has been delegated to East Lothian for three years and will be available as from 01.04.15. Details of the proposals are being worked on at the moment.

MA requested that a financial report including allocations should be available for the next scheduled Sub Committee meeting on 30.04.15 and at that point there will be more detail to hand from the Shadow Board.

#### **ACTION: DK**

MA reported visiting the Torbay partnership recently which he found very interesting. Members should contact him for details.

### **2.0 Minutes of Previous Meeting held on 30.10.14**

Agreed as accurate record.

### **3.0 Action Note Previous Meeting**

DG reported a gap in housing representation in the Shadow Strategic Planning Group. CL attending a meeting with the Housing Forum last week therefore feedback is awaited.

ELCH and Integrated Care Facility – This will be covered by DAS in his report.

LUCS review – This item to be discussed at the next meeting scheduled for 30.04.15. A public meeting was held recently in Midlothian and was attended by some East Lothian residents. Sian Tucker is currently working through all the comments however she will be invited to the April meeting of CHP Sub Committee.

Crookston – Ann McCarthy visited and felt very positive. She commented there was a commitment to rehab therefore people may be more ready to go home. Noted that the ground floor and first floor are local authority care home and the second floor is NHS step down and in time step up.

Delayed discharges - MA requested a regular update of discharge situation.

#### **4.0 Matters Arising**

##### **4.1 East Lothian Community Hospital**

Please refer to 6.1 (Joint Director's Report).

##### **4.2 LUCS Review**

Please refer to 6.1 (Joint Director's Report).

#### **5.0 Items for Discussion**

Nil.

#### **6.0 Performance Reports**

##### **6.1 Joint Director's Report**

Consultation on the Scheme of Integration is now complete and initial consultation on the draft Strategic Plan is now complete. The Scheme of Integration has been approved by NHS Board on 4<sup>th</sup> March 2015 and is awaiting approval by ELC on 10th March 2015. The CHP Sub Committee will continue in its role for NHS services until the IJB is established which is likely to be July 2015.

Proposals for Joint Management Structure is being worked on and discussion will take place at NHS and ELC Corporate Management Teams. Consultation on the proposals will follow that. New structures will be implemented over the coming months with a range of managers having shared responsibility for Health and Social Care.

Following consultation the proposals will be presented to the Council and NHS Board for agreement.

Stakeholder sessions in respect of the East Lothian Community Hospital have been delayed for about a month. Capita have been requested to do remodelling of bed numbers as these require being refreshed.

Engagement sessions will probably take place in April and the Outline Business Case will be delivered in the middle of 2015.

##### **6.2 Head of Health Update**

ELSIE commenced operations on 2<sup>nd</sup> February and there is an ELSIE Clinical Operations Group in place which manages all operational aspects. ELSIE Consultant is now in post half time per week. Prestonpans Health

Centre is the first GP practice to be involved and Tranent GPs will be visited next week and hopefully fairly soon this will be available to all GPs in East Lothian.

A team “huddle” takes place in Roodlands Day Hospital every morning at 830am. MA plans to meet this “huddle” in the near future and he will circulate dates in the event that any member may wish to join him.

**ACTION: MA**

Scottish Government will be filming the “huddle” at some point which demonstrates a good example of integration work on the ground.

GW enquired if people living in sheltered accommodation are eligible for this support to which JT replied all East Lothian residents are eligible. Hospital to Home was set up as a response to the challenge of getting packages of care and this is working as a re-enablement method, which has been very successful with 95% satisfaction recorded with carers and relatives.

Step down care beds within Crookston Care Facility, Tranent are fully functional and already working to discharge to assess principles.

Discussion has commenced around the Blindwells development and the need for a GP Practice.

Health Children’s Services will remain the responsibility of the Joint Director.

Noted experiencing increasing difficulty in recruiting Band 6 Health Visitors with c 20% vacancies in East Lothian. Discussions are ongoing on a pan Lothian basis to find solutions. Funding is available for this and ongoing work is being done with Queen Margaret University to recruit.

MA requested it would be useful for CHP Sub Committee to be aware of implications surrounding this shortage.

**ACTION: AMacD**

**6.3 Staff Governance Report**

AMacD reported sickness absence recorded as 5.1 in February which is down from last month however work is continually being carried out in this area. Some of these figures are recorded as hosted services. There are restrictions on agency staffing at the moment, however East Lothian have not used agencies in the past three years.

**6.4 Prison Healthcare Report**

A proposal has been made that the Prison service will now be delegated to Edinburgh H&SCP however no timescale has been indicated.

Scottish Government issued a news release on 26.10.15 announcing that current plans for a female prison in Inverclyde will not go ahead. The Scottish Government and Scottish Prison Service will now undertake a period of extensive engagement with key partners with a view to investing in smaller regional and community-based custodial facilities across the country. This will also involve looking at international models of best practice.

**6.5 Clinical Director’s Report**

JT reported that DAS had convened two meetings with GP Practices



discussing significant areas of housing planned.

Blindwells – outcome that probably a new practice will be developed for this community however discussion needs to be taken forward.

Wallyford / Musselburgh East area – conclusion was that it was agreed to take forward a working group with the three Musselburgh practices. Hopefully with correct support and development looking at new ways of cooperative working. Physical capacity in terms of space is available in the Musselburgh Primary Care Centre.

DG reported that Wallyford will have an extra 1,000 houses plus any additional housing agreed through the LDP which DAS noted would potentially equate to 7,000 or 8,000 new patients across the three Musselburgh Practices.

The three GP Practices at Newton Port will take on new residents from Letham Mains and Haddington West.

MA reported that the population of East Lothian is in fact the fastest growing in Scotland. DK noted that East Lothian will therefore receive a bigger share of the GMS budget.

Concern raised regarding shortage of doctors in Care of the Elderly as Dr Jamieson is leaving his post at the end of March. Currently working with the services of a locum. Recent interviews for the vacant posts led to the appointment of three new consultant posts however they all expressed a preference for work based at RIE rather than Roodlands however two were willing to hold sessions at Roodlands in their job plan. Plan is that running costs will be handed over to RIE / Liberton but has to include ELSIE, Hospital to Home, Discharge “huddle” etc. JT is attending a meeting this afternoon and will report back result.

**ACTION: JT**

## **6.6 Finance Report / Financial Plan 2015/16**

DK presented the finance paper which laid out the financial position of the CHP to the end of January 2015. This showed an over spend of c. £1.3m of which c. £0.6m was within the prescribing position. The CHP will not meet its financial target in year. The pressure within Prescribing has been driven by higher than projected average prices with the other operational pressures being largely driven by pressures arising from the high level of delayed discharge across the system. This has meant that some LRP schemes which were based upon ward reconfiguration had been delayed and that all the CHP's wards are now working at maximum capacity all of the time and this is generating financial pressures within the nurse staffing budgets. A great deal of work was underway to improve the delayed discharge position and this will have a concomitant improvement on the overall financial position.

The important lesson from 2014/15 which has already been reflected in the planning for 2015/16 was to ensure an early start to actioning the LRP schemes and a full set of LRP schemes has already been developed by the management team and this is attached to the report for information.

## **6.7 Delayed Discharges**

MA voiced concerns regarding delayed discharges as the CHP require to be assured actions have been taken.

January figure recorded as 36 and February 29 for East Lothian. Noted that mix of reasons for delays are changing with people waiting for care homes now down to 10. People waiting for packages of care and home care have increased therefore we are looking at focussing on additional packages of care and assessment process.

A Delayed Discharge Workshop is being held on 6<sup>th</sup> March 2015 and people will be requested to help with the process of delayed discharges.

Noted that with the opening of Crookston with 20 beds it has been slightly disappointing overall that the delayed discharges figure has not decreased by the same amount.

A Delayed Discharge Taskforce Meeting has been established weekly on a Thursday with the Chief Executives attending once monthly.

DAS reported that by 01.04.15 we have to achieve a two week target.

MA requested that this be added to Agenda at each CHP Sub Committee meeting.

**ACTION: DAS / BG**

## **7.0 Public Partnership Forum Report**

GW stated a meeting is taking place on 24.03.15 which will possibly be the last, but they may wish to continue until the IJB takes over but discussion will take place. A meeting was held on 10.02.15 which DAS attended and talked about Strategic Plan. ELHN sent comments back to CL and a copy is attached to the ELHN minutes that have been distributed to CHP. It is not clear how community engagement will work in the future. Engaging with Area Partnerships is useful as with Community Councils but it is very difficult to see how it will work. A Citizen's panel has been mentioned also.

MA stated there is no way IJB can work without meaningful engagement MD stated the Health Network (PPF) wants to leave some legacy and they are looking at how things may work better in the future. This follows on from the paper that went to CHP eighteen months ago about public involvement in integration. They attended the GP Forum and gave a presentation to encourage setting up Patient Participation Groups within practices. MD is working with Kenneth (chair) to produce a paper reflecting on the work of the Health Network. This draft paper will be discussed at the Health Network meeting in March and will come to CHP.

DAS stated a communications plan is being worked on for the IJB.

MA commented there is an engagement and consultation template produced by community planning. In the regulations there is an approach of a Scottish community engagement model and IJBs will be required to use this model. MD has been part of the working group who produced People's Voice, East Lothian Partnerships Community Engagement framework People's Voice. A suggestion is to send it round CHP for staff to use. This was agreed.

**ACTION: MD**

DAS stated that if this is the last meeting of the CHP that the ELHN would attend he would like to express thanks to everybody as he has always found this a positive relationship. On a practical level, public membership of Sub Committee needs to be discussed If ELHN ceases to exist.

GW stated that it is likely that ELHN would agree to continue and to attend the Sub Committee.

MA stated it would be helpful for the CHP to continue until IJB commences.

MD noted that Kenneth will ask at the next Health Network meeting if members want to host further meetings on the New Community Hospital and the next consultation of the draft strategic plan.

**8.0 Carer's Forum Report**

In the absence of Andrew Tweedy, Carer's Forum Report not to hand.

**9.0 AOCB**

It was agreed the Sub Committee would need to meet probably twice more with final meeting in July.

DAS reported that Murray Leys has resigned from ELC and conveyed his thanks to him for his contribution to the EL CHP Sub Committee. The Chief Social Work Officer will be covered by service managers and a rota is in place at present. A decision will be made in the next couple of months on recruitment.

**Dates of Future Meetings**

30 April 2015

1400 – 1600

Council Chamber, Town House, Haddington

## **EAST LOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP SHADOW BOARD**

The draft minutes of the meeting held on 26 February 2015 are attached.

Key issues discussed included:

- **Scheme of Integration Update** – Various amendments reported which included the hosted service Prison Healthcare moving to Edinburgh IJB, East Lothian will continue with LUCS. School Nursing and Health Visitors to be a delegated function to East Lothian. Noted Children's Wellbeing will not be a delegated function in 2015/16.
- **Strategic Plan** – Consultation process on the first draft closed on 17<sup>th</sup> February 2015. Nineteen presentations have been completed with another scheduled next week to the housing department. To date thirty-two responses have been received.
- **Integrated Care Fund** – Draft Integrated Care Fund plans submitted to members for comments.
- **Joint Financial Planning** – A report will be submitted at the next meeting on 03.04.15 laying out the projected 2015/16 budget.

Key issues on the horizon are:

- **Scheme of Integration Update**
- **Strategic Plan**
- **Integrated Care Fund**
- **Joint Financial Planning**

Mike Ash

Chair/Executive Lead

# East Lothian H&SCP



## MINUTES OF SHADOW BOARD

26<sup>th</sup> FEBRUARY 2015

1400 – 1600

Council Chamber, Town House, Haddington

<b>Present:</b>	Donald Grant, Vice Chair (DG) Shamin Akhtar (SA) Maureen Allan (MAI) Alastair Clubb (AC) Stuart Currie (SC) Jim Goodfellow (JG) David King (DK) Murray Leys (ML) Carol Lumsden (CL) Alison MacDonald (AMac) Joanne McCabe (JM) Alison Meiklejohn (AM) Thomas Miller (TM) David Small (DAS) Jon Turvill (JT)
<b>Apologies:</b>	Michael Ash (Chair) (MA) Sarah Fortune (SF) Professor John Iredale (JI) Alex Joyce (AJ) Angela Leitch (AL) Margaret McKay (MMcK) Eliot Stark (ES) Graeme Warner (GW)
<b>Scribe:</b>	Barbara Gilbert

1. **Welcome and Apologies**

Mike Ash's apologies were noted. Donald Grant took the chair in Mike's absence. Donald Grant noted that this meeting is not quorate therefore all decisions will be noted and any matter of substance will be brought forward to next meeting.

2. **Minutes of Previous Meeting**

Keith Maloney was present.

Noted that public engagement on community hospital is the end of March.

Noted that NHS Board budget setting will be 1<sup>st</sup> April – bring to next meeting joint financial paper.

3. **Matters Arising**

None.

4. **Standing Items**

4.1 **Chair's Report** – No report.

4.2 **Director's Report** – DS reported that Murray Leys, Head of Adult Wellbeing and Chief Social Work Officer has resigned from his post as from 28.02.15. A rota will be implemented for Chief Social Work Officer until new post is filled. DG conveyed his thanks to Murray Leys for his service over the past five years and wished him well for the future.

The final Scheme of Integration will be presented to NHS Board meeting on 04.03.15 and to ELC on 10.03.15

Work is continuing on the outline business case for the East Lothian Community Hospital and Capita has been asked to review the bed numbers and a meeting will be convened at the end of March on this. There will be a need to decant East Fortune House and Day Hospital. A Stakeholder Event is planned for 20<sup>th</sup> March 2015 and invites have been sent to all previously involved members from our partner agencies. KM queried how will group be established and if carers will be included. DAS will talk to Miriam Anderson and offer meeting with Keith Maloney and Margaret McKay

**ACTION: DAS / Miriam Anderson**

Work is underway to design a joint management structure that brings together related elements of health and social care functions. Joint management arrangements are being worked on and this will be consulted on in March. Shadow Board members will be involved in consultation.

**ACTION: DAS**

There will be a joint Inspection of Adult Services in East Lothian in late summer. Office work commencing in June and field work in August. This will be carried out by the Care Inspectorate and Healthcare Improvement Scotland. Pilot inspections have been carried out in Moray and Aberdeenshire and a full inspection in Fife. These reports are available on the Care Inspectorate website. A Steering Group has been set up and a launch event was held on 9<sup>th</sup> February 2015.

SC commented that Delayed Discharges was not an item included in this

report. DAS reported that a weekly update regarding Delayed Discharges will be distributed to Shadow Board members. Delayed discharges will be included in future reports as well. DAS updated on priorities for delayed discharge funding and reported that there were fewer people waiting for care homes and more waiting for packages of care. SC commented that he felt there should still be investment in care home capacity.

**ACTION: DAS**

CL commented that in terms of the Strategic Plan the government have published twenty draft indicators therefore, if helpful, work can be formulated in respect of regular framework data.

**ACTION: CL**

**5. Items for Discussion**

**5.1 Scheme of Integration Update**

JMcC circulated papers regarding the scheme. JMcC reported various amendments which included the hosted service Prison Healthcare moving to Edinburgh IJB, East Lothian will continue with LUCS and School Nursing and Health Visitors under age of 18 years to be a delegated function to east Lothian. It was noted that Childrens Wellbeing would not be a delegated function in 2015/16. Nine responses were received from East Lothian during the consultation. JMcC will circulate the finalised scheme to Shadow Board members.

**ACTION: JMcC**

DG conveyed his thanks to JMcC for her hard work on behalf of the Shadow Board.

**5.2 Strategic Plan**

CL reported the consultation process on the first draft closed on 17<sup>th</sup> February 2015. Nineteen presentations have been completed with another one scheduled next week to the housing department. To date thirty-two responses have been received. Most consistent theme received was access to primary care. There was also comment on low level mental health support and support to deliver self care and self management. These key themes will be taken onboard to develop and refine the second iteration together with budgets.

KM requested a strong focus be adopted on how the service users are involved and reported this might be a positive for the adult services inspection.

**ACTION: CL**

**5.3 Integrated Care Fund**

CL requested members to note the draft Integrated Care Fund submission, submission and intentions, note the key risks. Further updates on progress will be circulated. Since this meeting is not quorate this item will be carried forward to next Shadow Board scheduled on 2nd April 2015.

The Integrated Care Fund for East Lothian is £1.76 million per annum and will be available from April 2015 subject to approval of submitted proposals.

DG explained that Margaret McKay in her absence today had submitted

questions to put to the Shadow Board however as the meeting is non quorate today this will be carried forward to next meeting on 03.04.15.

DG thanked CL for her hard work on behalf of the Shadow Board.

**ACTION: DAS/CL**

#### **5.4 Joint Financial Planning**

DK presented a paper laying out the current position in the IJB budget setting process, the next planned steps and an early indication of the financial and operational risks that the IJB would have to manage. It had been intended that a financial quantification of the IJB's budget would be available for this meeting but NHS Lothian has not yet finalised its financial plan and this information will not be available until April 2015. DK will bring a report to the next meeting of the IJB laying out the projected 2015/16 budget.

**ACTION: DK**

#### **6. Any Other Business**

MAI suggested a presentation of Care at Home for a future meeting which was accepted.

SC requested a glossary being implemented for NHSL and ELC which would benefit members. DG indicated this would be helpful as NHSL and ELC have very different acronyms and technical terms.

**ACTION: DAS**

#### **7. Dates of Future Meetings**

Next meeting 2<sup>nd</sup> April 2015 2pm Saltire Room 2 John Muir House

**Development Session – 11 March 2015**

1400 – 1700

Saltire Rooms 1 & 2, John Muir House, Haddington

**Development Session – 4 June 2015**

0900 – 1200

Adam Room, John Muir House, Haddington

**Meeting - 2 April 2015 – 1400 – 1600**

Saltire Room 2, John Muir House, Haddington



## EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB COMMITTEE MEETING

The draft minutes of the meeting held on 11 February 2015 are attached.

Key issues discussed included:

Integration; Scheme Consultation/Locality Development  
NHS Board Arrangements Following Disestablishment of CHPs  
Infrastructure and Capital Reports  
Increasing Population and Primary Care Premises  
Nursing Workforce Report  
Winter Plan Update/Unscheduled Care – Opening of Gylemuir  
Finance Updates  
Young Carers ID Card

Key issues on the horizon are:

- ❖ Financial positions facing the IJB when established.
- ❖ Primary Care growing instability.
- ❖ Integrated Children's partnership.
- ❖ Momentum with support to Primary Care Infrastructure Development.
- ❖ Combination of vacancies/sickness/vacancy freeze/national shortages causing problems in several service areas.

Chair of the CHP – Shulah Allan

# EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB COMMITTEE MEETING

DATE: Wednesday 11<sup>th</sup> February 2015 at 2pm

VENUE: SMART Centre, AAH

## Present

Shulah Allan, Chair, ECHP and Non-Executive Director, NHS Lothian  
David White, Assistant General Manager  
Sheena Muir, Assistant General Manager, Astley Ainslie & Associated Hospitals  
Wanda Fairgrieve, Lead Partnership Representative, Edinburgh CHP  
Peter Gabbitas, Director of Health and Social Care  
Sally Arnison, Pharmacist  
Bob Martin, Finance Partner, Edinburgh CHP  
Angela Lindsay, AHP Manager  
Dr Ramon McDermott, GP Sub/Lothian LMC  
Maureen Reid, South West LHP  
Christine Farquhar, Member, Shadow Integrated Joint Board  
Aleisha Hunter, Development Manager, ECHP (Minutes)

## Apologies

Dr Ian MacKay, Clinical Director, Edinburgh CHP  
Councillor Ricky Henderson  
Anne-Marie Comber, Patient Involvement Worker, ECHP  
Maggie Gray, Project Manager, Edinburgh CHP  
Lynda Cowie, Chief Nurse, Edinburgh CP  
Eileen McGuire, Service Manager, Edinburgh CHP

## Action

### 1. Welcome & Introductions

Apologies were noted as above.

SA (Chair) welcomed those present. Brief introductions were made.

SA welcomed Christine Farquhar to the Committee. Christine is a carer and member of the Shadow Integrated Joint Board. She will sit on this Committee until the Integrated Joint Board is established.

### 2. Minutes of previous meeting of 13<sup>th</sup> November

The minutes from 13<sup>th</sup> November were accepted as an accurate record.

### 3. Matters arising

#### **IPCC Bed Reconfiguration**

All changes to IPCC are now complete. A review will take place nationally, led by the Scottish Government, on the IPCC criteria. The direction of travel may potentially lead to a reduction in the number of IPCC beds. The requirement for Continuing Care will still be there but perhaps with less NHS provision, which will lead to an increase in demand in care home beds.

#### **Development of Localities**

There has been very positive feedback on the direction of travel. Timescales have yet to be confirmed but April 2016 has been suggested for getting organisational arrangements in place. Brief discussion took place around GP

Practices who have patient populations split across the new boundaries. DW confirmed that agreements will be made with these practices.

Carers are supportive of the locality development plans but have highlighted concerns over the mechanisms for carers organisations to manage within them. This is not a local problem as there has been an overall reduction of 30% in funding resulting in concern over unmet need. It was recognised that it will be important to strengthen links and relationships with third sector organisations and having shared public sector boundaries should be helpful. Brief discussion took place around awareness raising with GP surgeries and it was recognised that GPs are not necessarily the gateway to people with long term conditions. In response to a concern over procurement of services being mainly with public bodies, it was confirmed that the majority are outsourced.

The importance of involving pharmacy in the planning stages was recognised.

### **Integration Scheme Consultation**

The Draft Integration Scheme was approved by NHS Lothian and CEC in January and it is out for consultation at the moment. It is hoped that the scheme will be signed off by the Board in March. It will then be approved by both parent bodies and submitted to the Scottish Government by 31<sup>st</sup> March. The Integrated Joint Board is likely to meet for the first time in July. The process for Chief Officer appointments is yet to be confirmed.

The financial position for 2015/16 was discussed. The Council's Social Care budget will see a significant reduction, approximately £9 million less than current expenditure. In addition to this, £7.5 million of efficiency savings have already been approved. This places immense pressure on services. PG will produce an action plan setting out the consequences of these decisions.

The NHS Lothian budget will increase by approximately £35 million overall but this is already absorbed on pressures around drugs, pay etc. Increases to NHS funding are continuing at Scottish Government level but the Council budget is decreasing. NHS Lothian is currently 0.5% away from achieving a balanced budget. The NHS Board total allocation will increase by 3.5% next year and it is important to look at what this means for the CHP. It was noted that this increase is inclusive of the new money to tackle delayed discharges etc so funding will not necessarily come into the CHP, it may go to support people in more appropriate care settings. The Primary Care development money has yet to be allocated from Scottish Government; no information has been divulged on this yet. We face very significant financial challenges.

### **NHS Board Arrangements Following Disestablishment of CHPs**

Edinburgh CHP will continue to be a Sub Committee of NHS Lothian Board from 1<sup>st</sup> April and for as long as it takes the Integrated Joint Board to be established.

There was discussion around ensuring adequate professional representation on the IJB and the Strategic Planning Group. The Professional Advisory Committee was established to give professional advice and thought is going into how reps gather views, inform opinion etc.

It was highlighted that the CHP and IJB are very different in terms of responsibility. The IJB has a huge remit and locality planning and neighbourhood work will be important going forward.

There are plans for an Integrated Children's Partnership and planning for this may begin as early as April.

Brief discussion took place around community pharmacy input and it was recognised that engaging pharmacy now can help to provide answers to some upcoming challenges.

#### **4. Infrastructure Group**

The Infrastructure Group looks to find solutions on infrastructure challenges around premises etc. Main issues at present are:

- How clustering for district nursing can be better supported. GPs and social care colleagues will be engaged in this and various options are being explored.
- The Access Practice currently located at Cowgate may be reprovided from Spittal Street.
- Leith Walk surgery are exploring premises adjacent to their current building, discussions are ongoing.
- There are concerns on the arrangements around the property at Boroughloch and discussions are ongoing.

The group meets every three months and could potentially be joined up with social care in the future. This is currently being explored.

#### **Population / Premises**

Meetings have taken place with GPs across the city regarding opportunities / requirements etc and a summary is now in place for each area. Work is being taken forward with PCCO looking at restricted practices.

Brief discussion took place around disbanding practices due to partners retiring and the importance of being prepared for this was highlighted. Various options must be explored. The impact of the new locality boundaries on disbanding practices was discussed. Most practices have a small area and we could potentially explore swapping patients between practices based on area.

There were 8 – 9 small LEGUP schemes delivered this year which worked very well, however, it was noted that we must continue the momentum into larger schemes to allow premises to keep up with population.

#### **5. Workforce Report**

Aileen Kenny gave an update on nursing workforce.

There is significant pressure in IPCC in terms of staffing, with 25 vacancies at present. The ratio of registered nurses to non registered nurses is an issue and the sickness level is currently 75%. The areas with most vacancies have the highest sickness levels. IPCC is currently exempt from the vacancy freeze and agency ban. Winter beds require additional staffing.

Vacancies in rehab medicine are subject to the recruitment freeze and there are retirements and resignations pending. This area will be monitored for patient safety. MEARS ward has support in place at the moment to help it improve.

The National shortage of Health Visitors continues and there are many band 6 vacancies across the city. The staffing issues are impacting on sickness absence and this is on the CHP risk register.

School nursing is subject to a National review, moving from a school based to a child based service and work is ongoing across NHS Lothian.

The Care Home Liaison Service has high absence rates and the District Nurse

Service is spending a lot of time supporting care homes without nurses. The key risks were outlined.

Discussion took place around the IPCC criteria potentially changing. If bed numbers reduce we must have a staffing model that reflects the needs of patients in this area. This will be discussed further at the next meeting.

Unison have raised concerns re workforce issues.

## **6. Report on Capital Schemes**

David White gave an update on Capital Schemes.

There has been a delay in the business cases going forward for the bundle projects and also the REH due to a National issue around risk transfer and tax.

Ratho continues to make progress. The current premises have been repaired and the developer is working on planning for the new premises.

Discussions are taking place with a student accommodation company to explore the possibility of Dalkeith Road and Southside practices being brought together into the old Homebase building.

## **7. Winter Plan Update / Unscheduled Care**

Sheena Muir gave an update on winter planning / unscheduled care. Gylemuir opened at the start of January with 30 beds for Edinburgh care home delay. RVH is still being used for delayed discharges and patient flow is being supported by utilising beds flexibly. Balfour has not been opened at all.

The winter process has been managed very well and effective planning has resulted in a reduction in delayed discharge beds, from 140 to 80. Targets for supporting delays have been exceeded over the past six weeks and the social care input towards this has been outstanding. It was noted that, although hugely successful, this option has been very costly and will not be available going forward.

## **8. Finance Updates**

Bob Martin gave a finance update.

The CHP is currently just under £5.6 million overspent. Regular discussions are taking place with NHS Board senior management on addressing current financial pressure drivers and in taking forward the major savings schemes. Some of the pressures going into next year have been identified as workforce issues, pay uplift, pension changes and changes to parental leave.

The risks associated with transferring from a CHP budget to a Health and Social Care budget will be discussed at future meetings. These risks must be considered by the CHP and handed over to the Integrated Joint Board. They will be reported to both.

## **9. AOCB**

### **Young Carers ID Card**

Julie Deegan Wood, Assistant Strategic Programme Manager, NHS Lothian and Abigail Jackson, Project Manager, Broomhouse Young Carers Project asked the Committee to note the introduction of the Young Carers ID Card and to promote its use.

JDW gave the background to the project and highlighted the issues that young carers can have being recognised by professionals. The ID card is to acknowledge the role of young carers and to allow them to have input into care for the family. It will also highlight to schools, colleges, hospitals etc that these young people have extra responsibility. The card is not automatic for every young carer, consent will be sought from the cared for person in order for the young person to have the card.

It is hoped that the card will be launched at Carers week and a leaflet will be developed for practitioners. Work is underway to raise awareness among professionals and there will be leaflets / publicity in place. It was recognised that broad communication is vital in order to legitimise the card.

An evaluation of the project will take place and will be based on the SHINARI outcomes for GIFEC. The card has been in use in Fife for approx. 18 months and the full evaluation has yet to be published. It is thought that approx. 500 young carers may participate pan Lothian in the first year, increasing to around 1000 by the end of year 2.

Brief discussion took place around benefits of carrying the card for young people and Youngscot was suggested. A range of options are currently being explored.

There was very positive feedback from the Committee and it was confirmed that the project has the support of the Integrated Carers Team.

## **10. D.O.N.M.**

To be confirmed

## **EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB COMMITTEE MEETING**

The draft minutes of the meeting held on 15<sup>th</sup> April 2015 are attached.

Key issues discussed included:

Primary Care Capacity  
Integration: Scheme progress/Strategic Commissioning  
AHP Update – Living it Up Implementation  
Report on Capital Schemes  
Finance Updates

Key issues on the horizon are:

- ❖ Cost of 'emergency' assistance to GP Practices in crisis.
- ❖ H&SLP on track to become a legal entity by July 2015.
- ❖ Delay and associated cost with ISA10 delay to 'Bundle' projects.
- ❖ Management of IPCC reduction and National Review with new criteria on the way.
- ❖ Risk of prescribing costs highlighted.

Chair of the CHP – Shulah Allan

# EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB COMMITTEE MEETING

DATE: Wednesday 15<sup>th</sup> April at 1pm  
VENUE: Board Room, Admin Block, AAH

## Present

Shulah Allan, Chair, ECHP and Non-Executive Director, NHS Lothian  
David White, Assistant General Manager  
Sheena Muir, Assistant General Manager, Astley Ainslie & Associated Hospitals  
Peter Gabbitas, Director of Health and Social Care  
Bob Martin, Finance Partner, Edinburgh CHP  
Dr Ramon McDermott, GP Sub/Lothian LMC  
Maureen Reid, South West LHP  
Christine Farquhar, Member, Shadow Integrated Joint Board  
Dr Ian MacKay, Clinical Director, Edinburgh CHP  
Maggie Gray, Project Manager, Edinburgh CHP  
Aleisha Hunter, Development Manager, ECHP (Minutes)  
Kirsten Leath, Project Manager, Living It Up

## Apologies

Lynda Cowie, Chief Nurse, Edinburgh CHP  
Angela Lindsay, AHP Manager, Edinburgh CHP  
Wanda Fairgrieve, Lead Partnership Representative, Edinburgh CHP  
Sally Arnison, Pharmacist

## Action

### 1. Welcome & Introductions

Apologies were noted as above.

SA (Chair) welcomed those present. Brief introductions were made.

### 2. Minutes of previous meeting of 11<sup>th</sup> February 2015

The minutes from 11<sup>th</sup> February were accepted as an accurate record.

### 3. Matters arising

#### **Primary Care Capacity**

David White tabled two papers regarding special measures that are being put in place to stabilise a small number of GP practices within Edinburgh. A national shortage of GPs and the significantly reduced availability of locum doctors has created a critical situation within primary care and the CHP are working hard to minimise the impact on patient care. Urgent support is being put in place and considerable cost is attached to addressing the difficulties, however, this cost is less than what would be required if practices were forced to close.

This is a very difficult situation and is demanding significant time input from a small team of senior CHP and PCCO staff. It is important to formalise the processes that are being undertaken as this is a completely new situation and those taking difficult decisions need clarity over flexibility and constraints. This may be the height of the crisis, but that seems unlikely and it is possible that things may worsen. There is extreme concern over a number of GP practices being unable to continue to operate.

It is estimated that £1 million is required Lothian wide for emergency assistance



for primary care over the next 3 years. Brief discussion took place around £1 million already identified for primary care potentially being spent on new developments. There was general agreement that this funding should be considered as the first option to address the crisis. It was recognised that funding alone will not solve the issues we face and building a more stable workforce for the future is key.

There are a number of factors contributing to the staffing difficulties; large numbers of staff retiring, the very high GP workload making locum work an easier option, younger staff not finding general practice an attractive option due to the working hours and the requirement for work – life balance etc. Many younger doctors have a preference to work in secondary care as there they work within a team and have more support. The reduction in GP training numbers is also a factor. It is crucial to explore new ways of working and to modernise, potentially looking at Nurse Practitioners etc. The impact of premises was discussed as they do play a role in the instability of practices, however, the underlying issue is the lack of doctors. It was noted that this is not a Lothian specific issue; other Boards are facing the same challenges.

PG has raised this formally at the NHS Lothian Corporate Management Team and DW has taken a paper to the Primary Care Joint Management Group and is working on developing a list of potential mitigating actions relevant to all Lothian Health and Social Care Partnerships. SA will take the opportunity to raise the issue at the Healthcare Governance Committee.

#### **Healthcare Governance Committee**

SA sits on the Healthcare Governance Committee and gave a brief update on two agenda items from the last meeting; mandatory training and serious adverse events.

The CHP performance in mandatory training remains a concern, although compliance rates exceed other service areas. Notably in violence & aggression training.

In order to redress a perceived disconnect between the Committee and QIT for reporting serious adverse events IM will highlight the main issues from the QIT as required.

#### **4. Integration**

The Integration Scheme was formally approved by both the Council and NHS Lothian and submitted to Scottish Government on 16<sup>th</sup> March. S. G. has 8 weeks to approve the scheme and it will then be laid out in parliament. The Integrated Joint Board should be live in July but the integrated budget will not be in place until 1<sup>st</sup> April 2016. It was highlighted that as soon as the Scottish Government approves the scheme it becomes a legal entity from that point.

The Strategic Commissioning Planning Group is in place and has comprehensive membership. The Strategic plan is being produced in a joint, co-produced way and is a major piece of work. The first draft should be complete by the end of June and extensive consultation will take place thereafter. The plan is the start of a long process to achieve major shifts in the balance of care and it is important to manage expectations around this. It will not solve everything quickly; realistically it is a 10 year plan, which will be updated annually. Work is already underway on financial due diligence.

## **5. AHP Update – Living It Up**

Kirsten Leath, Project Manager for Living It Up gave a presentation to the Committee. Kirsten explained the background to the project and explained how it looks and how it is currently being used in Lothian.

In response to a query on communications Kirsten advised that Living It Up has Community Engagement Officers who host pop up stands at various venues and every GP practice in Lothian has been contacted and sent information. Radio adverts have also been used and will be used again. Customised PowerPoint slides can be sent to anyone who requests them.

Concerns were raised over the NHS working in isolation, not linking with existing community groups, libraries etc. It is important to clarify who this service is actually for and figure out how to reach isolated / lonely people. It is important to have a bridge to them and community groups could help with this. It is vital that we make best use of our connections.

At present, the future of Living It Up is being thought out. There is a need to clarify exactly who the service is for, what its main purpose is etc. An evaluation of the project will take place in November.

Kirsten advised that it is hoped to run a 'Spring in Your Step' challenge after May. Pedometers will be available to those taking part. If members know of any groups etc who may be interested they should contact Kirsten directly.

## **6. Report on Capital Schemes**

Maggie Gray gave an update on Capital Schemes.

- Construction of the new partnership centres has been delayed pending a resolution on the ongoing National issue re around risk transfer and tax. Work will be ready to start as soon as a resolution is reached.
- The planning application for the new Ratho surgery was submitted in late March and legal discussions with the developer are ongoing.
- It is hoped that the business case for the reprovision of Leith Walk surgery will be finalised over April / May.
- Brunton Place surgery is a priority for new premises and options are being explored. They could potentially go into the Meadowbank site redevelopment.
- Dalkeith and Southside practices could be reprovided from the Homebase site at St Leonards. The original planning application was turned down but has been resubmitted.
- The business case for the extension to Liberton Practice will be submitted in May, which is timely due to the new housing development in that area.
- Work will soon commence at Bellevue practice to increase capacity.
- Applications will be progressed for more funding for minor schemes.

## **7. IPCC**

We are currently reducing beds on the RVH site; 22 IPCC beds and 12 non recurring delayed discharge beds give a total reduction of 34 beds. No further admissions are being taken until the beds are closed, which is happening as the beds become available. Patients have already been advised informally and letters are going out this week. The intention is to move patients out in small groups.

This is phase 1 of a large complex picture. Funding was granted from NHS Lothian as part of a 2015/16 settlement in acknowledgement of staffing pressures and £0.5 million of that was set aside for IPCC nursing. This was to invest in increasing staffing ratios / establishment. In IPCC ten beds were closed due to staffing issues and now ten beds for dementia patients with challenging behaviour are transferring across from REAS and the staff will come with them. £1.1 million has been set aside for IPCC wards for extra staffing and 10 extra beds. This solution gives a more appropriate setting for patients, better staffing establishment and will reduce agency staffing and associated costs. There was a query over activities for these patients. Activity Co-ordinators are in place at REAS but it is not known if they will also move across. SM will take this forward.

**SM**

A meeting has been planned to look at medical staffing for IPCC although it was highlighted that the impact on IPCC is a net reduction of 22 beds. Care home pressures were highlighted, which impact on length of stay in IPCC.

A National review of IPCC criteria is currently underway and it is crucial that geriatricians are well engaged and consulted. When the new criteria comes into play those patients admitted under the old criteria will not be disadvantaged.

## **8. Finance Updates**

Bob Martin gave a finance update.

A £7.6 million overspend is reported for the CHP and total unmet LRP across the CHP and REAS was £1 Million. The CHP delivered 80% of it's LRP target for 2014/15. The unmet target will be carried forward into the new financial year and the new LRP target added to that.

Key risks were highlighted. The CHP has a recurrent shortfall of £2.4 million. An additional exposure has been identified with 18 Specialist Trainees potentially being eligible for back payments due to non-compliant rotas. This has been taken into account. Prescribing is a key risk; with an estimated overspend of £5 million. £4.5 million has been given from NHS Lothian for pressures in 2015/16.

There was brief discussion around the costs of prescribing in secondary care. There is a need for secondary care to be aware of the cost implications and impact of this.

## **9. AOCB**

No items were raised.

## **10. D.O.N.M.**

17<sup>th</sup> June at 1pm in the SMART Centre, AAH.



# 1.17

**MINUTES of MEETING of the MIDLOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP SHADOW BOARD** held in the Committee Room, Midlothian House, Buccleuch Street, Dalkeith on Thursday 19 February at 10.00am.

**Present:-**

**NHS Lothian:** – P Johnston (Chair), P Eccles (NHS Lothian)

**Midlothian Council:** – C Johnstone (Vice-Chair)

**In Attendance:-**

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

**Third Sector Representative:** – R McCabe (Alzheimer Scotland).

**NHS Lothian:** - A Short (Head of Health), David King

**Midlothian Council:** – E McHugh (Joint Director of Health and Social Care), T Welsh (Integration Manager), A White (Head of Adult Social Care), Ruth Nichols (Senior Accountant), Sandra Pinkman (Minutes)

**1. Apologies:** – Alex Joyce, Melanie Johnson, Carol Levstein, Hamish Reid

**2. Order of business**  
As per agenda

**3. Declaration of Interest**  
None

**4(a) Minutes of Meeting**

The Minutes of Meeting of 19 December 2014 were submitted and agreed as an accurate record.

**4(b) Matters Arising –**

MFIN report and the National Report on Feeding Britain have not yet been circulated by G Wilson.

**5. Update on IJB's Financial Planning for 2015/16 and beyond**

Eibhlin McHugh outlined the current progress in the preparation of budgets for the IJB, the processes surrounding that budget setting and identifies the risks that are currently being considered.

The “go live” date for the IJB is June 2015 and following this and the agreement of the strategic plan, financial resources will be made available.

The four elements to the budget to be delegated to the IJB are the Adult Social Care, the CHP budget, a share of hosted services and acute services. The budget will also, in future, include any new monies delegated to the IJB via the Council or NHS Lothian.

At the last Council Audit Committee, a report was brought forward on what audit functions will be required around the IJB. The NHS audit plan includes looking at how NHS Lothian decided on the budget to be devolved to the IJB. Officers in both organisations are starting to plan how they will carry out audit plans and support for the IJB.

A number of financial and operational risks have been identified and these were itemised in the report. Consideration will be required on how these risks can be mitigated and further work will be undertaken to manage this.

Once the Strategic Plan is agreed, the budget will be allocated, but further consideration will need to be given on how monies from hosted and acute services are allocated to the IJB. This is likely to be done on a service by service basis and formulas need to be looked at to decide what is allocated against each service. The IJB will be kept informed of how budgets are allocated.

## **6. Integration Scheme**

The Integration Scheme is a document which all partnerships have to produce and submit to Scottish Government before IJBs go live. A consultation has been undertaken on the Integration Scheme, which produced 86 responses. There was general support for integration, along with concern about where children’s services fitted in. Further work is now to be undertaken in relation to finance and issues in relation to clinical governance. The Integration Scheme document will go back to NHS Lothian and the Council in March, followed by submission to Scottish Government and it estimated that it will take around two months before a response is received.

## **7. Establishment of Strategic Planning Group**

Tom Welsh spoke to this report which outlines the proposals for the establishment of the Midlothian Strategic Planning Group for Health and Care and makes recommendations regarding membership and chairing arrangements.

The Public Bodies (Joint Working) Scotland Act 2014 requires the integration authority (the Health and Social Care Partnership Board) to prepare a strategic plan, which should describe how the partnership plans to use its resources to meet the health and wellbeing outcomes of the local population. There is also a requirement to set out how the partnership will carry out its integration functions for each designated locality. Each partnership area is required to have a minimum of two localities.

The report explained that regulations prescribe the groups of people who should be represented on the strategic planning group, these include – health professionals, users/carers of users of health care, social care professionals

and users/carers of users of social care. The diagram appended to the report illustrated various groups of stakeholder groups who would be involved and consulted as necessary. There is also a requirement to have a “member” of both the NHS and the Council on the group. Tom Welsh indicated that these members can be officers and his proposal was that these two roles be filled by Allister Short (Strategic Lead for Older People) and Alison White (Strategic Lead for Adults).

Effective chairing arrangements are vital, particularly in the early stages of developing the group’s sense of purpose, its relationships to other planning forums and its relationship to the Integration Joint Board.

The Shadow Board were asked to consider the appointment of Alex McMahon, Director of Strategic Planning, Performance Reporting & Information with NHS to chair the Strategic Planning Group.

Members of the Strategic Planning Group will be different from those who will sit on the Shadow Board.

The Shadow Board agreed:-

that officers will approach individuals from stakeholder groups to sit on the strategic planning group;

that Peter Johnston writes to Alex McMahon regarding chairing arrangements for the Strategic Planning Group

and that a further report is brought forward detailing named representatives following discussions with relevant organisations.

## **8. Liberton Hospital Reprovision**

Allister Short spoke to this report which outlined the initial work being developed around the reprovision of Liberton Hospital in relation to Midlothian Patients.

A key development is the proposed reprovision of care for Midlothian patients who would normally be cared for in Liberton Hospital within Midlothian Community Hospital and in other community settings. This supports the overall direction of travel within Midlothian to deliver care closer to the community.

Four clinic rooms at MCH would become more effectively used under these proposals and consideration is being given to looking at what these rooms could be used for, eg locality clinics and expansion of x-ray service.

Work is being undertaken to identify community based options to provide the required level of patient care and to establish hospital-based care for patients who require more acute care than can be met in the community. This will begin to reduce the number of patients being sent to Liberton from hospital or home.

Midlothian Shadow Board noted the report.

## **9. CHP Arrangements**

The CHP has governance over all the health community activities in Midlothian. Due to legislation, all CHPs come to an end next month. A paper was submitted to the NHSL Board recommending that the Midlothian CHP should continue to meet until the Shadow Board goes live and will provide governance and this was agreed. Arrangements are being made for one additional meeting to be held at this stage.

Eibhlin McHugh will report back to the next CHP meeting on work being undertaken in relation to governance on children's health services in the interim. Children's services will not be included in the first phase of the IJB.

## **10. NHS Lothian Board Nominees – Integration Joint Board**

The Shadow Board noted the changes to the NHS Lothian Board Nominees for the Midlothian IJB – Peter Johnston, Dr Morag Bryce (Non-Executive Director), Melanie Johnson (Director of Nursing) and Alex Joyce (Non-Executive Director/Employee Director).

Chairing of the Shadow Board should pass to Midlothian Council from April. Councillor Peter Johnston and Eibhlin McHugh to further discuss this off-line. Councillor Catherine Johnston will check previous minutes regarding decisions taken about Councillor representation on the Shadow Board. This is something that may need to be revisited by the Council.

Further non-voting members for the Shadow Board need to be identified in keeping with the legislation. These need to include medics and nursing staff. A workforce representative also needs to be identified. Eibhlin McHugh and Tom Welsh to look at the process for taking this forward.

Councillor Peter Johnston will write to those Board members who have now moved on to record the Shadow Boards thanks and appreciation for their involvement in the work carried out so far.

Patsy Eccles reported that discussions are ongoing with the Scottish Staff Council regarding involvement of staff partnerships with IJBs. This issue may come back to the Board at some point in the future.

Jane Cuthbert and Jean Foster were recruited to the Board during the shadow period. Discussions now need to be undertaken with them on their experience during this time and if they wish to continue once the IJB is formally in place.

## **11. Report of the Independent Chair of the Adult Protection Committee of East Lothian and Midlothian 2012 – 14**

The Shadow Board noted the third biennial report of East and Midlothian Adult Protection Committee. The report was submitted to Scottish Government on 31 October 2014.

Alison White highlighted the need for all services considered with the Strategic Commissioning Plan to pay particular attention to ensuring the safety and protection of service users.

## **12. Future Meetings and Service Visits**

Eibhlin spoke on challenges being faced in Midlothian in ensuring the sustainability and development of Primary Care as is being seen across Scotland. Recently NHS Lothian Board held a very successful Board development session to examine these challenges, which involved both NHS Board members and general practitioners. Hamish Reid, Clinical Director, has agreed to organise a similar event for the Shadow Board in Midlothian, which will be held on 2 April, from 2:00-4:30 pm. A number of local GPs will also be invited to the session, which will be an opportunity to hear from GPs about the changing demands on their role, the challenges that they're facing in recruitment and some of the early thinking on how some improvements may be achieved.

Further Shadow Board visits have also been scheduled for May, September and October on Substance Misuse, Learning Disabilities and Mental Health. Confirmation of dates for these events will be circulated once finalised. Meantime, Shadow Board members are asked to note the April event in diaries. .

## **13. Any Other Business**

Allister Short confirmed that delayed discharges in February for Midlothian was 0 over the 2 weeks and 4 weeks targets.

Councillor Peter Johnston commented that this was very encouraging, but also noted the new challenge arising from the target of 72 hours due to be introduced to accelerate progress in reducing delayed discharge.

## **14. Date of Next Meeting**

The Shadow Board noted that the next meeting is due to take place on **Thursday 30 April 2015 at 2.00 pm in Fairfield House, Dalkeith.**



MEETING	KEY ISSUES	ACTION
West Lothian CHCP Sub- Committee 16 <sup>th</sup> April	Report on Single Outcome Agreement (SOA) – Older People	Noted report
	Reablement Service	Report providing an update on the activities of the Reablement Service
	Crisis Care Team	Report detailing the ongoing work of the Crisis Care Team
	Rapid Elderly Assessment Care Team (REACT)	Report detailing the work being carried out by the REACT team
	Strategic Plan	Report detailing the requirement for the Integrated Joint Board (IJB) to develop a strategic plan
	Integrated Care Fund	Report stating the submission to the Scottish Government for the Integrated Care Fund which has now been approved and the subsequent development of West Lothian Integrated Care Fund Plan
	Young Carers' ID Card	Report to inform the committee of the implementation to pilot Young Carers' card for children and young people aged 12 – 18 across Lothian

West Lothian  
Community Health and Care Partnership

DRAFT

Minutes of the West Lothian Sub Committee held on 16<sup>th</sup> April 2015 , 1400 – 1600, Strathbrock Partnership Centre.

Present	<p>Frank Toner (FT) Jim Forrest (JF) Alan Bell (AB)</p> <p>Gill Cottrell (GC) Jane Kellock (JK) Lindsay Seywright (LS) Mary Vest (MV) Elaine Duncan (ED) Pat Donald (PD) Mary-Denise McKernan (MMc) Pamela Main</p>	<p>Chair, West Lothian CHCP Director, West Lothian CHCP Senior Manager, Community Care Support &amp; Service Chief Nurse Head of Social Policy (Interim) West Lothian College H &amp; WB Co ordinator Clinical Director CHCP Acting AHP Manager Manager, Carers of West Lothian Senior Manager</p>
Apologies	<p>Ian Buchanan (IB) Marion Christie (MC) Chris Stirling (CS) Lorraine Gillies (LG) Jane Houston (JH) Alistair Shaw (AS) Moirra Niven (MN) Julie Cassidy (JC) Margaret Clarke</p>	<p>Public Partnership Forum Rep Head of Health / General Manager, WLCHCP SJH Site Director Community Planning Development Manager Partnership Lead Head of Service WLC Deputy Chief Executive Public Involvement Co-ordinator</p>
In Attendance	<p>Marjory Brisbane</p>	<p>Admin Manager (Minutes)</p>

1. **APOLOGIES**  
As above.
2. **ORDER OF BUSINESS INCLUDING NOTICE OF URGENT BUSINESS**  
As agenda
3. **ANY OTHER BUSINESS FOR TODAY**  
No other business notified.
4. **DECLARATION OF INTEREST**  
FT declared he is chair of the CHCP and non executive member of NHS Lothian.
5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**  
The minutes of the meeting held on 12<sup>th</sup> February were approved as being an accurate record.
6. **CONFIRMATION OF ACTION POINTS**  
No action points

7. **MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING**  
Noted Minutes of 25/2/15 and 2/4/15
8. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**  
Noted minutes of 12/2/15
9. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT**  
Noted Minutes of 17/2/15
10. **MINUTES OF COMMUNITY PLANNING STEERING GROUP**  
Noted minutes of 3/11/14
11. **OLDER PEOPLE– COVALENT REPORT**  
AB provided an overview of the progress of work being measured through Covalent for Older People Services.
- The Sub Committee noted the report
12. **REABLEMENT**  
PM talked to the report providing an update on the activities of the Reablement Service which has a particular reference to promoting independence and reducing unnecessary delays in hospital discharge.
- The service is reporting excellent outcomes and has had a positive impact in contributing to the Single Outcome Agreement; We live longer healthier lives and have reduced health inequalities. An estimation of 69,000 hours of homes services has been avoided through the work being carried out to promote independence.
- PM highlighted the challenge around the delayed discharge post April 2015 where partnerships will be measured against a reduced target of two weeks.
- Two case studies were provided with the report highlighting services working together resulting in positive outcomes for the patients.
- The Sub Committee noted the report
13. **CRISIS CARE**  
PM talked to the report detailing the ongoing work of the Crisis Care Team who responds to health and social care emergencies, which contribute to the avoidance of unnecessary admissions to the hospital.
- The service was established in January 2012 at the same time as the Reablement service and provides a 24/7 response to people experiencing a health or social care emergency to deal with the immediate crisis in their own home.
- Figures were produced highlighting the increased volume of activity from 2013 – 2014 at the same time managing to reduce the response time. The service works closely with REACT, Ambulance service and Housing.
- ED commented on the work being carried out by the Crisis Care service and the considerable amount of time and effort previously spent to solve these issues by other services and the positive outcomes this has resulted by avoiding delays for patients.
- The Sub Committee noted the report.

**ACTION**

- 14. RAPID ELDERLY ASSESSMENT CARE TEAM (REACT)**  
 GC talked to the report stating REACT is the third component to the two services previously mentioned and was established in May 2013. REACT aim is to facilitate prevention of admission and early supported discharge through models of care.
- REACT provides 2 phases, phase 1 virtual ward and phase 2 rehabilitation. The REACT service provides rapid assessment of adults primarily over the aged of 75 in their own home preventing hospital admissions where safe to do so. The team is run by medics, nurses and AHP. The initial assessment is nurse led with consultation with consultant. The medical responsibility whilst in the virtual ward lies with the REACT consultant and each patient care is reviewed regularly at home either by the medics, nurses or AHPs as appropriate. In phase 1 the figures have shown an increase from May 2013 to May 2014 from 41 per month to January 2014 – January 2015 to 60 with an average length of stay reducing from 7 days to 4. (Due to reporting dates they have been unable to reflect on the same period)
- The second phase, rehabilitation lasting approximately 4 – 6 weeks has also had an increase from May 2013 a total number of 434 patients were referred with an average length of stay of 40 days and from January 2014 – 15 over 500 referrals were received with an average length of stay of 18 days with an onward transfer to the Reablement team.
- From February 2015 REACT have now established a presence on TRAK following the development of a virtual ward.
- The REACT service continues in a ‘pilot’ phase supported through funding from the Integration fund.
- The Sub Committee noted the report.
- 15. STRATEGIC PLAN**  
 JF talked to the report detailing the requirement for the Integrated Joint Board (IJB) to develop a strategic plan and the process to facilitate this.
- This will require a strategic planning group with involvement with key stakeholders including links with Carers and Voluntary sector. IJB will not assume responsibility for the planning, resourcing and operational delivery of all integrated services until such time as the strategic plan and associated locality arrangements have been prepared and considered fit for purpose by the Health board and local authority.
- To avoid delay it is important the strategic planning group is established at the earliest opportunity.
- The Sub Committee noted the report
- 16. INTEGRATED CARE PLAN**  
 AB talked to the report stating the submission to the Scottish Government for the Integrated Care Fund has now been approved. This replaces the funding received through the change fund. West Lothian allocation is £2.85m this is over £1m increase from the Older People Change Fund although the scope of the fund is greater.
- The funding will support partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions to reduce demand for emergency hospital activity and emergency admissions.
- The Scottish Government expect local partnerships to be established comprising NHS, local authorities, third sector and independent sector to develop a local integrated care fund plan to oversee the delivery of this.

**ACTION**

A copy of the West Lothian Integrated Fund Care Plan was provided as a appendix

**ACTION**

The Sub Committee noted the report

**17.**

**YOUNG CARERS ID CARD**

MDM talked to the report to inform the committee of plans implemented to pilot Young Carers' card for children and young people aged 12 – 18 across Lothian during 2014 in line with Getting it Right for Young Carers Strategy Scotland 2010- 2015.

The purpose of the card is to alert professional staff that the young person is a carers and to take this in to consideration.

The suggestion for the card was introduced at the Scottish Young Carers Festival in 2013 as a way of enabling young carers to be more involved in the care and support of the person being cared for. The card is purely for awareness and does not automatically give them permission to discuss anything about the cared person.

The Sub Committee noted the report.

**18 .**

**ANY OTHER COMPETENT BUSINESS**

The meeting closed at 3.30pm

**DATE, TIME OF NEXT MEETINGS**

CHCP Sub Committee meetings at 2pm – 4pm in Strathbrock Partnership Centre.

The Sub Committee has now been disestablished.

The chair thanks everyone for all their support and hard work during his time as chair.

MEETING	KEY ISSUES	ACTION
West Lothian CHCP Board 7 April 2015	Frail Elderly Programme	Board supported the establishment of the Frail Elderly Programme.
	Health and Social Care Integration	Board noted progress made to date to implement the Public Bodies (Joint Working) Scotland) Act 2014.
	Clinical Governance	Board noted the development of a risk assessment tool to identify vulnerable practices and agreed to support new initiatives to maintain and develop care provision in West Lothian.
	Care Governance	Board noted the Social Policy Management Plan 2015 – 2016.
	Staff Governance	Board noted updates on shared parental leave, mediation service, Lothian Pension Fund, employee health and wellbeing and policies on tobacco and substance misuse.
	Director's Report	Board noted work undertaken in relation to Head of Social Policy role, Brock Garden Centre, National Care Homes Falls booklet, Faith Handbook and West Life.

MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189(A) WEST MAIN STREET, BROXBURN EH52 5LH, on 7 APRIL 2015.

Present – Frank Toner (Chair), Brian Houston, Jane Houston, John McGinty, Anne McMillan and Ed Russell-Smith

Apologies – Janet Campbell

Absent – Alison Mitchell

In attendance – Jim Forrest (CHCP Director), Jane Kellock (Interim Head of Council Services), Dr Elaine Duncan (Clinical Director), Gill Cottrell (Chief Nurse, NHS Lothian), Alan Bell (Senior Manager, Communities and Information) and Ian Buchanan (PPF)

Apologies – Marion Christie (Head of Health Services) and Carol Mitchell (Assistant Director of Finance, NHS Lothian)

1. DECLARATIONS OF INTEREST

Councillor Frank Toner declared a non-financial interest as he was the council's appointment to the Board of NHS Lothian as Non-Executive Director.

2. MINUTE

The Board approved the minute of its meeting held on 3 February 2015 as a correct record.

3. CHCP RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decision

To note and agree the Running Action Note.

4. NOTE MINUTE OF MEETING OF THE CHCP SUB-COMMITTEE

The Board noted the minute of the CHCP Sub-Committee held on 18 December 2014.

5. FRAIL ELDERLY PROGRAMME

The Board noted a presentation by the Senior Manager Community Care

Support and Services, providing an update on the programme of change relating to the frail elderly programme pathway.

The main objective of the frail elderly programme was to redesign the pathway to deliver a quality, financially sustainable and cost effective service provision which would meet the health and care needs of frail elderly adults, reducing hospital admissions and re-admissions and minimise delayed discharges. The Board was advised that there would be four distinct projects within the overall programme, each of which would have their own separate project organisation and controls. The projects would report to a programme board on a monthly basis.

The programme would be consistent with the requirement of the integrated health and care partnership to prepare a strategic commissioning plan, establishing the arrangements for delivery of integrated functions and how these arrangements would achieve the national health and wellbeing outcomes.

The Board commended the work carried out to redesign the delivery of the frail elderly programme service provision.

Following the conclusion of the presentation the Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director providing details of the programme of change proposed by West Lothian to apply across the whole frailty pathway.

The report recalled that West Lothian has a positive approach to partnership working between health and social care and examined the options to build upon this solid foundation of partnership working to apply a whole system redesign across the whole frailty pathway.

The programme would result in sustainable and cost effective service provision which would meet the health and care needs of frail elderly adults, reducing hospital admission and re-admission and minimise delayed discharge. West Lothian's Frail Elderly Programme would be an important contribution to the requirement of the integrated health and care partnership to prepare a strategic commissioning plan, establishing the arrangements for delivery of integrated functions and how these arrangements would achieve the national health and wellbeing outcomes.

The Board supported the establishment of the Frail Elderly Programme.

#### Decision

1. To note the presentation; and
2. To approve the terms of the report.

#### 6. HEALTH AND SOCIAL CARE INTEGRATION.

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director providing an update



on the progress made relating to the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014.

The report recalled the background to the Public Bodies (Joint Working) (Scotland) Act 2014 which required new arrangements to be put in place for the delivery of integrated health and social care functions. A draft integration Scheme was developed for West Lothian in line with the model issued by the Scottish Government. The agreed draft was approved for public consultation which took place from 15 January until 20 February 2015. All prescribed consultees were given the opportunity to comment on the draft scheme. The draft scheme was also posted on the West Lothian Community Health and Care Partnership website to allow wider exposure and comments invited. The draft scheme was also considered and approved by NHS Lothian at its Board meeting on 4 March 2015.

The report went on to provide details of the consultation responses received, which were reviewed and taken into consideration in the production of the final version of the scheme. No changes were considered to be necessary as a result.

The revised draft scheme was submitted to the Council Executive for approval on 10 March 2015. The Council Executive agreed the scheme subject to an amendment being made to the Chairperson's term of office. The revised wording has since been agreed with NHS Lothian and approved by Council Executive at its meeting held on 24 March 2015, a copy of which was attached as an appendix to the report. The draft Integration Scheme was therefore approved for submission to Scottish Ministers by the due date of 31 March 2015.

The Board was asked to note the progress made to date to implement the Public Bodies (Joint Working) (Scotland) Act 2014.

#### Decision

To note the terms of the report.

### 7. CLINICAL GOVERNANCE: DEVELOPMENT OF A RISK REGISTER FOR WEST LOTHIAN PRACTICES

The Board considered a report (copies of which had been circulated) by the Clinical Director providing details of the development of a risk assessment tool to identify vulnerable practices.

The report explained that over the last 1-2 years a number of practices in West Lothian found it challenging to maintain service provision and requested assistance from West Lothian CHCP. In July 2014 West Lothian CHCP carried out a workforce survey to measure the recruitment issues practices were facing. Due to the number of practices affected and further practices reaching crisis point and requiring assistance, the need to identify vulnerable practices in a timely manner and work with them to improve their resilience became a priority.

A risk register for West Lothian practices was developed and designed to

provide an indication of the practices robustness and resilience and their ability to cope with adversity. This would help to identify vulnerable practices before their ability to maintain service provision was compromised and would enable work to be carried out to strengthen the areas that were putting them at risk. Some crisis incidents could arise unexpectedly and there was little that could be done to prevent these, however other crises start out as “accidents waiting to happen” and it was these cases that would be identified through the risk register.

The Board was advised that the Risk Register was not yet fully developed and certain information was lacking for some practices. Details of how the register was constructed was provided and once completed, the register would provide the opportunity to target those practices which were “below the radar” but scoring at the higher end of the spectrum, to discuss ways of improving resilience and strengthen their ability to maintain service continuity.

The report went on to explain the next steps that would be taken to refine the register to provide more graded weightings to the different elements to enable the information to be mapped to the domains of the National Patient Safety Matrix. Within West Lothian there were a number of approaches that could be looked at which would help to strengthen the service as a whole.

The Board was asked to:

1. Note the contents of the report;
2. Be reassured that West Lothian CHCP were being pro-active in identifying and supporting practices in difficulty to maintain service continuity throughout West Lothian; and
3. Support new initiatives to maintain and develop care provision in West Lothian.

#### Decision

To approve the terms of the report.

#### 8. CARE GOVERNANCE

The Board considered a report (copies of which had been circulated) by the Interim Head of Social Policy providing details of the Social Policy Management Plan 2015-2016.

The report explained that as a means of delivering outcomes effectively and efficiently, West Lothian Council identified Management Plans as an essential driver for the provision of excellent services. As such they were collated and presented at the service group level, under the responsibility of the Head of Service. The Social Policy Management Plan 2015/16 was attached as an appendix to the report and set out how the service would drive performance and be utilised by the management team and stakeholders to assess and gauge performance and improvement. The

measurers, targets and actions of the plan would be available for management monitoring and reporting on the corporate performance management system (Covalent).

The Board was asked to note the details of the Social Policy Management Plan 2015-2016.

#### Decision

To note the terms of the report.

### 9. STAFF GOVERNANCE

The Board considered a joint report (copies of which had been circulated) by the Interim Head of Social Policy and the Head of Health Services providing an update on staff issues within the Community Health and Care Partnership.

The report provided details of the new regulations relating to Shared Parental Leave; the recently launched mediation service; details of the Lothian Pension Fund roadshow scheduled to be held in April 2015; Employee Health and Wellbeing and policies relating to Tobacco and Substance Misuse.

The Board was asked to note updates on the following:

1. Shared Parental Leave;
2. Mediation Service;
3. Lothian Pension Fund;
4. Employee Health and Wellbeing; and
5. Policies on Tobacco and Substance Misuse.

#### Decision

To note the contents of the report.

### 10. DIRECTOR'S REPORT

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director providing an update on key areas of work in which the partnership had been involved since the last meeting of the Board.

#### Decision

To note the information and work undertaken in relation to:-

1. Head of Social Policy role;

2. Brock Garden Centre;
3. National Care Homes Falls Booklet;
4. Faith Handbook; and
5. West Life.

## NHS Lothian Patients' Private Funds - Annual Accounts 2014/15

### 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 2015 for Lothian NHS Board be approved. These accounts were presented to the Audit and Risk Committee for recommendation on 22 June 2015. 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 2015.
- 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 2015.

### 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 give an unqualified opinion on the abstract of accounts which have been prepared on the basis required by the NHS Scotland Manual of Accounts. Their full audit report on Patients Private Funds is attached.

The report identifies no errors in their receipts and payments testing and made one recommendation 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

16 June 2015

[susan.goldsmith@nhslothian.scot.nhs.uk](mailto:susan.goldsmith@nhslothian.scot.nhs.uk)

#### **List of Appendices**

Appendix 1: Patients' Private Funds Year Ended 31 March 2015

Appendix 2: Management Letter

# **LOTHIAN NHS BOARD**



## **Patients' Private Funds Year Ended 31 March 2015**

## **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 2014 to 31 March 2015 and in preparing the abstract of receipts and payments.

..... (Chairman)  
Brian Houston

..... (Chief Executive)  
Tim Davison

24 June 2015



NHS Lothian

SFR 19.0

PATIENTS PRIVATE FUNDS

FOR THE YEAR ENDED 31 MARCH 2015

2014 £		TOTAL £
	<b>RECEIPTS</b>	
	Opening Balances:	
28,803	Cash in Bank	25,275
12,775	Cash on Hand	16,775
<u>1,252,427</u>	Other Funds	<u>1,221,967</u>
<u>1,294,005</u>		<u>1,264,017</u>
1,966,286	From or on behalf of Patients	1,443,162
5,381	Interest on Patients' Fund Account	2,703
<b><u>3,265,672</u></b>	<b>Total Receipts</b>	<b><u>2,709,882</u></b>
	<b>PAYMENTS</b>	
2,001,655	To or on behalf of Patients	1,662,684
0	Extra Comforts etc.	0
	Closing Balances:	
25,275	Cash in Bank	50,500
16,775	Cash on Hand	16,775
<u>1,221,967</u>	Other Funds	<u>979,923</u>
<u>1,264,017</u>		<u>1,047,198</u>
<b><u>3,265,672</u></b>	<b>Total Payments</b>	<b><u>2,709,882</u></b>
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
1,264,055	Credit Balances	1,047,285
(38)	Less: Debit Balances	(87)
<u>1,264,017</u>		<u>1,047,198</u>
0	Interest Received but not Credited	0
<b><u>1,264,017</u></b>	<b>Total Closing Balance</b>	<b><u>1,047,198</u></b>

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 24 June 2015

The abstract of Receipts and Payments was submitted at the NHS Board Meeting on 24 June 2015 and duly approved.

Chief Executive \_\_\_\_\_ Date 24 June 2015

**NHS Lothian  
Patients' Private Funds  
Year ended 31 March 2015**

**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 2014-15 NHS Board Accounts Manual.

## **Independent auditor's report to Lothian NHS Board**

We have audited the Abstract of Receipts and Payments of Patients' Private 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 2015.

**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

1 June 2015

Our Ref: GD/MXL/SBS

Dear Sirs

**NHS Lothian – Patients' Private Funds  
Management Letter for year ended 31 March 2015**

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 2015.

In the course of our audit of the abstract of receipts and payments of patients' private funds for the year ended 31 March 2015 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 £1,047,198 as at 31 March 2015.

**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.

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Robert Mackenzie, Gareth Magee,  
Mark McRae, Paul Renz, Marc Shenken,  
Wemyss Stewart, Morag Watson



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The Board of Directors

1 June 2015

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 patient's funds transactions for individuals at: Ellen's Glen, Findlay House, Learning Disabilities (Glenlomond & Islay Centre) and Ferryfield.

The total of the patients' funds as at 31 March 2015 was £1,047,198 of which our testing was based at individual wards within areas holding £666,144 (64% 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.

**Issue raised**

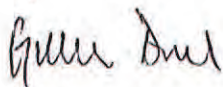
*Issue and recommendation:*

a) The patients' funds team do not currently hold a comprehensive set of clearly documented desktop procedures for the administration of patients' private funds. This has not led to significant risk to date given the consistency of the finance team and the significant experience they have. However, desktop procedures should be reviewed and documented to ensure that any changes in personnel do not have a detrimental impact on the administration of patients' private funds.

If you require further information regarding anything 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**



**Gillian Donald**  
**Partner**  
gillian.donald@scott-moncrieff.com

Board Meeting  
24 June 2015

Director of Finance

## ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

### 1 Purpose of the Report

- 1.1 The purpose of this report is to present the Annual Accounts for the year ended 31 March 2015 for Board approval.
- 1.2 Any member wishing additional information on the detail of this paper should be raised with the Executive Lead prior to the meeting.

### 2 Recommendation

- 2.1 Members of the Board are asked to note that the Draft Annual Accounts are subject of separate confidential circulation with the Board papers, as these cannot be presented formally in the public domain until laid before Parliament in the Autumn. This has been confirmed by officers within the Scottish Government Health & Social Care Directorates (SGHSCD). Copies have also been circulated to Board members, as part of the Audit Committee papers for the meeting to be held on 22 June.
- 2.2 Members of the Board are asked to approve and adopt the Annual Accounts for the year ended 31 March 2015.
- 2.3 Members of the Board are asked to authorise the designated signatories (Chief Executive, Chair and Director of Finance) to sign the Accounts on behalf of the Board, where indicated in the document.
- 2.4 Members of the Board are asked to authorise the Chief Executive's signature of the Representation Letter to the auditors, on behalf of the Board

### 3 Discussion of Key Issues

- 3.1 The year-end accounts (appendix 1) comprise of a number of sections, namely
  - Annual Report – Management Commentary, which consists of two sections; Section A: Strategic Report and Section B: Director Report
  - Remuneration Report
  - Statutory Accountability confirmation statements by the Accountable Officer and Directors.
  - Governance Statement
  - Independent Auditor's report
  - Primary Financial Statements
  - Notes on the accounts

The Scottish Government revised the NHS Boards accounts manual, replacing the Operating and Financial Review with a Strategic Report and a Directors' Report. Whilst there is an additional disclosure on social, community and human rights, the overall content is essentially the same as previous years. A particular effort has been made to present the material in line with the structure as set out the manual, and to control the volume of text, so as to improve the overall quality of reporting

3.2 The Board had three financial targets during the year:

- i. Revenue Resource Limit – a resource budget for ongoing expenditure; split into Core and Non-Core elements.
- ii. Capital Resource Limit – a resource budget for new capital investment; split into Core and Non-Core elements where applicable.
- iii. Cash requirement – a financing requirement to fund the cash consequences of the ongoing expenditure and new capital investment.

3.3 Performance against these targets is shown in the draft accounts (page 7) and summarised below:

	Limit as set by SGHSCD £'000	Actual Outturn £'000	Variance (Over)/Under £'000
Core Revenue Resource Limit	1,328,048	1,327,809	239
Non-Core Revenue Resource Limit	65,002	65,002	0
Core Capital Resource Limit	28,798	28,798	0
Non-Core Capital Resource Limit	17,815	17,815	0
Cash Requirement	1,503,000	1,502,305	695

#### **Prior Year Adjustment to 2014/15 comparatives**

3.4 Prior year adjustments relate to a retrospective restatement of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). This new provision recognises the Board's share of the total liability of NHS Scotland as advised by the Scottish Government. Note 26 details how the prior year figures have been restated. There are no other prior year adjustments in relation to the Board's figures. This provision can be seen in note 17 – page 80 – Balance at 31 March 2015 £43.2m (2013/14 £50.9m).

#### **Accounting Policies**

3.5 The accounting policies incorporated into these accounts were subject to a separate paper to the Committee in April 2015 at which the accounting policies proposed were approved.

## **Audit and completion**

- 3.6 The Auditors, Audit Scotland, intend to issue an unqualified opinion on the accounts. Their draft ISA 260 report includes a statement of unadjusted differences which are not material to the accounts, and no adjustments are proposed. However, following review by the Board, there may be minor changes to the textual content from that of the circulated version. The Board are being asked to approve that any such minor amendments be negotiated and agreed by the Director of Finance up to the date the accounts are signed by the auditors.
- 3.7 The Audit Committee of the Board is due to complete their review of accounts, and supporting governance and internal control assurances at their meeting on 22 June 2015.
- 3.8 However, there may be matters arising between the date of writing this report and the Audit Committee date, and following the review by the NHS Board on 24 June, which may necessitate minor changes to the textual content of the Governance Report. The Board are being asked to approve that any such minor amendments are negotiated and agreed by the Director of Finance, up to the date of sign off by Audit Scotland.
- 3.9 The accounts are to be submitted to SGHSCD by 30 June 2015 and will be in the public domain after they are laid before Parliament in the Autumn.
- 3.10 The full report on the audit of the financial statements from Audit Scotland (ISA 260) will be presented to the Board in October 2015, following detailed scrutiny by the Audit Committee.

## **Representation Letter**

- 3.11 International Standard on Auditing (ISA 580) requires External Auditors to obtain written confirmation of representations received from management on matters material to the financial statements when other sufficient audit evidence cannot reasonably be expected to exist, before their audit report on the Annual Accounts is issued.
- 3.12 Specific representations are particularly relevant in relation to assertions that judgement or intent or that may not be complete.
- 3.13 Auditors normally obtain evidence of the directors' acknowledgement of collective responsibility for the provision of financial statements by obtaining a formal letter of representation, alongside the provision of signed accounts which incorporate statements of responsibility in respect of the accounts.
- 3.14 The Representation Letter will be considered by the Audit Committee at its meeting on 22 June. The representation letter is attached at Appendix 2.

## **4 Key Risks**

- 4.1 The underlying risks associated with the financial position were highlighted throughout the year, and continue to be captured in routine monthly financial reporting. Whilst actions have been put in place to manage these through the



financial planning process, it is likely that some aspects will continue throughout 2015/16 and beyond.

## **5 Risk Register**

5.1 There is nothing to add to the Risk Register at this stage.

## **6 Impact on Inequalities, including Health Inequalities**

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

## **7 Involving People**

7.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

## **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

17 June 2015

[Susan.goldsmith@nhslothian.scot.nhs.uk](mailto:Susan.goldsmith@nhslothian.scot.nhs.uk)

## **List of Appendices**

Appendix 1: Annual Accounts 2014 - 15

Appendix 2: Management Representation Letter



**Annual Report and Accounts**

**Year ended 31<sup>st</sup> March 2015**

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# ANNUAL REPORT

## MANAGEMENT COMMENTARY

### SECTION A: STRATEGIC REPORT

#### 1. Strategy, Principal Activities, and Review of the Year

##### 1A – Background

Lothian Health Board (the “Board”) was established in 1974 under the National Health Service (Scotland) Act 1972, and is commonly referred to as “Lothian NHS Board”. The National Health Service (Scotland) Act 1978, other law, and Government directions determine the Board’s constitution, duties and functions. Health Boards carry out functions on behalf of the Scottish Ministers, and are required to follow any regulations or directions that may be made.

Lothian NHS Board, as part of NHS Scotland, is responsible for the healthcare services for the residents of four local authority areas (City of Edinburgh, East Lothian, Midlothian and West Lothian). The National Records of Scotland projections for 2010 to 2025 show a 15% increase in total Lothian population from 836,711 to 965,007.

The Board also provides a wide range of specialist services for people from across Scotland, including liver and kidney transplantation, neo-natal intensive care, cancer services and complex surgery.

Further information on the Board, including its history and details of its services and locations can be found on its website:

<http://www.nhsllothian.scot.nhs.uk/OurOrganisation/AboutUs/Pages/default.aspx>

##### 1B – The Current Business Model

The Scottish Government’s Health & Social Care Directorate (“SGHSCD”) provides most of the Board’s funding. The Board works with the local authorities to support and inform their work to improve health through better housing, social work and environmental health services. Tackling inequalities in access to health services is a major priority for the Board, as is engaging with patients, staff and local communities to ensure that their views are the driving force behind the continuous improvement of its services.

NHS services are commonly described as being primary, secondary, and tertiary care

Subject	What is it	Who are the key staff / functions that deliver it?
Primary (and community) Care	<p>Primary care is the first point of consultation with the patient. For most people contact with the NHS begins and ends in primary &amp; community care.</p> <p>In NHS Lothian, the community services are managed through Community Health Partnerships (CHP), and in West Lothian, a Community Health and Care Partnership (CHCP).</p> <p>Contracts with the independent contractors are managed by the Primary Care Contractor Organisation (PCCO), on behalf of CHPs.</p>	<p>Independent (from the NHS) Contractors:</p> <ul style="list-style-type: none"> <li>• General Practitioners</li> <li>• Optometrists</li> <li>• Community Pharmacists</li> <li>• General Dental Practitioners</li> </ul> <p>NHS Staff:</p> <ul style="list-style-type: none"> <li>• Community Nurses</li> <li>• Health Visitors</li> <li>• Community</li> </ul>

Subject	What is it	Who are the key staff / functions that deliver it?
	<p>Primary and community care accounts for roughly 90% of all patient contacts with the health service, co-ordinating diagnosis, treatment and care and ensuring that more of these services are provided as close to home as possible.</p> <p>Primary and community care services include the management of “chronic” (or long term conditions) diseases and illnesses. These include:</p> <ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Diabetes</li> <li>• Depression</li> <li>• Arthritis</li> <li>• Chronic Obstructive Pulmonary Disease (COPD)</li> <li>• Rheumatoid arthritis</li> </ul>	<p>Pharmacists</p> <ul style="list-style-type: none"> <li>• School nurses</li> <li>• Physiotherapists</li> <li>• Occupational Therapists</li> <li>• Podiatrists</li> <li>• Speech and Language Therapists</li> <li>• Dieticians</li> <li>• Psychiatrists / Psychologists</li> </ul>
<p>Secondary (or acute) Care</p>	<p>Patients will enter secondary or acute care when they require a specific clinical intervention.</p> <p>The patients would normally be referred to secondary care by their GP. If it is an emergency, the patient will be brought straight into the hospital.</p> <p>Patients can present in secondary care in five different ways:</p> <ul style="list-style-type: none"> <li>• Referral from a GP for diagnostic (e.g. X-rays, scans) services or other assessment.</li> <li>• Elective inpatient or day case surgery (where the episode of care is planned and scheduled in advance)</li> <li>• Emergency Inpatient</li> <li>• Outpatient</li> <li>• Accident &amp; Emergency (can be classed as primary or secondary care, depending on whether it is the first patient consultation)</li> </ul>	<p>The main secondary care sites in NHS Lothian are the Royal Hospital for Sick Children, Royal Infirmary of Edinburgh, St John’s Hospital, and the Western General Hospital.</p> <p>There are other hospital services managed by the CHPs, however they are sites of secondary care. These include:</p> <ul style="list-style-type: none"> <li>• Rehabilitation services for people after they have had secondary care, e.g. people recovering from stroke, heart attack, brain injuries. (Astley Ainslie)</li> <li>• Provision of mobility/ technological services to those with physical disabilities. (Astley Ainslie)</li> <li>• Acute psychiatric and mental health services, learning disabilities and dementia. Specialist services include the treatment of eating disorders, alcohol problems, and young people’s mental health</li> </ul>

Subject	What is it	Who are the key staff / functions that deliver it?
		(Royal Edinburgh Hospital). <ul style="list-style-type: none"> <li>• Medical and geriatric rehabilitation services, care of the elderly. (Roodlands, Liberton)</li> </ul>
Tertiary Care	This is highly specialised care, provided in facilities with dedicated experts and technology to conduct advanced investigations and treatment. Tertiary care can be initiated by a referral by the patient's GP but is usually a referral from one (secondary care) consultant to another.	Examples of tertiary care are: <ul style="list-style-type: none"> <li>• Cancer services</li> <li>• Brain surgery</li> <li>• Burns care</li> <li>• Plastic surgery.</li> </ul>

A complete A-Z list of the Board's services can be found on the Board's website at: [www.nhslothian.scot.nhs.uk/Services/A-Z](http://www.nhslothian.scot.nhs.uk/Services/A-Z)

### 1C – The Developing Business Model

The Board and the local authorities have submitted four integration schemes to the Scottish Ministers for approval, under the Public Bodies (Joint Working) (Scotland) Act 2014. This will lead to the establishment of a new integration joint board (IJB) in each local authority area during 2015/16. The IJBs will be new legal entities that are distinct from the NHS Board and the relevant local authority.

The NHS Board and the relevant local authority will delegate functions to the new IJB, and it will then become wholly responsible for carrying out those functions. The IJB will prepare a strategic plan for the delegated functions in the local authority area, and direct the NHS Board and the relevant local authority as to how those functions are to be carried out. The IJB will be required to have regard to the [national health & wellbeing outcomes, the integration delivery principles \(as set out in the Act\)](#), and the localities within the local authority area.

The NHS Board and the relevant local authority must delegate certain functions to the extent that they are provided to people who are at least 18 years old, namely adult social care, and all adult community health care and specific adult hospital services relating to unscheduled care. The relevant services are:

- **Social Work Functions:** Residential Care – Older People, Extra Care Housing and Sheltered Housing (Housing Support provided), Intermediate Care, Supported Housing-Learning Disability, Rehabilitation-Mental Health, Day Services and Local Area Coordination-LD; Older People; Mental Health, Care at Home services and enablement—all client groups, Rapid Response, Telecare, Respite services-all client groups, Quality assurance and Contracts, Assessment and Care Management-including OT services, Specialist Services-Sensory Impairment, Drugs and Alcohol.
- **Hospital services:** (includes associated services – e.g. allied health professionals) A&E, general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine, psychiatry of learning disability, palliative care, hospital services provided by GPs, mental health services provided in a hospital with exception of forensic mental health services, and services relating to an addiction or dependence on any substance.
- **Community Health Services:** District nursing, services relating to an addiction or dependence on any substance, services provided by allied health professionals, public dental service, primary medical services (GP), general dental services, ophthalmic services, pharmaceutical services, out-of-hours primary medical services, community geriatric medicine, palliative care, mental health services, continence services, kidney dialysis, and services to promote public health.

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The NHS Board and the local authority have the option to delegate further functions. An example of this is the provision of the following services to people who are under 18 years of age:

- Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
- General Dental Services, Public Dental Services and the Edinburgh Dental Institute
- General Ophthalmic Services
- General Pharmaceutical Services
- Out of Hours Primary Medical Services
- Learning Disabilities

The NHS Board may not delegate regional and national health services, as well as certain functions relating to contracting. The NHS Board and the local authorities have committed within the integration schemes to review their systems of governance and their professional, administrative and technical support functions, in light of this new business model. The NHS Board will continue to directly carry out all its functions which have not been delegated to IJBs.

The Scottish Government maintains a webpage with information on health & social care integration.  
<http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration>

1D – The Board’s Strategy

The Board agreed that a Strategic Plan should be developed in order to implement the Strategic Clinical Framework which it previously agreed in May 2013. The Board’s Strategic Planning Committee led the development of the Strategic Plan 2014-2024 (“*Our Health, Our Care, Our Future*”), which set out in detail the challenges that the Board faces, under four broad headings, namely:

- Demography, inequalities and ill health
- Multimorbidity
- Health service demand
- Tighter finances

<http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Lists/BoardPapers/NHS%20Lothian%20Board%20Papers%2002-04-14.pdf>

The draft Strategic Plan was issued for public consultation and the Board considered a report on the feedback on 1 October 2014. Overall feedback from the consultation confirmed support for the strategic aims and broadly endorsed the intended direction of travel, and delivery of NHS Scotland’s 2020 vision as the Board’s primary focus. The Board agreed that an updated strategic plan be brought to the Board in February 2015 to allow further development work to be concluded, and to align it with the Board’s financial planning process and the development of the integration schemes. The Board held a development session in January 2015 to specifically consider the issue of access to, and capacity within primary care, in light of the feedback from the consultation.

In February 2015 the Board considered a “Summary Report on Key Propositions 30 January 2015” and agreed to undertake further development of the following policy choices, to ensure successful delivery of the ambitions within the plan:

- A renewed emphasis on providing services in the community, to support people to remain at home, regardless of the time of day or night, with hospital admission being the exception and only when it is clinically required;
- Discharging patients as soon as possible to assess their ongoing needs at home, instead of retaining them in hospital beyond their acute clinical need;
- Rehabilitating patients in their home, rather than retaining them in hospital beyond their acute clinical need;
- Phasing out the provision of delayed discharge beds in hospitals, in favour of appropriate levels of social care;
- The closure and disposal of outmoded institutions and their replacement with integrated care facilities and other such models of care;
- Re-profiling of the workforce to support more appropriate and contemporary models of care.
- Ring fence elective beds

The Summary Report set out how a variety of propositions within the Strategic Plan 2014-2024 (“*Our Health, Our Care, Our Future*”) will be prioritised and developed. It also had a chart demonstrating the timelines and interdependencies between the various elements, and the Board’s Property and Asset Management

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Investment Plan 2015/16-2019/20. The Board supported all the recommendations in the paper to implement “Our Health, Our Care, Our Future”.

The Board’s Strategic Planning Committee has structured its forward agendas to monitor the delivery of the plan. An annual planning cycle is under development, with the aim of providing the committee with assurance that previously agreed strategies and plan are implemented.

As has been described earlier, integration will change the Board’s business model. The NHS Board will nominate half the voting membership of the new integration joint boards, and in that role those nominees can ensure that “Our Health, Our Care, Our Future” informs their strategic plan and directions. However it is for each integration joint board to determine its own strategic plan. Consequently “Our Health, Our Care, Our Future” will be subject to continuous review.

1E – The Principal Risks Facing the Board

Following a strategic review of the Corporate Risk Register, the Board approved the following as the principal risks facing the Board:-

- Healthcare Associated Infection
- Achieving the emergency 4-hour standard
- Achieving the delayed discharge targets
- The scale or quality of the Board’s services is reduced in the future due to failure to respond to financial challenge.

2. Financial Performance and Position

2A – 2014/15 Financial Results

The Scottish Government sets 3 budget limits at Health Board level on an annual basis. These limits are:

- Revenue resource limit (RRL) – a resource budget for ongoing operations;
- Capital resource limit – a resource budget for new capital investment; and
- Cash requirement – a financing requirement to fund the cash consequences of the ongoing operations and the new capital investment.

Health Boards are expected to stay within these limits, and report on any variation from the limits as set. The Board’s 2014/15 performance against these limits is as follows:

		Limit as set by SGHSCD £’000	Actual Outturn £’000	Variance (Over)/Under £’000
1	Core Revenue Resource Limit	1,328,048	1,327,809	239
	Non-Core Revenue Resource Limit	65,002	65,002	0
2	Core Capital Resource Limit	28,798	28,798	0
	Non-Core Capital Resource Limit	17,815	17,815	0
3	Cash Requirement	1,503,000	1,502,305	695



**Memorandum of In Year Outturn**

Brought forward surplus from previous financial year	324
Excess against in year total Revenue Resource Limit	85
Net Savings against RRL	239

The Board has therefore operated within the Scottish Government’s financial limits in 2014/15.

The notes to the accounts provide further detail on the Board’s income and expenditure during the year. The NHS Scotland Unified Board Accounts Manual 2014/15 requires certain items to be disclosed in the directors’ report.

Details of NHS Lothian's Net Operating Costs and RRL outturn are set out in Notes 2 to 8 to the Accounts. The Board’s Revenue and Capital Resource limits have been split between two component elements. Core revenue and capital have a cash or near-cash impact on the Board’s net expenditure. Non cash revenue and capital elements of net expenditure such as impairments, provisions and depreciation on assets have a non-core impact.

Demand led income and expenditure in respect of Family Health Services (including Dental, Ophthalmic and Pharmacy services) is not included in RRL and net expenditure is deducted from the Statement of Consolidated Comprehensive Net Expenditure in measuring performance against the Board’s revenue resource limit. This is set out in the Resource Outturn Statement on page 46.

The Board has recognised £10.350 million income relating to an ongoing back dated rates review which is expected to be finalised mid 2015.

At 31 March 2015 NHS Lothian carried a provision for bad debts of £0.4m (31 March 2014 £0.4m). Details of the movement on the provision are contained in Note 13 to the Accounts.

Provision for Clinical and Medical Negligence at 31 March 2015 amounted to £29.7m (31 March 2014 £50.2m). Most of the provisions are recoverable under the NHS Clinical Negligence and Other Risks Insurance Scheme (CNORIS). During 2014/15 there have been some significant movements in the CNORIS provision and associated debtor (see note 17) balances due to reassessment and finalisation of a number of material cases. This is reflected in the negative expenditure figures in note 7 and negative income figures in note 8. Contingent liabilities for Clinical and Medical Negligence decreased by £2.4m; principally through the revaluation of existing claims.

**2B – REVIEW OF FINANCIAL PERFORMANCE AND OUTLOOK**

The Board was provided with the Financial Plan 2015/16- 2019/20 at its meeting of 1 April 2015. <http://www.nhslotthian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx>

The Financial Plan sets out in detail the financial risks that the Board faces.

The projected growth in the Board’s expenditure will always exceed the projected growth in funding. This is because the demand and nature of health services is constantly growing and evolving, and the costs of some things will increase faster than the general rate of inflation and the rate of funding growth.

Therefore in order to secure medium to long term financial sustainability, health boards need to deliver recurring efficiency savings every year. Recurring savings are where costs have been permanently removed from the cost of running the service, and therefore the benefit is yielded on a recurring basis in future years. Non-recurring savings are where there has been an in-year financial benefit without any service re-design, and the cost base has not changed e.g. savings from having vacancies in the short term.

There is also an expectation that the health board should set a 3% “efficient government” target every year.

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In 2014/15 the Board achieved all of its financial targets. The Board also delivered £29m of efficiency savings in the year against a target of £39.4m, leaving a shortfall of £10.4m. However as only £21.9m of the £29.M savings were of a recurring nature, a total of £17.5m of the 2014/15 required recurring savings needs to be carried forward and added to the target for 2015/16.

The Board’s financial plan indicates that as a minimum, £30m worth of savings will need to be delivered in 2015/16 to achieve financial balance in that year. There is an overall efficiency target of £48m for 2015/16, however the financial plan has made an assumption that £30m is a more realistic figure for delivery, albeit that delivery of £30m has significant risks.

The financial plan indicates that the service is likely to be required to deliver savings of 3-5% in future years. This has been factored into the development of the Board’s 10-year Strategic Plan, *Our Health, Our Care, Our Future*.

The Board is aware that there are inherent uncertainties and associated risks within the financial plan. Throughout 2015/16 these issues are going to be closely examined by a “Delivering Financial Balance” Core Steering Group, which the Chief Executive chairs. Additionally the Board’s Finance & Resources Committee will be undertaking further scrutiny of the assumptions within the plan on capacity, and closely reviewing the plans for, and delivery of efficiencies.

### 3. Performance against Key Non-Financial Targets

All NHS Boards annually agree a delivery contract with the Scottish Government – the Local Delivery Plan. The Board submits a draft Local Delivery Plan to the Scottish Government for approval before the start of each financial year. The Local Delivery Plan is aligned to the Board’s strategies and corporate objectives for the forthcoming year.

The Board received the 2014/15 Local Delivery Plan at its meeting of 2 April 2014. The Local Delivery Plan identified 15 HEAT indicators and 8 HEAT national standards, the risks associated with the delivery of each, and how those risks would be managed.



HEAT targets are grouped into four priorities:






- **Health Improvement for the people of Scotland** - improving life expectancy and healthy life expectancy;
- **Efficiency and Governance Improvements** - continually improve the efficiency and effectiveness of the NHS (dealt with in the financial and sustainability sections below);
- **Access to Services** - recognising patients' need for quicker and easier use of NHS services; and
- **Treatment Appropriate to Individuals** - ensure patients receive high quality services that meet their needs.

The Scottish Government publishes information on the performance of all NHS Boards against the HEAT targets on the Scottish Government website. This information can be found here:






<http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance>






The Board monitors NHS Lothian’s performance against the HEAT targets and other standards which contribute towards delivery of the Scottish Government’s Purpose and National Outcomes, and NHS Scotland’s Quality Ambitions. The most up-to-date data for each target at March 2015 is still to be published and reported to NHS Lothian Board. A summary of the Board’s performance against the HEAT indicators and standards is given in the next table.

<b>Key to Current Performance Assessment</b>	
	<b>Meets</b> the overall target
	<b>Does not meet</b> the overall target

HEAT Indicator	Target Date	Target	Lothian Performance Current Period	Status
<b>Health Improvement</b>				
<p><b>H6.1 Smoking Cessation – most deprived (SIMD)</b></p> <p>NHS Scotland to deliver universal smoking cessation services to achieve at least 12,000 successful quits, at 12 weeks post quit, in the 40% most deprived within-board SIMD areas (60% for island health boards) over 1 year ending March 2015</p>	March 2015	<b>830 Quits</b>	Latest data published by ISD up to 30 September 2014, 237 successful quits against a target of 830 (71.4% below target)	
<p><b>H10.1 Detect Cancer Early (DCE)</b></p> <p>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.</p>	2014/15	<b>25%</b>	The DCE baseline programme is measured using the 2-year 2010 and 2011 position. Since the DCE programme baseline position, NHS Lothian's performance has moved from 22.6% to 25.8% based on national, validated ISD published data.	
<p><b>H11.1 Early Access to Antenatal Care</b></p> <p>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.</p>	Mar 15	<b>80% booked by 12<sup>th</sup> week of gestation</b>	Performance in March 2015 was 91.8% overall.	
<b>Efficiency and Governance Improvement</b>				
<p><b>E5.1 Financial Performance</b></p> <p>NHS Boards are required to operate within their Revenue Resource Limit (RRL), their Capital Resource Limit (CRL) and meet their Cash Requirement.</p>	Mar 15	<b>Delivery of Financial Break Even</b>	The Board's financial performance has been discussed at Section 2 of this Strategic Report.	
<p><b>E8.1 Reduce CO2 Emissions</b></p> <p>CO2 emissions from hospital sites for oil, gas, butane and propane usage annually by 3% to 2014/15</p>	2014/15	<b>17,284 tonnes of reported emissions</b>	<p>This HEAT target is based on hospitals fossil fuels consumption, which accounts for approximately 35% of the total emissions from our buildings energy consumption.</p> <p>With regard to the HEAT target for the period from</p>	



HEAT Indicator	Target Date	Target	Lothian Performance Current Period	Status
			<p>April to December 2014 there were 17,620 tonnes of emissions, which is 1.94% above the target.</p> <p>Within the Sustainability and Environmental Reporting section of the Directors' report, there is further detail on how NHS Lothian has successfully reduced its emissions from all building energy consumption.</p>	
<p><b>E8.2 Reduce Energy Consumption</b></p> <p>NHS Scotland to continue to reduce energy consumption annually by 1% to 2014/15</p>	2014/15	<b>596,290 GJ</b>	In the period from 1 April 2014-31 December 2014, the Board had consumed 570,857 GJ, 4.27% below the target.	
<b>Access to Service</b>				
<p><b>A12.1 Faster Access to Mental Health Services - CAHMS</b></p> <p>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks from December 2014;</p>	Dec 14	<b>90%</b>	Data published up to 31 December 2014 shows the Boards performance was 54.2% against a target of 90% (494 waiting more than 18 weeks)	
<p><b>A12.1 Faster Access to Mental Health Services</b></p> <p>18 weeks referral to treatment for Psychological Therapies from December 2014</p>	Dec 14	<b>90%</b>	Data published up to 31 December 2014 shows the boards performance was 37.1% against a target of 90% (1,144 waiting more than 18 weeks)	
<p><b>A13.1 IVF Treatment Waiting Times</b></p> <p>Eligible patients will commence IVF treatment within 12 months by 31 March 2015</p>	Mar 15	<b>90%</b>	At March 2015, no patients were waiting over 12 months	
<p><b>A14.1 A&amp;E Waiting Times</b></p> <p>95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by year ending September 2014.</p>	Sept 14	<b>95%</b>	In March 2015, the percentage of patients in A&E seen within 4 hours was 92.6%	

HEAT Indicator	Target Date	Target	Lothian Performance Current Period	Status
<b>Treatment Appropriate to Individuals</b>				
<b>T11.1 MRSA / MSSA Bacteraemias</b> Staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1,000 acute occupied bed days;	Mar 15	<b>SAB 0.24 or less per 1,000 acute occupied bed days</b>	The latest data published on 30 September 2014 shows performance was 0.34 against a target of 0.24	
<b>T11.2 Clostridium difficile infections ages 65+</b> the rate of Clostridium difficile infections in patients aged 15 and over is 0.32 cases or less per 1,000 total occupied bed days.	Mar 15	<b>C Diff 0.32 cases or less per 1,000 occupied bed days</b>	The latest data published on 31 December 2014 shows performance was 0.49 against a target of 0.32	
<b>T12.1 Reduction in emergency bed days for patients aged 75+</b> Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population by at least 12% between 2009/10 and 2014/15	2014/15	<b>12% reduction in emergency bed days</b>	The latest data published by ISD up to 30 November 2014 shows performance of 4,742 occupied bed days per 1,000 population of over 75 year olds (0.4% below target). Data published in March 2015 show for the previous rolling year (December 2013 to November 2014) NHS Lothian has seen an overall decrease of 14.8% (interim) in bed days.	
<b>T15.1 28 Days Delayed Discharge</b> From April 2015, no people will wait more than 14 days to be discharged from hospital to a more appropriate care setting.	Apr 15	28 days	Census information at 15 March 2015 indicates there was a total of 148 delayed discharges of which 57 were over 28 days, and 84 delays over 14 days.	
<b>T16.1 Dementia Post Diagnostic Support</b> To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.	2015/16	<b>All people newly diagnosed with dementia will have a minimum of 1 year post diagnostic support</b>	Alzheimer Scotland Post Diagnostic Link workers are in post in West Lothian, Midlothian and City of Edinburgh, recruitment is underway in East Lothian. The link workers are delivering 5 pillars model of post diagnostic support. Data is being submitted to ISD, there have been data/recording issues on the ISD management reports and this is being followed up by Mental Health and Well-being Programme.	

HEAT Indicator	Target Date	Target	Lothian Performance Current Period	Status
			<p>Work is on-going with secondary care and community mental health teams to identify and record post diagnostic support which they undertake and this will be included in future submissions to ISD.</p> <p>For people at a later stage of the dementia journey, Midlothian is a test site for the 8 pillars dementia practice coordinator role.</p>	

**Further Commentary on Performance on HEAT Indicators**

Smoking Cessation

NHS Lothian will sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% Scottish Index of Multiple Deprivation (“SIMD”) areas by providing an accessible cessation service. Priorities for the service remain providing an effective cessation service to hospital patients (both in acute and mental health hospitals), young people, pregnant women and their families, and prisoners. The Board will set local targets for each of these priority groups once further information regarding national targets for 2015-16 is available.

Carbon Monoxide monitoring at booking and referral to stop smoking service is now well established in NHS Lothian and the stop smoking service is working with Early Years Collaborative to improve engagement with pregnant women.

NHS Lothian plans to re-design our stop smoking service to improve skill mix and become more cost effective, and will take a community development, asset based approach when developing services. NHS Lothian will also consider ways of providing prevention and cessation to young people in a more effective way. Employees within the smoking cessation service will complete on-line national centre smoking cessation training (NCSCT) until a new national training programme is established for Scotland. This, together with an in-house training programme will improve their knowledge, skills and practice. A training programme will continue to be delivered to community pharmacies to enhance their knowledge and skills, towards increase their smoking cessation activity.

Child and Adolescent Mental Health Services (CAHMS)

NHS Lothian did not meet the target of all children and young people starting treatment with 18 weeks of referral by December 2014. A recovery plan is in place, and new employees were recruited during October and November. Good progress is now being made against the agreed trajectory. The agreed trajectory predicts that the target will be met by the end of May 2015. However a significant increase in referrals in the last quarter of 2014 and January 2015, along with reduced capacity due to accommodation issues, may delay meeting the target until the end of July 2015.

There were 428 patients waiting over 18 weeks at the end of January 2015. For patients seen for their first treatment in January, 51% were seen within 18 weeks. This level of performance will be expected to continue whilst there is a focus on clearing the backlog of patients waiting over 18 weeks.

Psychological Therapies

NHS Lothian did not meet the target of 18 weeks for referral to treatment for a psychological therapy by December 2014. Performance against the target was 44% at end of January 2015. There continues to be a significant and increasing backlog of patients waiting over 18 weeks for a psychological therapy. At the end of

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January there were 3,095 patients waiting for psychological therapy with 1,201 (39% of all those waiting) currently waiting over 18 weeks.

The Board considered a comprehensive report on improving access to psychological therapies at its meeting in April 2015. The Board supported the following actions to be undertaken during 2015-16 to support delivery 18 week target for psychological therapies.

- Additional measures to quality assure service data and ensure greater devolved ownership of the 18 week target
- Improved data governance and governance processes to ensure safe and effective therapy
- Strengthen the service delivery structures to ensure ownership and local accountability for delivery of waiting times
- Recognition that demand for psychological therapies continue to outweigh capacity
- Further consideration of the best way to maximise additional Scottish Government funding for mental health innovation to support improvement in the provision of psychological therapies

Accident & Emergency Waits (4 hour target)

NHS Lothian has reviewed the current models for unscheduled care during 2014/15. This has involved reviewing front door models of care at our acute hospitals, the roll of out of community frailty models to reduce re-admission, analysis of patient flow systems and tackling delays.

NHS Lothian has recruited a number of Emergency Medicine Consultant posts to support completion of a 3 year consultant expansion programme. Appointment of Clinical Development Fellows will commence in August 2015 to cover a number of specialties including Emergency Medicine. These positions have proved to be both attractive in filling gaps in A&E and front door specialties and will assist to support:

- Sustainability of services in the face of a continued rise in A&E attendances
- Provide increased consultant presence within our acute hospitals
- Improve time from triage, clinical decision time and the total time individuals are required to be in emergency departments

Delayed Discharge

NHS Lothian is working closely with the four Lothian health & social care partnerships to support delivery in 2015-16 of the delayed discharge standards to ensure people are discharged within 72 hours where clinically ready for discharge, and no people wait more than 14 days to be discharged to a more appropriate care setting. The Scottish Government has provided additional funds in 2015-16 to support delivery of these standards, and the Lothian Health and Social Care Partnerships are developing proposals as to how to best use this funding.


Hospital Acquired Infections (Clostridium, Difficile and Staphylococcus aureus Bacteraemia)







The highest risk of infection is associated with the use of invasive devices such as urinary catheters. A key priority in reducing infection rates is through ensuring enhanced care associated with the use of any such invasive devices.

A revised Antibiotic Prescribing Guideline was implemented from February 2015 to support infection control, and the impact of this revised guidelines will be monitored during 2015-16.

**Performance on 2014-15 HEAT National Standards**

The Board's performance on 2014-15 HEAT Standards (most recent available data) was as follows:

2014-15 HEAT National Standards	Status
<p><b>95% of all patients diagnosed with cancer begin treatment within 31 days of decision to treat, and 95% of those referred urgently with suspicion of cancer to begin treatment within 62 days of receipt of arrival</b></p> <p>The latest cancer waiting times published on 31 March 2015 for the quarter October to December 2014 indicates 62 day performance was 95.6% and 31 day performance was 97.0%.</p>	

2014-15 HEAT National Standards	Status
<p><b>90% of planned / elective patients to commence treatment within 18 weeks from referral</b></p> <p>During February 2015, 88% of planned / elective patients were treated within 18 weeks of referral.</p>	
<p><b>Provide 48 hour access or advance booking to an appropriate member of the GP practice team</b></p> <p>The performance measure for this standard is measured by the Health and Care Experience Survey. Information from this survey for 2013/14 (published in May 2014) shows that the proportion of positive responses for 48-hour access to an appropriate healthcare professional in Lothian was 92.4% (against a standard of 90.0%). The 2014/15 survey has not yet been published.</p>	
<p><b>No patient will wait longer than 12 weeks from referral (all sources) to first outpatient appointment</b></p> <p>At the end of February 2015, there were 2,682 patients waiting over 12 weeks.</p>	
<p><b>NHS Boards to achieve a sickness absence rate of 4% from 31 March 2009</b></p> <p>The average rate of sickness absence over the year was 4.71%.</p>	
<p><b>NHS Board and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three established settings (Primary Care, A&amp;E, antenatal). In addition they will continue to develop delivery of alcohol brief interventions in wider settings.</b></p> <p>2014/15 NHS Lothian ABI delivery is anticipated to be in the region of 23,751 interventions against a target of 9,938. This has been achieved through embedding interventions within consultation in the 3 established settings and ensuring systems are in place to record interventions have taken place.</p>	
<p><b>90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports recovery</b></p> <p>During 2014-15, 90% of people waited no longer than 3 weeks from referral received to appropriate drug or alcohol treatment to support their recovery. This includes treatment from council, voluntary sector and NHS services. Further work is being undertaken in some NHS Lothian services, particularly in Edinburgh, to increase capacity and improve performance where the target has not been met.</p>	

Treatment Time Guarantees

NHS Lothian recognises the importance of patients being seen within the expected timescales. Unfortunately despite the investment made over the last three years to improve our waiting times performance difficulties still remain. The effect of the number of people boarding or delayed remains a significant risk as does the number of people presenting at our Accident and Emergency departments. All of these pressures make it difficult to protect elective beds. We continue to be dependent on the independent sector as highlighted in our acute recovery plan 'Delivering for Patients'. The rate at which we wished to repatriate and build internal capacity has not to be realised.

NHS Lothian anticipates achieving the Treatment Time Guarantees towards the end of 2015.



Drug and Alcohol Treatment

Working with our partners in the three Alcohol and Drug Partnerships (ADPs) in Lothian, there will be further developments to enhance local treatment and care systems to make them more responsive, person centred and recovery focused. We will continue to work to ensure that people access treatment promptly (within 3 weeks of referral) and are supported in their recovery by services provided locally and in an integrated way.

#### 4. Sustainability and Environmental Reporting

The Climate Change Scotland Act (2009) imposes “climate change duties” on public bodies such as NHS Boards. The Act sets out a target to reduce greenhouse gas emissions 42% by 2020 and 80% by 2050. NHS Scotland set two HEAT targets in 2010/11 related to these duties:

- An annual 1% reduction in energy consumption
- An annual 3% CO2 emissions reduction from fossil fuel sources (oil, gas, butane and propane)

Health Facilities Scotland will be reviewing these targets in 2015, on behalf of the Scottish Government.

The last two years have seen a large improvement in NHS Lothian's performance in these areas. In 2013/14 energy consumption reduced from 342million kWh to 312million kWh. The CO2 emissions arising from this energy consumption showed a corresponding reduction from 95,621 tonnes in 2012/13 to 89,653 tonnes in 2013/14. By the end of December 2014, there had been a further reduction of energy consumption and CO2 emissions by 6% from 2013/14.

The reduction in energy consumption and CO2 emission follows investment programmes which have included major improvements at the Royal Infirmary of Edinburgh, Western General and Astley Ainslie Hospitals. Capital investment has been difficult to obtain in 2014/15 but NHSL has developed a £2.2million investment programme for next year and is presently evaluating tenders for a major energy infrastructure improvement at St John's Hospital.

The continuing strength of NHSL's performance in reducing CO2 emissions has again been recognised in 2014/15 by re-accreditation to the quality management system the Carbon Trust Standard. There is now a progression of continued full accreditation covering all the NHS Lothian estate extending from 4 years to 6 years. This is an internationally recognised system, assessed by independent external auditors, and NHS Lothian is the only NHS body in Scotland to maintain this standard.

The Good Corporate Citizenship Assessment Model (GCCAM) is a tool to help NHS bodies to develop their activities to become more sustainable, and achieve the above HEAT targets. The tool was adapted by taking into account already existing work, policy and requirements in the six key areas, namely: Travel, Procurement, Community Engagement, Facilities Management, Buildings and Workforce.

NHS Lothian has developed its Sustainable Development Action Plan (SDAP). There is a Programme Board, a Sustainability Champion (the Director of Human Resources and Organisational Development) and identified Project Leads covering the 6 facets arising from GCCAM; There are a large number of projects and initiatives within the SDAP, and some examples provided below are taken from each of the facets:

Transport	Set up a dedicated transport helpline to coordinate the transport of patients, staff and goods.
Procurement	Ensure our purchasing and supply activities contribute positively to our overarching Sustainability Policy and to our local community's Local Agenda 21 Plan.
Facilities Management	£2.2million energy efficiency investment programme to be funded from various sources and a >£5million infrastructure upgrade at St John's to reduce CO2 emissions by 40%.
Employment and Skills	Aim to achieve gold standard across sites in Scotland's health at work scheme carried out by healthy working lives
Community Engagement	Continued support and working alongside Cyrenians, a project which supports individuals who face severe problems including poverty and homelessness. Projects include the Royal Edinburgh Hospital

	Community Gardens.
New Builds and Refurbishments	Procurement of new buildings and large refurbishments to target a BREEAM Excellent outcome. BREEAM Healthcare is the leading design and assessment method for sustainable buildings in the NHS

NHS Lothian will be publishing more information on 2014/15 through the Public Sector Sustainability Reporting mechanism in September 2015.

## 5. Social, Community and Human Rights

The Board approved NHS Lothian Equality Rights and Outcomes 2013-17 at its meeting of 27 March 2013. This sets out how NHS Lothian will continue to work towards equality, diversity and Children’s and Human Rights in the period to April 2017, and includes five 5 Equity Standards, namely:

- Standard 1: NHS Lothian is fair and equitable in the way it develops its policies and strategies, and in the way it employs its workforce.
- Standard 2: Access to NHS Lothian’s healthcare services is equitable.
- Standard 3: NHS Lothian’s healthcare services deliver an equitable quality of care to all patients.
- Standard 4: NHS Lothian involves and consults with people in an inclusive and equitable way when developing services or policies.
- Standard 5: NHS Lothian promotes equality and diversity in its work with partners, in its contracts and in its procurement of goods and services.

The Board has published a progress report on the above, as well as an equal pay statement and a mainstreaming report on its website.

NHS Lothian has developed its approach to impact assessment, by approving a revised approach in March 2015 which routinely considers human rights and children’s rights. The Board has approved its strategy for children and young people for the period 2014-2020, and this includes a commitment to embed children’s rights in the design and delivery of local policies and services.

Going forward, when the new integration joint boards are preparing their strategic plans, they are required to have regard to the integration delivery principles and the national health & wellbeing outcomes, as set out in the [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#). One of those integration delivery principles is to provide services in a way which “respects the rights of service users”.

As at 31 March 2015, the profile of the Board by gender was as follows:

GROUP	MALE	FEMALE
Executive Board members	2	3
Non-Executive Board Members	11	7
<b>All Board members</b>	<b>13</b>	<b>10</b>

As at 31 March 2015, the profile of the Board’s senior managers and other employees, by gender, is as follows:

GROUP	MALE	FEMALE
Employees on the executive and senior manager pay scales	60	51
All other employees	5,856	20,916
<b>Total</b>	<b>5,916</b>	<b>20,967</b>

## 6. Accounting Convention

The Annual Accounts and Notes have been prepared under the historical cost convention modified by the revaluation of property, plant and equipment, intangible assets, inventories, available-for-sale financial assets and financial assets and liabilities (including derivative instruments) at fair value through the Statement of Comprehensive Net Expenditure. The Accounts have been prepared under a direction issued by Scottish Ministers, which is reproduced as an appendix to these Accounts.

The statement of the accounting policies, which have been adopted, is shown at Note 1.

.....  
Tim Davison,  
Chief Executive and Accountable Officer  
24 June 2015

## SECTION B: DIRECTORS' REPORT

### 7. Date of Issue

The Board presents this report and the audited accounts for the year ended 31 March 2015. The Board approved these accounts on 24 June 2015 for submission to the Scottish Government.

### 8. Appointment of the Board's External Auditors

The Auditor General has appointed David McConnell, Assistant Director of Audit Services, Audit Scotland to undertake the audit of Lothian NHS Board for the financial years 2011/12 to 2015/16.

### 9. Board Membership

The Cabinet Secretary (Health & Wellbeing) appoints all NHS Board members. The Board is made up of executive and non-executive members. The members are collectively responsible for the governance of the organisation, and the Board is accountable to the Scottish Government.

The Board discharges its governance role through regular Board meetings and the work of its committees. The Board publishes all papers for its public Board meetings on the website at:

<http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx>

As at 31 March 2015 the Board had five executive Board members and eighteen non-executive Board members (as at 24 June 2015 there are seventeen non-executives). The Board's non-executive members include nominees from key stakeholders, and lay members who have applied through a public appointment process. Members are selected on the basis of their position as stakeholders or the particular expertise which enables them to contribute to the decision making process at a strategic level.

Table 1 below sets out the Board members serving from 1 April 2014 up to 31 March 2015.

Table 1: Board Members from 1 April 2014 up to 31 March 2015

Name	Position	Board Meetings	
		Eligible to Attend	Attended
Brian Houston	Non-executive, Chair	8	8
Tim Davison	Chief Executive	8	8
Dr David Farquharson	Medical Director	8	8
Susan Goldsmith	Director of Finance	8	7
Melanie Johnson	Nurse Director	8	8
Professor Alison McCallum	Director of Public Health & Health Policy	8	7
Shulah Allan MBE	Non-executive, vice-Chair	8	7
Michael Ash	Non-executive	8	6
Kay Blair	Non-executive	8	5
Jeremy Brettell	Non-executive (until 28 February 2015)	7	6
Dr Morag Bryce	Non-executive	8	5
Cllr Donald Grant	Non-executive (East Lothian Council)	8	7
Cllr Ricky Henderson	Non-executive (City of Edinburgh Council), until 31 March 2015	8	7
Prof John Iredale	Non-executive (University of Edinburgh)	8	6
Cllr Catherine Johnstone	Non-executive (Midlothian Council)	8	5

Name	Position	Board Meetings	
		Eligible to Attend	Attended
Peter Johnston	Non-executive	8	7
Alex Joyce	Non-executive ((Employee Director)	8	7
Julie McDowell	Non-executive	8	5
Alison Meiklejohn	Non-executive (Area Clinical Forum)	8	7
Alison Mitchell	Non-executive	8	8
Cllr Frank Toner	Non-executive (Midlothian Council)	8	7
George Walker	Non-executive	8	6
Graham Warner	Non-executive	8	3
Dr Richard Williams	Non-executive (GP Representative)	8	7
Robert Wilson	Non-executive, until 31 December 2014	5	4

The Board members' responsibilities in relation to the accounts are set out on page 34.

## 10. Board Members' and Senior Managers' Interests

All Board members are subject to the Ethical Standards in Public Life (Scotland) Act 2002. The members are required to maintain a Register of Interests, and this can be found on the Board's website at:

<http://www.nhslothian.scot.nhs.uk/YourRights/FOI/Pages/default.aspx>

Details of any interests of Board members and other senior staff and senior managers in contracts or potential contracts with third parties are disclosed in Note 28 to the annual accounts.

All Board members are also trustees of charitable funds that the Board holds. The Trustees govern the charitable funds distinctly from the Board's exchequer funds. Lothian Health Board Endowment Fund (commonly known as the Edinburgh & Lothian Health Foundation) is a charity registered with the Office of the Scottish Charity Regulator under number [SCO07342](#). The Board is required to consolidate the financial statements of Lothian Health Board Endowment Fund within the Board's Annual Accounts. Note 32 details how these consolidated Financial Statements have been calculated.

## 11. Board Members' Third Party Indemnity Provisions

During financial year 2014/15 the Board paid for directors & officer's liability insurance for its members at a premium cost of £23,240 (2013/14 - £23,000).

## 12. Pension Liabilities

The accounting policy note for pensions is provided in Note 1 and disclosure of the costs is shown within Note 24 and the remuneration report.

## 13. Remuneration for Non-Audit Work

The remuneration of the auditors is disclosed in note 3 to the accounts. During the year 2014/15 the Board's external auditors received no fees in relation to non-audit work.

## 14. Public Services Reform (Scotland) Act 2010

This Act imposes duties on the Board to publish information on expenditure and certain other matters as soon as is reasonably practicable after the end of each financial year.

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The relevant information on expenditure greater than £25,000, overseas travel, consultancy and public relations expenditure is disclosed under the Board’s website at:

<http://www.nhsllothian.scot.nhs.uk/OurOrganisation/KeyDocuments/Pages/Financial.aspx>

15. Sickness Absence Data and Personal Data Related Incidents

Sickness Absence

The average sickness absence rate over the year to 31 March 2015 was 4.71% (2013/14-4.39%). This remained below the average across Scotland (5.04%) and was the lowest amongst teaching boards in Scotland.

In order to support delivery of the sickness absence standard, NHS Lothian will review and refresh the Promoting Attendance Policy during 2015. The Human Resources team continue to provide support and governance frameworks to assist managers to achieve the target. Guidance will also be developed on managing the health of an ageing workforce, and NHS Lothian will continue to champion a strong partnership ethos in the management of staff sickness absence

Personal Data Related Incidents

During 2014/15, NHS Lothian reported one incident to the Information Commissioner’s Office for review. Other individuals reported a further five incidents which related to NHS Lothian to the Information Commissioner’s Office for review. NHS Lothian referred one of those six incidents to Police Scotland.

16. Payment Policy

The Scottish Government’s Health & Social Care Directorate (SGHSCD) is committed to supporting business by paying bills more quickly, aiming to pay all undisputed invoices within 10 working days. The Board calculates this by comparing the date that payment was made, to the date that it received the invoice.

In 2014/15 the average number of days the Board took to pay an invoice was 7 days (2013/14 – 8 days).

	2014/15	2013/14
% of Invoices by Value, paid within 30 days	96%	89%
% of Invoices by Value, paid within 10 days	89%	81%
% of Invoices by Volume, paid within 30 days	96%	96%
% of Invoices by Volume, paid within 10 days	89%	90%

No payments were made under Late payment of Commercial Debts (interest) Act 1998 in 2014/15 (2013/14 - Nil).

17. Corporate Governance

The Board approves the establishment of any committees, approves their terms of reference, and appoints their members. The Board is required to have certain committees due to regulations (e.g. Pharmacy Practices Committee) discipline and reference committees relating to family health services, community health partnership sub-committees) or Scottish Government direction (e.g. remuneration committee), but may establish further committees if it wishes.

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Details of the Selected Board Committees as at 31 March 2015

Name	Remit	Chair	Other Lothian NHS Board Members	Frequency of Meetings
Audit & Risk	The main objective of the Audit & Risk Committee is to support the Accountable Officer and the Board in meeting their assurance needs.	Julie McDowell	Michael Ash, Morag Bryce, Donald Grant, Ricky Henderson, and Catherine Johnstone.	No less than four times in a calendar year.
Healthcare Governance	The Healthcare Governance Committee is to provide assurance to the Board that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard. The Committee will also provide assurance to the Board that NHS Lothian meets its responsibilities with respect to:- <ul style="list-style-type: none"> <li>• NHS Lothian Participation Standards</li> <li>• Volunteers/Carers</li> <li>• Information Governance</li> <li>• Protection of Vulnerable People including children, adults, offenders</li> <li>• Relevant Statutory Equality Duties</li> </ul>	Morag Bryce	Shulah Allan, Alex Joyce, Alison Meiklejohn, Frank Toner, Graeme Warner, and Richard Williams.	At least every two months.
Staff Governance	The role of this Committee is to support and maintain a culture within NHS Lothian where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within NHS Lothian and is built upon partnership and collaboration. The	Alex Joyce	David Farquharson, Donald Grant, Brian Houston, Melanie Johnson, Peter Johnston Julie McDowell, Alison Meiklejohn, Alison Mitchell, and Graeme Warner.	No less than four times in a calendar year

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Name	Remit	Chair	Other Lothian NHS Board Members	Frequency of Meetings
	Staff Governance Committee must ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored.			
Finance & Resources	There are three core elements to the committees remit: 1. Financial Governance 2. Property and Asset Management Strategy 3. Strategic/ Capital Projects.	George Walker	Kay Blair, Tim Davison, David Farquharson, Susan Goldsmith, Ricky Henderson, Brian Houston, John Iredale, Melanie Johnson, and Peter Johnston.	Six times a year
Strategic Planning	Oversight of the development of strategy and implementation of Strategic Clinical Framework and individual strategies.	Brian Houston	Kay Blair, Tim Davison, David Farquharson, Susan Goldsmith, John Iredale, Melanie Johnson, Alex Joyce, Alison McCallum, Alison Meiklejohn, Alison Mitchell, George Walker, and Richard Williams.	Monthly
Acute Hospitals	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 acute hospitals.	Kay Blair	Alex Joyce, Alison Meiklejohn, Alison Mitchell, George Walker and David Farquharson.	Six times a year

The Board did operate four community health partnership sub-committees during 2014/15, however these are no longer a requirement from 1 April 2015. The Board has also operated four shadow integration joint boards to assist in the preparation for integration and the establishment of integration joint boards in 2015/16.

Members' Attendance at Selected Meetings from 1 April – 31 March 2015

The table below sets out the attendance of appointed committee members at those committees. For simplicity it does not capture the occasions where a Board member who is not a committee member has attended a meeting of that committee.



	Acute Hospitals	Strategic Planning	Healthcare Governance	Staff Governance	Finance & Resource	Audit & Risk
Number of Meetings in the Year	4	11	6	4	7	5
Brian Houston		11		3	6	
Tim Davison		8			3	
Dr David Farquharson	3	7		2	7	
Susan Goldsmith		5			7	
Melanie Johnson		8		0	3	
Professor Alison McCallum		11				
Shulah Allan MBE			4 out of 4			
Michael Ash						3
Kay Blair	4	6			6	0 out of 1
Jeremy Brettell		6 out of 10			5 out of 6	5
Dr Morag Bryce			6			2
Cllr Donald Grant						4
Cllr Ricky Henderson					6	5
Prof John Iredale					2	
Cllr Catherine Johnstone						4
Peter Johnston				0 out of 2	5	
Alex Joyce	3	6	4	4		
Julie McDowell				1 out of 2		2 out of 3
Alison Meiklejohn	1 out of 1	8	6	3		
Alison Mitchell	1 out of 1	10		4		
Cllr Frank Toner			2			
George Walker	2	0			6	
Graham Warner			1	2		
Dr Richard Williams		9	5			
Robert Wilson	3 out of 3	4 out of 8	0 out of 2	0 out of 2		

## 18. Disclosure of Information to Auditors

The Board members who held office at the date of approval of this report confirm that so far as they are aware, there is no relevant audit information of which the Board’s auditors are unaware; and each Board member has taken all the steps that they ought reasonably to have taken as a Board member to make themselves aware of any relevant audit information, and to establish that the Board’s auditors are aware of that information.

## 19. Human Resources

As an equal opportunities employer, the Board welcomes applications for employment from disabled persons and actively seeks to provide an environment where they and any employees who become disabled can continue to contribute to the work of the Board.

The Board adopted a renewed set of Values in July 2013, those Values being:

- *Care and Compassion*
- *Dignity and Respect*
- *Openness, Honesty and Responsibility*
- *Quality*
- *Teamwork*

These Values are NHS Scotland Values, the development of which was informed by the extensive work already undertaken within the Board to develop a set of shared core values. The Board agrees that it is essential that the Board and the wider organisation “lives” these Values. The Values will be implemented by

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threading them through the Board’s approach to strategic planning, its corporate objectives, and supported by continuing and structured engagement with employees throughout the organisation.

These renewed Values aim to build upon what is already in place in the Board. All NHS Boards have a legal duty to put and keep in place arrangements to improve the management of their officers, to monitor that management, as well workforce planning. This is primarily discharged through the [NHS Scotland Staff Governance Standard](#). The NHS Lothian Staff Governance Committee has a primary role to seek assurance that this Standard is systematically implemented throughout NHS Lothian.

The Standard requires all NHS Boards to demonstrate that all employees are:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

The Board provides employees with information on matters of interest to them as employees by regular communication through the monthly Team Brief and a bi-monthly *Connections* newspaper. The Board also has an intranet with information on all aspects of the organisation. On 1 October 2013 the Board launched “HR online” on the intranet, which provides a particular focus on HR policies and their application, as well as other staff-related information. Additionally there is a “Staff Room” page on the intranet which provides further general staff information, including information on staff benefits.

The Board consults employees and their representatives so their views are taken into account in decisions affecting their interests. There is a well established system of partnership working in NHS Lothian, and an associated network of Partnership Forum. The Board has systems in place to consult employees during the development of organisational strategies and policies.

## 20. Financial Instruments

Information in respect of the financial risk management objectives and policies of the Board and the exposure of the Board to price risk, credit risk, liquidity risk and cash flow risk is disclosed in note 27.

## 21. Approval and Signing of the Directors’ Report

The Accountable Officer authorised these financial statements for issue on 24 June 2015.

.....

Tim Davison,  
Chief Executive and Accountable Officer  
24 June 2015

**REMUNERATION REPORT**

**1. Board Members' and Senior Employees' Remuneration**

Information disclosed in this report relates to the remuneration of Board Members and senior managers who directly report to the Chief Executive. Other disclosures in these accounts provide details of the interests of Board Members and senior managers, and information about related party transactions.

Board Members and senior managers are remunerated in accordance with approved national pay rates. All posts at this level are subject to rigorous job evaluation arrangements and the pay scales applied reflect the outcomes of these processes. All extant policy guidance issued by Scottish Government Health & Social Care Directorate (SGHSCD) has been appropriately applied and agreed by the Remuneration Committee. Determination of individual salary placement on appointment is guided by the terms of circulars Health Department Letter (HDL) (2006)23 and HDL (2006)59 as amended by subsequent directives issued by SGHSCD.

All senior manager posts have been evaluated using the HAY methodology through the National Evaluation Committee. NHS Lothian Executive Board Members are appointed and graded within the new Executive Cohort in accordance with HDL (2006)23. Other senior managers, other than those in transitional grades as determined by NHS Management Executive Letter (MEL) (2000)25, are appointed and graded to a new Senior Manager cohort in compliance with HDL (2006)59. Managers within transitional grades have been re-evaluated to grades within Agenda for Change pay-scales.

In accordance with the Financial Reporting Manual (FReM) and the Companies Act, 2013-14 was the first year that publication of the "pension benefits" was required. This calculation aims to bring public bodies in line with other industries in disclosing an assessed cumulative pension benefit for a standard 20 year period, which is the estimated life span following retirement.

Details of Board Members' remuneration are disclosed in notes 2a – 2e of the remuneration report and have been subject to audit.

## REMUNERATION REPORT (AUDITED)

## 2(a). Board Members' and Senior Employees' Remuneration – 2014/15

	Gross Salary (Bands of £5,000)	Benefits in kind (£'000)	Total Earnings in Year (Bands of £5,000)	Pension Benefits (£'000)	Total Remuneration (Bands of £5,000)
<b>Remuneration of: Executive Members</b>					
Mr Tim Davison, Chief Executive	175 – 180	0.6	175 - 180	32	210 - 215
Prof Alison McCallum, Director of Public Health and Health Policy	120 – 125	-	120 – 125	17	135 – 140
Mrs Susan Goldsmith, Director of Finance	120 – 125	-	120 - 125	7	130 – 135
Ms Melanie Johnson, Executive Director Nursing, AHPs and Unscheduled Care	140 – 145	-	140 – 145	12	155 – 160
Dr David Farquharson, Medical Director	200 – 205	-	200 - 205	41	240 - 245
<b>Non Executive Members</b>					
Mr Brian Houston, Chairman	40 – 45	-	40 – 45	-	40 – 45
Mr Alex Joyce, Employee Director <sup>Note 1</sup>	45 – 50	-	45 - 50	7	55 – 60
Professor John Iredale, University of Edinburgh	10 – 15	-	10 - 15	-	10 – 15
Cllr Donald Grant, East Lothian Council	5 – 10	-	5 - 10	2	10 – 15
Cllr Ricky Henderson, City of Edinburgh Council	15 – 20	-	15 - 20	2	15 – 20
Cllr Catherine Johnstone, Midlothian Council	5 – 10	-	5 - 10	-	5 - 10
Cllr Frank Toner, West Lothian Council	15 – 20	-	15 - 20	-	15 – 20
Mr Peter Johnston	15 – 20	-	15 - 20	-	15 – 20
Mr George Walker	15 – 20	-	15 – 20	-	15 – 20
Dr Morag Bryce	15 – 20	-	15 – 20	-	15 – 20
Mrs Julie McDowell	5 – 10	-	5 - 10	-	5 – 10
Dr Richard Williams <sup>Note 2</sup>	120 – 125	-	120 - 125	15	135 – 140
Ms Shulah Allan MBE, Public Partnership Forum Member and Vice Chair	15 – 20	-	15 – 20	-	15 – 20
Mr Jeremy Brettell (resigned 28 February 2015)	15 – 20	-	15 – 20	-	15 – 20
Mr Michael Ash	15 – 20	-	15 – 20	-	15 – 20
Ms Kay Blair	15 – 20	-	15 – 20	-	15 – 20
Mr Robert Wilson (resigned 31 December 2014)	5 – 10	-	5 - 10	-	5 – 10
Ms Alison Mitchell	5 – 10	-	5 - 10	-	5 – 10
Mr Graeme Warner	5 – 10	-	5 - 10	-	5 – 10
Mrs Alison Meiklejohn, Chair of Lothian Area Clinical Forum <sup>Note 3</sup>	65 – 70	-	65 – 70	8	70 – 75
<b>Other Senior Employees</b>					
Mr James Forrest, Director of West Lothian Health & Social Care <sup>Note 4</sup>	45 – 50	0.9	45 - 50	1	45 – 50
Mr Peter Gabbitas, Director of Edinburgh Health & Social Care <sup>Note 5</sup>	65 – 70	-	65 – 70	21	85 – 90
Mr David Small, Director of East Lothian Health & Social Care Partnership <sup>Note 6</sup>	45 – 50	-	45 - 50	17	60 – 65
Professor Alex McMahon, Director of Strategic Planning	85 – 90	-	85 - 90	9	95 – 100
Mr Alan Boyter, Director of Human Resources & Organisational Development	125 – 130	-	125 – 130	3	130 – 135
Mr Jim Crombie, Director of Scheduled Care	105 – 110	1.5	110 – 115	44	150 - 155
Mrs Eibhlin McHugh, Director of Midlothian Health & Social Care Partnership <sup>Note 7</sup>	45 – 50	-	45 – 50	-	45 - 50
Total Members & Senior Employees		3.0		238	

There were no Performance related bonus payable for 2014-15.

REMUNERATION REPORT (AUDITED)

2(b). Board Members' and Senior Employees' Remuneration – 2013/14 (Restated)

	Gross Salary (Bands of £5,000)	Benefits in kind (£'000)	Total in Year (Bands of £5,000)	Pension Benefits (£'000)	Total Remuneration (Bands of £5,000)
<b>Remuneration of: Executive Members</b>					
Mr Tim Davison, Chief Executive	175 – 180	0.4	175 – 180	30	205 – 210
Prof Alison McCallum, Director of Public Health and Health Policy	115 – 120	-	115 – 120	9	125 – 130
Mrs Susan Goldsmith, Director of Finance	120 – 125	-	120 – 125	11	130 – 135
Ms Melanie Johnson, (Hornett) Executive Director, AHPs and Unscheduled Care	140 – 145	-	140 – 145	42	185 – 190
Dr David Farquharson, Medical Director	200 – 205	-	200 – 205	-	200 – 205
<b>Non Executive Members</b>					
Mr Brian Houston, Chair (from 15 April 2013)	35 – 40	-	35 – 40	-	35 – 40
Mr Alex Joyce, Employee Director <sup>Note 1</sup>	45 – 50	-	45 – 50	4	50 – 55
Professor John Iredale, University of Edinburgh	10 – 15	-	10 – 15	-	10 – 15
Cllr Donald Grant, East Lothian Council	5 – 10	-	5 – 10	3	10 – 15
Cllr Ricky Henderson, City of Edinburgh Council	15 – 20	-	15 – 20	3	15 – 20
Cllr Catherine Johnstone, Midlothian Council	5 – 10	-	5 – 10	-	5 – 10
Cllr Frank Toner, West Lothian Council	15 – 20	-	15 – 20	-	15 – 20
Mr Peter Johnston	15 – 20	-	15 – 20	-	15 – 20
Mr George Walker	5 – 10	-	5 – 10	-	5 – 10
Dr Morag Bryce	5 – 10	-	5 – 10	-	5 – 10
Mrs Julie McDowell	5 – 10	-	5 – 10	-	5 – 10
Dr Richard Williams <sup>Note 2</sup>	120 – 125	-	120 – 125	9	130 – 135
Mr Billy Peacock, Public Partnership Forum Member, (until 30 November 2013)	5 – 10	-	5 – 10	-	5 – 10
Ms Shulah Allan MBE, Public Partnership Forum Member and Vice Chair	15 – 20	-	15 – 20	-	15 – 20
Mr Jeremy Brettell	5 – 10	-	5 – 10	-	5 – 10
Mr Michael Ash	20 – 25	-	20 – 25	-	20 – 25
Ms Kay Blair	5 – 10	-	5 – 10	-	5 – 10
Mr Robert Wilson	5 – 10	-	5 – 10	-	5 – 10
Ms Alison Mitchell	5 – 10	-	5 – 10	-	5 – 10
Mr Graeme Warner	5 – 10	-	5 – 10	-	5 – 10
Mrs Alison Meiklejohn, Chair of Lothian Area Clinical Forum <sup>Note 3</sup>	60 – 65	-	60 – 65	5	65 – 70
<b>Other Senior Employees</b>					
Mr James Forrest, Director of West Lothian Health & Social Care <sup>Note 4</sup>	45 – 50	0.6	45 – 50	64	105 – 110
Mr Peter Gabbittas, Director of Edinburgh Health & Social Care <sup>Note 5</sup>	60 – 65	-	60 – 65	20	80 – 85
Mr David Small, Director of East Lothian Health & Social Care Partnership <sup>Note 6</sup>	45 – 50	-	45 – 50	32	75 – 80
Professor Alex McMahon, Director of Strategic Planning	85 – 90	-	85 – 90	23	110 – 115
Mr Alan Boyter, Director of Human Resources & Organisational Development	130 – 135	-	130 – 135	1	130 – 135
Mr Jim Crombie, Director of Scheduled Care	40 – 45	2.4	40 – 45	46	90 – 95
Mrs Eibhlin McHugh, Director of Midlothian Health & Social Care Partnership (from 1 August 2013) <sup>Note 7</sup>	30 – 35	-	30 – 35	-	30 – 35
Total Members & Senior Employees		3.4		302	

There were no Performance related bonus payable for 2013-14.

**Notes to Remuneration Tables 2(a) & 2(b)**

1. Alex Joyce's gross salary includes £41,000 in respect of non-board duties.
2. Richard Williams's gross salary includes £114,000 in respect of non-board duties.
3. Alison Meiklejohn's gross salary includes £57,000 in respect of non-board duties.
4. 50% of the costs for James Forrest are charged to West Lothian Council.
5. 50% of the costs for Peter Gabbitts are charged to The City of Edinburgh Council.
6. 50% of the costs for David Small are charged to East Lothian Council.
7. Eibhlin McHugh is employed by Midlothian Council and 50% of her salary is recharged to NHS Lothian

## 2(c) Cash Equivalent Transfer Value (CETV) of deferred pension rights 2014/15

	Total accrued pension at age 60 at 31 March (Bands of £5,000)	Real increase in pension at age 60 (Bands of £2,500)	Total accrued lump sum at age 60 at 31 March (Bands of £5,000)	Real increase in lump sum at age 60 (Bands of £2,500)	Cash Equivalent Transfer Value (CETV) at 31 March 2015 £'000	Cash Equivalent Transfer Value (CETV) at 31 March 2014 £'000	Real increase / (Decrease) in CETV in year £'000
<b>Pension Values: Executive Members</b>							
Mr Tim Davison, Chief Executive	65 – 70	0.0 – 2.5	205 – 210	2.5 – 5.0	1,372	1,306	66
Prof Alison McCallum, Director of Public Health and Health Policy	40 – 45	0.0 – 2.5	120 – 125	2.5 – 5.0	860	805	38
Mrs Susan Goldsmith, Director of Finance	35 – 40	0.0 – 2.5	105 – 110	2.5 – 5.0	736	693	25
Ms Melanie Johnson, Executive Director Nursing, AHPs and Unscheduled Care	45 – 50	0.0 – 2.5	140 – 145	2.5 – 5.0	971	916	34
Dr David Farquharson, Medical Director	105 – 110	0.0 – 2.5	315 – 320	5.0 – 7.5	2,358	2,361	(4)
<b>Pension Values: Non Executive Members</b>							
Mr Alex Joyce, Employee Director	15 – 20	0.0 – 2.5	55 – 60	0.0 – 2.5	391	371	16
Mrs Alison Meiklejohn, Chair of Lothian Area Clinical Forum	25 – 30	0.0 – 2.5	80 – 85	0.0 – 2.5	512	485	19
Dr Richard Williams	45 – 50	0.0 – 2.5	140 – 145	2.5 – 5.0	1,091	1,029	45
Cllr Donald Grant	0 - 5	0.0 – 2.5	0 - 5	0.0 – 2.5	7	4	2
Cllr Ricky Henderson	0 - 5	0.0 – 2.5	0 - 5	0.0 – 2.5	5	3	1
<b>Pension Values: Other Senior Employees</b>							
Professor Alex McMahon, Director of Strategic Planning	10 – 15	0.0 – 2.5	35 – 40	2.5 – 5.0	222	199	10
Mr James Forrest, Director of West Lothian Health & Social Care	45 – 50	0.0 – 2.5	135 – 140	0.0 – 2.5	917	880	25
Mr Peter Gabbittas, Director of Edinburgh Health & Social Care	50 – 55	2.5 – 5.0	150 – 155	7.5 – 10.0	984	904	61
Mr David Small, Director of East Lothian Health & Social Care	35 – 40	0.0 – 2.5	105 – 110	5.0 – 7.5	710	650	47
Mr Jim Crombie, Director of Scheduled Care	30 – 35	2.5 – 5.0	95 – 100	7.5 – 10.0	608	544	49
Mr Alan Boyter, Director of Human Resources & Organisational Development	55 – 60	0.0 – 2.5	170 – 175	2.5 – 5.0	1,131	1,080	32
							466

The real discount rate used to evaluate CETV has been as advised by the UK Government Actuaries Department.

Unless also subject to an employment contract with the Board, non executive members have no deferred pension rights under the NHS Superannuation Scheme for Scotland. Such members are therefore not included in the schedule of CETV transfer values above.

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**2(d) Cash Equivalent Transfer Value (CETV) of deferred pension rights 2013/14 (Restated)**

	Total accrued pension at age 60 at 31 March 14 (Bands of £5,000)	Real increase in pension at age 60 (Bands of £2,500)	Total accrued lump sum at age 60 at 31 March (Bands of £5,000)	Real increase in lump sum at age 60 (Bands of £2,500)	Cash Equivalent Transfer Value (CETV) at 31 March 2014 £'000	Cash Equivalent Transfer Value (CETV) at 31 March 2013 £'000	Real increase / (Decrease) in CETV in year £'000
<b>Pension Values: Executive Members</b>							
Mr Tim Davison, Chief Executive from 30 <sup>th</sup> April 2012	65 – 70	0.0 – 2.5	200 – 205	5.0 – 7.5	1,290	1,190	21
Prof Alison McCallum, Director of Public Health and Health Policy	35 – 40	0.0 – 2.5	115 – 120	2.5 – 5.0	795	738	6
Mrs Susan Goldsmith, Director of Finance	30 – 35	0.0 – 2.5	100 – 105	2.5 – 5.0	684	630	8
Ms Melanie Johnson (Hornett), Executive Director of Nursing, AHPs and Unscheduled Care	45 – 50	2.5 – 5.0	135 – 140	7.5 – 10.0	906	813	33
Dr David Farquharson, Medical Director	100 – 105	(2.5) – 0.0	305 – 310	(5.0) – (2.5)	2,333	2,355	(24)
<b>Pension Values: Non Executive Members</b>							
Mr Alex Joyce, Employee Director	15 – 20	0.0 – 2.5	55 – 60	0.0 – 2.5	367	343	3
Mrs Alison Meiklejohn, Chair of Lothian Area Clinical Forum	25 – 30	0.0 – 2.5	75 – 80	0.0 – 2.5	480	449	3
Dr Richard Williams	45 – 50	0.0 – 2.5	135 – 140	2.5 – 5.0	1,017	946	8
Cllr Donald Grant	0 – 5	0.0 – 2.5	0 – 5	0.0 – 2.5	4	2	2
Cllr Ricky Henderson	0 – 5	0.0 – 2.5	0 – 5	0.0 – 2.5	3	1	2
<b>Pension Values: Other Senior Employees</b>							
Professor Alex McMahon, Director of Strategic Planning	10 – 15	0.0 – 2.5	30 – 35	2.5 – 5.0	197	163	15
Mr James Forrest, Director of West Lothian Health & Social Care	40 – 45	5.0 – 7.5	130 -135	17.5 – 20.0	870	716	108
Mr Peter Gabbitas, Director of Edinburgh Health & Social Care	45 – 50	0.0 – 2.5	140 – 145	5.0 – 7.5	893	808	30
Mr David Small, Director of East Lothian Health & Social Care	30 – 35	2.5 – 5.0	100 – 105	7.5 – 10.0	643	555	51
Mr Jim Crombie, Director of Scheduled Care (from 11 November 2013)	25 – 30	2.5 – 5.0	85 – 90	7.5 – 10.0	537	468	35
Mr Alan Boyter, Director of Human Resources & Organisational Development	55 – 60	0.0 – 2.5	165 – 170	0.0 – 2.5	1,068	1,005	(2)
							299

The real discount rate used to evaluate CETV has been as advised by the UK Government Actuaries Department.

Unless also subject to an employment contract with the Board, non executive members have no deferred pension rights under the NHS Superannuation Scheme for Scotland. Such members are therefore not included in the schedule of CETV transfer values above.



## 2(e). Additional disclosure in respect of Hutton Review on Fair Pay in the Public Sector

The Hutton Review reported its recommendations on disclosure of public sector pay in March 2011. The additional disclosure in respect of the highest earning executive member's remuneration is set out below.

	2014/15	2013/14
Highest Earning Member's Total Remuneration Band (£'000)	200 – 205	200 - 205
Median Total Remuneration (£)	£27,424	£28,332
Ratio of Highest Earning Member to Median	7.38	7.15

There is no significant change in the ratio.

### 3. Remuneration Committee

The remit of the Board's Remuneration Committee is to review the performance management and pay arrangements for the Chief Executive, executive directors and senior managers within the Board.

Committee Membership:

Brian Houston (Chair)  
Mr Michael Ash  
Mr George Walker  
Mrs Julie McDowell  
Mr Alex Joyce

During 2014/15 the Remuneration Committee met five times.

### 4. Senior Managers' Remuneration

The Board's policy on senior managers' remuneration is in line with MEL (2000)25 and subsequent guidance, with particular reference to HDL (2006)23 and HDL (2006)59.

The Board operates an appraisal system for all staff where personal development plans and objectives are agreed. Performance is assessed at half-yearly and at annual appraisals. Appraisals of Executive Directors are done by the Chief Executive. Appraisal of the Chief Executive is carried out by the Chairman. Outstanding Performance Awards are robustly reviewed and approved by the Remuneration Committee. The Committee also approves the individual objectives and assessment of those objectives of the Executive Directors within the Board.

Although Mr. John Matheson, the former Director of Finance, continues to be employed and paid by NHS Lothian, his remuneration since July 2008 is fully recharged to the Scottish Government Health and Social Care Directorate on a secondment basis, and is included in Notes 2(a) and 2(b) to the Annual Accounts.

24 June 2015 ..... Chief Executive and Accountable Officer

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**STATEMENT OF THE CHIEF EXECUTIVE’S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE HEALTH BOARD**

Under Section 15 of the Public Finance and Accountability (Scotland) Act, 2000, the Principal Accountable Officer (PAO) of the Scottish Government has appointed me as the Accountable Officer of the Board.

This designation carries with it responsibility for:

- The propriety and regularity of financial transactions under my control
- For the economical, efficient and effective use of resources placed at the Board’s disposal and
- Safeguarding of the assets of the Board.

In preparing the accounts I am required to comply with the requirements of the Government’s Financial Reporting Manual (FReM) and in particular to:

- Observe the accounts direction issued by Scottish Ministers including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the FReM have been followed and disclose and explain any material departures
- Prepare the accounts on a going concern basis.

I am responsible for ensuring proper records are maintained and that the Accounts are prepared under the principles and in the format directed by Scottish Ministers. To the best of my knowledge and belief, I have properly discharged my responsibilities as Accountable Officer as intimated in the Departmental Accountable Officers’ letter to me of the 28 April 2012.

24 June 2015 ..... Chief Executive and Accountable Officer

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STATEMENT OF HEALTH BOARD MEMBERS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

Under the National Health Service (Scotland) Act 1978, the Health Board is required to prepare accounts in accordance with the directions of Scottish Ministers which require that those accounts give a true and fair view of the state of affairs of the Health Board as at 31 March 2015 and of its operating costs for the year then ended. In preparing these accounts the Directors are required to:

- Apply on a consistent basis the accounting policies and standards approved for the NHS Scotland by Scottish Ministers.
- Make judgements and estimates that are reasonable and prudent.
- State where applicable accounting standards, as set out in the Financial Reporting Manual (FRM), have not been followed where the effect of the departure is material.
- Prepare the accounts on the going concern basis unless it is inappropriate to presume that the Board will continue to operate.

The Health Board members are responsible for ensuring that proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position of the Board and enable them to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of Scottish Ministers. They are also responsible for safeguarding the assets of the Board and hence taking reasonable steps for the prevention of fraud and other irregularities.

The NHS Board members confirm they have discharged the above responsibilities during the financial year and in preparing the accounts.

..... Director of Finance

..... Chairman

24 June 2015

**GOVERNANCE STATEMENT**

As Accountable Officer, I have responsibility for maintaining an adequate and effective system of internal control that supports the achievement of Lothian NHS Board (“the Board”) policies and promotes achievement of the Board’s aims and objectives, including those set by Scottish Ministers. I am also responsible for safeguarding the public funds and assets assigned to the Board.

In accordance with IAS 27 – Separate Financial Statements, the Financial Statements consolidate the Lothian Health Board Endowment Fund (SC007342). This statement includes any relevant disclosure in respect of these Endowment Accounts

**Purpose of System of Internal Control**

The system of internal control is based on an ongoing process designed to identify and mitigate the principal risks facing the organisation. The system aims to evaluate the nature and extent of those risks and to manage them efficiently, effectively and economically. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the Board’s policies, aims and objectives. As such it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year up to the date of the approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for efficiency, effectiveness and economy and promotes good practice and high standards of propriety.

**Governance Framework**

The Directors’ Report (at pages 19 - 25) of these accounts sets out the structure of the Board’s system of corporate governance. During 2014/15 the Board has maintained this structure by updating the membership of committees as and when required, and also reviewing and updating the terms of reference of the staff governance, remuneration, and acute hospitals committees. The Board routinely receives the minutes of committee meetings, with accompanying summaries from the committee chairs. I am a member of the Board, and consequently I am routinely informed of the output of work from all committees.

The Scottish Government issues circulars and other material from time to time which are directly relevant to the terms of reference of committees, e.g. the Audit Committee Handbook which is part of the Scottish Public Finance Manual, and the Staff Governance Standard. The Board develops the committee terms of reference so as to comply with these requirements.

The chairs of Board committees meet monthly with the Board Chairman, and this provides an additional opportunity for the chairs to discuss any governance matters of common interest.

The Strategic Report (at pages 3 - 18) describes the organisation’s business model, the Board’s approach to setting strategic direction, and how outcomes (in terms of performance) are established.

During 2014/15 the Board reviewed its Standing Orders, Scheme of Delegation, and the Code of Conduct for Board members. The revised Standing Orders confirmed that the matters reserved to the Board are:

- Standing Orders
- The establishment of, the terms of reference, and appointment of membership for all of its committees.
- Organisational Values.
- Strategic Planning
- The approval of its Local Delivery Plan before it is submitted to the Scottish Government.
- Corporate Objectives.
- Risk Management Policy, Risk Appetite and associated risk tolerance levels.

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- Health & Safety Policy.
- Financial Plan and the opening revenue and capital budgets for the forthcoming year.
- Standing Financial Instructions and a Scheme of Delegation.
- The Board annual accounts and report.
- Business cases that are beyond the scope of the Board's delegated financial authority (per the Scottish Capital Investment Manual)
- The content, format, and frequency of performance reporting to the Board
- The system for responding to any civil actions raised against the Board, as well as the system or responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence
- Any other item of business that the Board may be required by law or Scottish Government direction to approve e.g. the Integration Schemes for a local authority area.

The Directors' Report (at pages 19-25) provides further information on the Board, its committees, and how they have operated throughout the year.

The Board approved its 2014/15 Corporate Objectives in June 2014. These Corporate Objectives were aligned to the Scottish Government's triple aims for achieving the 2020 Vision for Health and Social Care, namely, improving the quality of care, improving the health of the population, and securing value and financial sustainability. The Corporate Objectives also cross-referred to the propositions in the Board's Strategic Plan (*Our Health, Our Care, Our Future*), as well as the risks on the Board's corporate risk register.

The Board has a Whistleblowing Policy. This is one of many human resources ("HR") policies which are available on the HR Online site on the Board's intranet. HR Online provides access to all human resources policies and procedures, and associated flow charts, tools & templates, and Frequently Asked Questions to support the understanding and effective implementation of policies. HR Online also has an HR Enquiry facility where a query regarding any HR issue can be emailed and a response will be provided. The Board routinely uses the internal bulletin, the Team Brief, to communicate when any new HR policy has been agreed. Additionally in April 2013 the National Confidential Alert Line was launched initially as a one-year pilot, and then subsequently extended for a further two years. Management have raised awareness of the National Confidential Alert Line through an internal communications exercise, which included placing posters on staff notice boards throughout NHS Lothian.

The Board has been concerned with its systems for handling and responding to feedback and complaints from patients and the public, as well as the processes for ensuring that the feedback leads to improvement in services. The Board commissioned an independent review and the report, *Listening and Learning from Feedback and Complaints*, was published in January 2015. Management ran four consultation events during February 2015 to allow a wide audience to consider and discuss the results of the review. The Board received the report, the results of the consultation, and an action plan at its meeting in April 2015.

The Board has a Public Involvement Co-ordinator and a Parliamentary Liaison Officer within its communications team, to ensure that public and political stakeholders are kept well informed and consulted on issues affecting health and care services. The Board approved an *Involving People Framework 2014-2017* in June 2014, which has taken into account the principles and propositions within the Board's Strategic Plan.

The Board approved a Corporate Communications Strategy (and associated action plan) in June 2014, with the aim to continuously improve its arrangements for engagement with all stakeholders.

The Board has had the topic of integration, the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014, on the agenda of every Board meeting during 2014/15. This subject radically changes the business model of the Board, and effectively means that a large proportion of the Board's functions will now be carried out by four new public bodies (integration joint boards) rather than the Board itself. The Strategic Report, at pages 3-18, provides further detail on this subject.

Integration will have an impact on all aspects of the Board's systems for corporate governance. The Board and each local authority for the respective local authority area set out in their integration schemes how they will adapt their systems of governance, so as to allow the new integration joint boards to effectively discharge their role for the delegated "integration functions". Throughout 2015/16 further work will be undertaken, together with the new

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integration joint boards, to develop sustainable and effective systems of governance, which will allow members of integration joint boards to have oversight of integration functions.

In taking forward the integration agenda, the Board is building on and developing its existing systems to deliver continuous improvement. The integration joint boards must develop their strategic plans with due regard to the integration delivery principles and the national health & wellbeing outcomes, which are all pertinent to the themes of Best Value. In addition to integration, Best Value is being progressed through various initiatives which have been set out within the Strategic Report and this Governance Statement.

The Board held a development session in March 2014, which was informed by the results from a member survey using the NHS Scotland Board Diagnostic Self-Assessment tool. This session identified the need to improve the systems for performance management, and to address the quality and volume of information that is presented to the Board so as to better focus the Board's attention on key strategic issues.

With regard to performance management, the work on integration schemes quickly led to the principle that in the future the new integration joint boards will become the primary focal point for performance management of the integration functions, rather than the NHS Board. Consequently the continuing work on integration systems will lead to the development of a long term solution for performance management. This will be informed by work that was undertaken during 2014/15 to map out the Board's current performance standards, targets and strategies, many of which directly relate to integration functions. The Board has already revised the membership and terms of reference of its strategic planning committee in light of integration, and other committees will be reviewed in 2015/16.

Several things have been progressed to improve the quality and volume of papers. Committee chairs now present an executive summary of the key issues raised in committee meetings, to accompany the minutes. The Board has continued with the "consent agenda" technique, to focus meeting time on the issues that are agreed by all to require discussion amongst the members. The Board approved its system of risk appetite and risk tolerance reporting during the year. The Board also clarified which matters are reserved to the Board in its review of its Standing Orders.

The Corporate Management Team recognises that more work needs to be done to improve the content of papers that are presented to the Board, its committees, and management meetings. This was discussed and agreed at the Corporate Management Team meeting in May 2015 and will be progressed during 2015/16.

**Process to Review Adequacy and Effectiveness**

As Accountable Officer I also have responsibility for reviewing the effectiveness of the system of internal control. The following processes have been established to inform my review of the effectiveness of the system of internal control.

The executive Board members and other senior managers convene formally on a monthly basis as the Corporate Management Team to discuss and progress the delivery of the Board's business. The Corporate Management Team also meets informally twice a month. I chair the Corporate Management Team meetings.

As part of the system of risk management, I chair a monthly Risk Management Steering Group. The role of the Group is to provide a leadership role and develop, review and oversee the implementation of NHS Lothian's Risk Management Policy and Procedure. The Risk Management Steering Group includes the Corporate Management Team and others involved in the management of risk. The Risk Management Steering Group produced an annual report on its activities which informed this statement.

Additionally my direct reports have provided me with certificates of assurance which have been informed by reviews of their systems of internal control, as required by the Scottish Public Finance Manual.

The Directors' report (page 22) sets out the committee structure of the Board. The committees provide governance oversight on the Board's activities on behalf of the Board. Their work also supports my role as Accountable Officer. This Governance Statement has been informed by the annual reports of the following committees:

- Audit & Risk Committee
- Healthcare Governance Committee
- Finance & Resources Committee
- Staff Governance Committee
- Information Governance Assurance Group (which reports into the Healthcare Governance Committee)

The Committee annual reports have three broad sections:

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1. Review of the effectiveness of the committee
2. Review of the adequacy and effectiveness of the systems of governance and internal control for the areas within the committee's remit. This includes a summary of the areas of high risk identified at the year end.
3. An assurance statement for the purposes of informing this Governance Statement.

The committees have confirmed through their annual reports that they have worked effectively in 2014/15. The committees have also confirmed that they are satisfied that where there are any areas of control weakness, these have been properly acknowledged and have been reflected into the Board's risk management processes.

The Board routinely receives the minutes of committees along with a summary report from the committee chair.

My review is also informed by the work of the Board's internal auditors and external auditors. I routinely attend the Audit & Risk Committee where all audit reports are considered, and all internal audit reports are also received at the Risk Management Steering Group.

In her annual report for 2014/15, the Chief Internal Auditor has provided the following internal audit opinion:

"Overall, internal audit's work indicates that NHS Lothian has a framework of controls in place that provides reasonable assurance regarding the effective and efficient achievement of the organisation's objectives and the management of key risks.

Proper arrangements are in place, in the areas internal audit has reviewed, to promote value for money, deliver best value and secure regularity and propriety in the administration and operation of the organisation."

**Risk Assessment**

The Board has a Risk Management Policy and Operational Procedure which was published in June 2012. The Audit & Risk Committee has governance oversight of system of risk management system, and that committee receives a report on risk management at every meeting. Other committees have responsibility for oversight of specific categories of risk. The Staff Governance Committee has oversight of risks relating to the Board's legal duty in relation to the governance of staff. The Healthcare Governance Committee has oversight of clinical risks and all matters relating to the Board's legal duty to monitor and improve the quality of health care which it provides. The Healthcare Governance Committee also provides oversight to the Board's responsibilities for information governance, through the Information Governance Assurance Board.

The Board has also reviewed the corporate risk register and an associated briefing in August 2014, October 2014, December 2014 and February 2015. The Board has also considered several papers relating to the risks associated with the workforce. Board papers are accessible to the public on the Board's website at:

<http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Pages/default.aspx>

Executive management are responsible for the implementation of risk management. As the Accountable Officer, I am required to ensure that risks are identified, that their significance is assessed and that appropriate remedial action is taken to reduce risk exposure, or eliminate it where possible. I have delegated the executive responsibility for the system of risk management to the Medical Director who is supported by an Associate Director for Quality Improvement & Safety.

The Risk Management Policy sets out the responsibility for managing risk at different levels in the organisation, and is clear that all employees have a role to play in managing risk in the organisation and that risk should be managed at the most devolved point in the organisation. The Board has a risk management system (DATIX), which has modules on risk management and adverse event management, which supports an organisation-wide approach to risk management.

In addition to the core risk management systems, there are also structures and systems in place to manage key risks on a topic basis, e.g. health & safety, patient safety, business continuity management, emergency planning and infection control.

The Risk Management Steering Group ("RMSG") (which I chair) ensures that there is executive management scrutiny of risks and the system of risk management on a monthly basis. The Audit & Risk Committee received the 2014/15 Risk Management Annual Report on 20 April 2015, and the key points are summarised below.

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The Board approved its risk appetite statement in February 2014. The Board approved the reporting framework to monitor its appetite against risk tolerance measures in August 2014, and it forms part of the regular reporting on the corporate risk register to the Board and the Audit & Risk Committee. This framework has shown that the Board is operating beyond the tolerances of its risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4). The Board is also operating beyond the tolerances of its risk appetite with respect to ensuring a sustainable financial framework.

The RMSG reviewed the controls and adequacy of controls of the corporate risk register along with rationale for risks that had been assessed as having either “inadequate” or “uncertain” systems of control, and reported the results of this exercise to the Audit & Risk Committee in June 2014.

The RMSG reviewed the corporate risk register again in December 2014 to ensure that the risk register adequately reflected NHS Lothian’s current challenges, and reported the results to the Audit & Risk Committee in February 2015 Audit & Risk Committee paper. The impact of this review was to reduce the number of risks, and revise the relative significance of the ones that did remain. The Board approved the revised corporate risk register in April 2015 which contained ten risks as follows:-

1. Healthcare Associated Infections
2. The scale or quality of the Board’s services is reduced in the future due to failure to respond to the financial challenge
3. Achieving the 4-hour emergency care target
4. Achieving the delayed discharge targets at 2 and 4 weeks
5. Delivery of the Scottish Patient Safety Programme work programme
6. Achievement of the national waiting times targets
7. Management of complaints and feedback
8. Medical workforce sustainability
9. Management of violence and aggression
10. Health and Social Care Integration

In June 2014 the Audit & Risk Committee approved a review of NHS Lothian’s risk management system using the Audit Scotland Best Value Toolkit for Risk Management. The RMSG considered the results of this review in March 2015, and they have informed an improvement plan which was presented to the June Audit & Risk Committee in June 2015.

The Board has an Adverse Event Policy and Procedure which the Healthcare Governance Committee approved in March 2014. Management developed an improvement plan to support its effective implementation, and the Healthcare Governance Committee monitors that plan. The plan has seven key domains/drivers for change. The 2014/15 Risk Management Annual Report provided an extensive list of examples of actions taken during 2014/15 to effectively implement this policy and procedure.

Executive management will continue to improve the systems for risk management throughout 2015/16. The priorities will be to implement the improvement plan arising from the Best Value Toolkit review, and improving reporting, monitoring and learning from significant adverse events.

**Disclosures**

My review of the effectiveness of the system of internal control has identified a number of issues which are appropriate for disclosure in this Governance Statement, and these are set out below.

NHS Lothian continues to hold equipment that cannot be encrypted without breaching the Medicines and Healthcare Products Regulatory Agency licence, and some out of date equipment that cannot be encrypted. Some services cannot store audiovisual clinical data on a secure electronic system. The Information Governance Assurance Group has highlighted this issue to the responsible directors. Services using audiovisual recording for diagnosis and treatment are using workarounds and, where notified, these are risk assessed and risks managed to enable clinical services to continue. In order to address these information security risks, management shall continue to review risks on a case by case basis when identified by the service, and appropriate mitigation to minimise risk will be agreed for local management.

Some departments have had to continue with using faxes or hard copy documents to transfer sensitive personal data to other departments. The Board’s standard is for such transfers to be carried out securely on IT systems. There are



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planned IT developments, both local and national, which will eventually eliminate the use of fax and hard copy. In the meantime any exceptional processes are clearly documented and risk assessed, with local departments responsible for managing the risk.

The Information Commissioner's Office (ICO) has been considering for some time whether or not to take any regulatory action in relation to several historic incidents relating to personal data. The ICO confirmed on 5 March 2015 that there were a number of areas where additional work was required before they could confirm whether any regulatory action will be required. Management are satisfied that adequate action has already been taken to address the root causes of the incidents being considered, but awaits ICO confirmation that this is acceptable.

The Board has failed to achieve its HEAT targets for healthcare associated infections. The rates of infection are not improving to the same degree as seen in other health boards. The Board has received a paper on healthcare associated infections at every meeting during 2014/15, and these set out the actions being taken forward to address the issue, as well as providing assurance on compliance with relevant policies and procedures. Management have taken forward work to implement the recommendations from the Vale of Leven enquiry. The Board was advised in April 2015 that these recommendations are either mostly implemented or partially implemented in NHS Lothian. During 2014/15 the Healthcare Environment Inspectorate has performed safety and cleanliness inspections at the Western General Hospital, St John's Hospital, and Ellen's Glen House. With regard to the Western General, the Inspectorate concluded that NHS Lothian was not complying with the NHS Quality Improvement Scotland HAI standard, and requested a 16 week update on the action plan developed following the Western General Hospital. As part of the Board's 2015/16 internal audit plan, internal audit will follow up management's progress in implementing that action plan.

The physical environment of the Western General Hospital site requires significant development, as there are many issues which can create risks with regard to patient experience, health & safety, infection control, and operational capacity. The Board has recognised the backlog maintenance risk is the largest quantum for an individual site and is in the final stages of developing a site master plan. This will set out the how the site may be re-developed over the long term to create a sustainable solution if funding permits. It will also take into account implementation of projects over the short term.

On 30 March 2015 the Scottish Fire & Rescue Service served an enforcement notice with respect to the Clock Tower Building at the Western General Hospital. On 28 May the Director of Human Resources & Organisational Development wrote to the Service to confirm that the majority of actions had been closed down, and provide an action plan for what remained. The letter included a request for a 20-day extension to the compliance deadline, to allow for the delivery and fitting of intumescent grilles, which had proven to be more difficult to source than originally envisaged. The Service granted the extension.

The Board has experienced difficulties with the management of complaints and patient feedback for some time. The Board commissioned an independent report into the subject, *Listening & Learning From Feedback and Complaints* (January 2015). At its meeting of 1 April 2015, the Board received a paper covering the broader subject of person-centred culture, feedback and complaints. It was agreed that the corporate responsibility for feedback and complaints should transfer to the Nurse Director from 1 May 2015, and that she should develop and implement an action plan to progress the issues raised in the report. The Healthcare Governance Committee will monitor the action being taken, so as to be assured that there is an adequate complaints management system in place, and the Board will be provided with regular reports.

The Board has not produced an annual pharmaceutical care services plan due to a shortage in staffing capacity. The Board is required to produce a plan by regulations. This plan will be produced in 2015/16, and will progressed with the development of clinical pathways, and work with the integration joint boards and acute services

NHS Scotland Counter Fraud Services are undertaking a major case involving a former employee, which covers offences carried out in previous years. The Board's internal auditors will be asked to carry out a comprehensive review of this case, with a view to identify to what extent the Board's systems of internal control facilitated the events. The review will also identify where the systems of control can be strengthened, so that the Board may do all that it reasonably can to prevent such incidents in the future.

The Corporate Management Team considered a report on data quality on 9 March 2015. It specifically highlighted that there were opportunities to improve the processes of recording of the discharge time of A&E patients. However following very robust analysis of the issue, it was confirmed that the problem is not caused by wilful manipulation of data, but rather the need to improve the understanding of the procedure, and to develop system solutions so that reliable data is always available to accurately record the discharge time. An updated standing operating procedure

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will be implemented across all sites during 2015/16. There will also be work undertaken to update the reporting processes for delayed discharge reporting, in light of new requirements to produce the figure several times within a month.

There are problems with data quality throughout the organisation, particularly in relation to unscheduled care. There needs to be significant improvements to the systems of internal control on data entry into TRAK, so that users of TRAK have confidence in the system as a basis for decision-making. It has been agreed that resources available with strategic planning will be re-structured in order to apply the same systematic rigour that is successfully applied to scheduled care waiting times systems, to all other systems.

It is anticipated that the integration joint boards will require public health intelligence and expertise in order to effectively discharge their role. At the moment the public health function does not have dedicated resource to address the intelligence demands, as it is part of the wider strategic planning function. This issue will be re-examined as part of the above mentioned re-structuring exercise. The Corporate Management Team will consider a comprehensive action plan in September 2015 to address these issues.

As part of the 2014/15 internal audit plan, the internal auditors reviewed arrangements in place for managing and monitoring compliance with policies & procedures. Whilst they found that there was an adequate framework of policies & procedures in place, the report concluded that managers are not able to demonstrate that staff are aware of and complying with all mandatory policies. The report also highlighted that there was data available within the organisation, and findings from other audits, which provided evidence of continued non-compliance with policies in some areas. This is a recognised issue for training grade medical staff (who may be only at the Board for four months at a time). Material has been developed covering Lothian, Borders and Fife to give FY1s and FY2s a competent induction, however there is no system to provide assurance that all levels of training grades are aware of all relevant policies.

It is recognised that what is required is a change in organisational culture to ensure there is an understanding at every level of the organisation, as to how to embed systems of control which will routinely provide assurance on compliance. In response to this a working group is being set up to take this forward. The chair of this working group will provide regular reports to the Corporate Management Team, and a progress report to the Audit & Risk Committee in December 2015.

The Board is facing a significant financial challenge going into 2015/16, and the Corporate Management Team, the Finance & Resources Committee and the Board have scrutinised this issue throughout 2014/15. The challenge is also set out in the Board's Local Delivery Plan. The Board received a Financial Plan 2015/16-2019/20 on 1 April 2015 which set out all the risks and assumptions. The Finance & Resources Committee considered the final draft of the financial plan at its meeting on the 11 March 2015 and agreed to recommend it for approval to the Board. This approval was subject to further work taking place to make assumptions in the plan on capacity explicit.

Throughout the year the Finance & Resources Committee has reviewed many business cases, strategies, as well as the financial position. The committee has on several occasions identified the need for more objective evidence to support the analysis of issues and decision-making. There are opportunities to improve how the likely impact of decisions on the Board's activity and finances, its outcomes, and efficiency & productivity are articulated. Given the increasing financial challenges that the Board has, it is essential that there are improvements in this area. The Committee has concluded that it does not have a clear understanding as to what the organisation's baseline operational capacity is, e.g. how many patients is each service able to treat in any given year? Without an understanding of that baseline, it is difficult to evaluate the merits of any given proposal, and monitor the impact of any actions taken on that baseline.

To help address this issue, the Board and the Scottish Government have commissioned Deloitte to carry out a data diagnostic review. The aims of the review are:

- To understand current practice and make recommendations as to how NHS Lothian could generate management information in a consistent, reliable and insightful way.
- To define key metrics and support the development of a "balanced scorecard" for use at a strategic level (Corporate Management Team or Board) to inform their decision making.
- To identify and evaluate areas of opportunity to reduce variation; improve productivity; and, maintain or improve quality.

The previously referred to work on improving the quality of papers that are presented to formal meetings, should also assist the Finance & Resources Committee in the conduct of its business.

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During the year I established and chaired a “Delivering Financial Balance” Core Steering Group, and this will continue to provide further executive focus on addressing the financial risks and the delivery of efficiencies.

The Board annually spends approximately £5m on locum medical staff. The Board has systems of control for this topic however in some service areas there is evidence of non-compliance with those systems, leading to some locums receiving a higher rate of pay than what has been agreed through contracting. The Board has an opportunity to make significant savings if all locums were engaged on the contracted rates. Management have an action plan in place to eliminate off-contract supply, and this will be progressed during 2015/16.

The Finance & Resources Committee has requested that further steps are taken to ensure that business cases, and the services they affect, are designed so as to ensure the revenue consequences are affordable. Whilst the Corporate Management Team already rigorously scrutinise all business cases before they are presented to the Committee, nevertheless business cases are still presented that rely on the delivery of efficiency savings in order to fund the revenue consequences of a business case. The Core Steering Group will examine this issue further in 2015/16.

The four new integration joint boards will be established during 2015/16, and the Board and the local authorities will delegate functions to them once the integration joint boards have each approved their strategic plan and stipulated a start day. It is anticipated that the start day will be 1 April 2016. 2015/16 will therefore be a preparatory shadow year, during which the NHS Board and the local authorities will be undertaking financial assurance work in relation to the resources that will be paid over to the integration joint boards, or set aside for their use. This work has already started, with due regard to the Scottish Government’s guidance on integration financial assurance. This work has already identified significant financial risks for the Edinburgh integration joint board, in light of the challenges it faces and the level of resources being allocated to it.

The integration joint boards, once established, will formally assess whether the resources to be made available to them are adequate for it to deliver its objectives and that the associated risks and assumptions are reasonable and clearly understood. The financial assurance work will be undertaken every financial year. Integration does offer many opportunities to improve planning, service delivery and health & wellbeing outcomes. However the creation of four new public bodies with the autonomy to determine their own approach and plans does complicate the arrangements for the financial governance of health and social care functions in Lothian. The NHS Board is a party to four integration schemes, and within them all are clear commitments to develop integrated governance arrangements. This work is being taken forward, and a project plan is in place.

..... Chief Executive and Accountable Officer

24th June 2015

## **Independent auditor's report to the members of Lothian Health Board, the Auditor General for Scotland and the Scottish Parliament**

I have audited the financial statements of Lothian Health Board and its group for the year ended 31 March 2015 under the National Health Service (Scotland) Act 1978. The financial statements comprise the Statement of Consolidated Comprehensive Net Expenditure, the Consolidated Balance Sheet, the Statement of Consolidated Cash Flow, the Statement of Consolidated Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2014/15 Government Financial Reporting Manual (the 2014/15 FReM).

This report is made solely to the parties to whom it is addressed in accordance with the Public Finance and Accountability (Scotland) Act 2000 and for no other purpose. In accordance with paragraph 125 of the Code of Audit Practice approved by the Auditor General for Scotland, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

### **Respective responsibilities of Accountable Officer and auditor**

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Health Board, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and is also responsible for ensuring the regularity of expenditure and income. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) as required by the Code of Audit Practice approved by the Auditor General for Scotland. Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors. I am also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Public Finance and Accountability (Scotland) Act 2000.

### **Scope of the audit of the financial statements**

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances of the board and its group and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. It also involves obtaining evidence about the regularity of expenditure and income. In addition, I read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements, irregularities, or inconsistencies I consider the implications for my report.

### **Opinion on financial statements**

In my opinion the financial statements:

- give a true and fair view in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers of the state of affairs of the board and its group as at 31 March 2015 and of their net operating costs for the year then ended;
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2014/15 FReM; and
- have been prepared in accordance with the requirements of the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

### **Opinion on regularity**

In my opinion in all material respects the expenditure and income in the financial statements were incurred or applied in accordance with any applicable enactments and guidance issued by the Scottish Ministers.

**Opinion on other prescribed matters**

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers; and
- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which I am required to report by exception**

I am required to report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- I have not received all the information and explanations I require for my audit; or
- the Governance Statement does not comply with guidance from the Scottish Ministers; or
- there has been a failure to achieve a prescribed financial objective.

I have nothing to report in respect of these matters.

David McConnell  
Assistant Director  
Audit Scotland  
4th Floor South Suite  
The Athenaeum Building  
8 Nelson Mandela Place  
GLASGOW  
G2 1BT

*June 2014*

## STATEMENT OF CONSOLIDATED COMPREHENSIVE NET EXPENDITURE

## FOR THE YEAR ENDED 31 MARCH 2015

Restated 2013 - 14 £'000		Note	£'000	£'000
	<b>Clinical Services Costs</b>			
1,321,341	Hospital and Community	<u>4</u>	1,370,280	
(249,457)	Less: Hospital and Community Income	<u>8</u>	(250,529)	
1,071,884				1,119,751
354,130	Family Health	<u>5</u>	358,607	
(10,986)	Less: Family Health Income	<u>8</u>	(11,456)	
343,144				347,151
<b>1,415,028</b>	<b>Total Clinical Services Costs</b>			<b>1,466,902</b>
9,852	Administration Costs	<u>6</u>		9,206
47,907	Other Non Clinical Services	<u>7</u>	4,860	
(46,466)	Less: Other Operating Income	<u>8</u>	(4,207)	
1,441				653
<b>1,426,321</b>	<b>Net Operating Costs</b>			<b>1,476,761</b>
	<b>OTHER COMPREHENSIVE NET EXPENDITURE</b>			
(24,742)	Net gain on revaluation of Property Plant and Equipment	<u>SOCTE</u>		(33,757)
550	Net loss on revaluation of available for sale financial assets			0
(2,348)	Unrealised & realised gains on Foundation investment assets	<u>SOCTE</u>		(4,900)
0	Reclassification of realised gains to net expenditure in year	<u>SOCTE</u>		474
(26,540)	Other Comprehensive Expenditure			(38,183)
<b>1,399,781</b>	<b>Total Comprehensive Expenditure</b>			<b>1,438,578</b>

<b>SUMMARY OF CORE REVENUE RESOURCE OUTTURN</b>	<b>£'000</b>	<b>£'000</b>
<b>Net Operating Costs</b>		<b>1,476,761</b>
Total Non Core Expenditure (see below)		(65,002)
FHS Non Discretionary Allocation		(82,029)
Donated Assets Income		968
Endowment Net Operating Costs		(2,889)
<b>Total Core Expenditure</b>		<b>1,327,809</b>
Core Revenue Resource Limit		1,328,048
<b>Saving/(excess) against Core Revenue Resource Limit</b>		<b>239</b>

<b>SUMMARY OF NON CORE REVENUE RESOURCE OUTTURN</b>		
Capital Grants to / (from) Other Bodies	18,843	
Depreciation/Amortisation	37,848	
Annually Managed Expenditure - Impairments	8,591	
Annually Managed Expenditure - Creation of Provisions	(5,853)	
Annually Managed Expenditure – Depreciation of Donated Assets	663	
Additional SGHSCD non core funding	3,553	
IFRS PFI Expenditure	1,357	
<b>Total Non Core Expenditure</b>		<b>65,002</b>
Non Core Revenue Resource Limit		65,002
<b>Saving/(excess) against Non Core Revenue Resource Limit</b>		<b>0</b>

<b>SUMMARY RESOURCE OUTTURN</b>	<b>Resource</b>	<b>Expenditure</b>	<b>Saving / (Excess)</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
Core	1,328,048	1,327,809	239
Non Core	65,002	65,002	0
<b>Total</b>	<b>1,393,050</b>	<b>1,392,811</b>	<b>239</b>

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CONSOLIDATED BALANCE SHEET

Restated Consolidated 2013 £'000	Board 2013 £'000	Restated Consolidated 2014 £'000	Board 2014 £'000	Note	Consolidated 2015 £'000	Board 2015 £'000	
<b>Non-current assets:</b>							
770,378	770,378	785,329	785,329	Property, plant and equipment	11d	810,978	810,978
5,983	5,983	2,624	2,624	Intangible assets	10	2,168	2,168
Financial assets:							
65,302	34	67,499	34	Available for sale financial assets	14	72,346	1,266
23,078	23,078	25,148	25,148	Trade and other receivables	13	22,234	22,234
<b>864,741</b>	<b>799,473</b>	<b>880,600</b>	<b>813,135</b>	<b>Total non-current assets</b>		<b>907,726</b>	<b>836,646</b>
<b>Current Assets:</b>							
13,435	13,435	14,393	14,393	Inventories	12	16,183	16,183
Financial assets:							
79,369	79,131	77,158	76,470	Trade and other receivables	13	86,981	86,648
5,531	1,374	5,845	1,133	Cash and cash equivalents	15	5,066	492
4,855	4,855	1,511	1,511	Assets classified as held for sale	11c	1,776	1,776
<b>103,190</b>	<b>98,795</b>	<b>98,907</b>	<b>93,507</b>	<b>Total current assets</b>		<b>110,006</b>	<b>105,099</b>
<b>967,931</b>	<b>898,268</b>	<b>979,507</b>	<b>906,642</b>	<b>Total assets</b>		<b>1,017,732</b>	<b>941,745</b>
<b>Current liabilities</b>							
(45,365)	(45,365)	(56,515)	(56,515)	Provisions	17	(35,096)	(35,096)
Financial liabilities:							
(233,807)	(232,700)	(201,379)	(197,465)	Trade and other payables	16	(194,040)	(188,541)
<b>(279,172)</b>	<b>(278,065)</b>	<b>(257,894)</b>	<b>(253,980)</b>	<b>Total current liabilities</b>		<b>(229,136)</b>	<b>(223,637)</b>
<b>688,759</b>	<b>620,203</b>	<b>721,613</b>	<b>652,662</b>	<b>Non-current assets plus/(less) net current assets/(liabilities)</b>		<b>788,596</b>	<b>718,108</b>
<b>Non-current liabilities</b>							
(64,464)	(64,464)	(68,531)	(68,531)	Provisions	17	(61,917)	(61,917)
Financial liabilities:							
(195,853)	(195,853)	(191,457)	(191,457)	Trade and other payables	16	(204,339)	(204,339)
<b>(260,317)</b>	<b>(260,317)</b>	<b>(259,988)</b>	<b>(259,988)</b>	<b>Total non-current liabilities</b>		<b>(266,256)</b>	<b>(266,256)</b>
<b>428,442</b>	<b>359,886</b>	<b>461,625</b>	<b>392,674</b>	<b>Assets less liabilities</b>		<b>522,340</b>	<b>451,852</b>
<b>Taxpayers' Equity</b>							
193,535	193,535	211,326	211,326	General fund	SOCTE	249,926	249,926
166,351	166,351	181,348	181,348	Revaluation reserve	SOCTE	201,926	201,926
68,556	0	68,951	0	Fund held on Trust	SOCTE	70,488	0
<b>428,442</b>	<b>359,886</b>	<b>461,625</b>	<b>392,674</b>	<b>Total taxpayers' equity</b>		<b>522,340</b>	<b>451,852</b>

The Notes to the Accounts, numbered 1 to 32, form an integral part of these Accounts.

..... Director of Finance

..... Chief Executive

24 June 2015



## STATEMENT OF CONSOLIDATED CASH FLOW

Restated 2013-14 £'000		Note	£'000	£'000
<b>Cash flows from operating activities</b>				
(1,426,321)	Net operating cost	<a href="#">SOCNE</a>	(1,476,761)	
42,757	Adjustments for non-cash transactions	<a href="#">3</a>	49,993	
29,526	Add back: interest payable recognised in net operating cost	<a href="#">3</a>	28,972	
(2,768)	Deduct: interest receivable recognised in net operating cost		(1,631)	
(332)	Investment income		(310)	
(828)	(Increase) / decrease in trade and other receivables		(7,663)	
(958)	(Increase) / decrease in inventories		(1,790)	
(35,157)	Increase / (decrease) in trade and other payables		9,549	
15,217	Increase / (decrease) in provisions		(28,033)	
<b>(1,378,864)</b>	<b>Net cash outflow from operating activities</b>			<b>(1,427,674)</b>
<b>Cash flows from investing activities</b>				
(27,238)	Purchase of property, plant and equipment		(44,478)	
(298)	Purchase of intangible assets	<a href="#">10</a>	(930)	
3,895	Proceeds of disposal of property, plant and equipment		2,518	
0	Investment Additions		(1,233)	
(392)	Receipts from sale of investments		(103)	
3,100	Interest received		1,941	
<b>(20,933)</b>	<b>Net cash outflow from investing activities</b>			<b>(42,285)</b>
<b>Cash flows from financing activities</b>				
1,433,586	Funding		1,502,946	
(241)	Movement in general fund working capital		(641)	
1,433,345	Cash drawn down	<a href="#">SOCTE</a>	1,502,305	
(3,708)	Capital element of payments in respect of finance leases and on-balance sheet PFI contracts		(4,153)	
(33)	Interest paid	<a href="#">3</a>	(23)	
(29,493)	Interest element of finance leases and on-balance sheet PFI/PPP contracts	<a href="#">3</a>	(28,949)	
<b>1,400,111</b>	<b>Net Financing</b>			<b>1,469,180</b>
314	<b>Net Increase / (decrease) in cash and cash equivalents in the period</b>			<b>(779)</b>
5,531	<b>Cash and cash equivalents at the beginning of the period</b>			<b>5,845</b>
<b>5,845</b>	<b>Cash and cash equivalents at the end of the period</b>			<b>5,066</b>
<b>Reconciliation of net cash flow to movement in net debt/cash</b>				
314	Increase/(decrease) in cash in year			(779)
5,531	Net debt/cash at 1 April	<a href="#">15</a>		5,845
<b>5,845</b>	<b>Net debt/cash at 31 March</b>	<a href="#">15</a>		<b>5,066</b>

Refer to Note 32c Consolidated Group Cashflow

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## STATEMENT OF CONSOLIDATED CHANGES IN TAXPAYERS' EQUITY

	Note	General Fund £'000	Revaluation Reserve £'000	Funds held in Trust £'000	Total Reserves £'000
<b>Balance at 31 March 2014</b>		211,326	181,348	68,951	461,625
Prior year adjustments for changes in accounting policy and materials errors	<a href="#">25</a>	0	0	0	0
<b>Restated balance at 1 April 2014</b>		<b>211,326</b>	<b>181,348</b>	<b>68,951</b>	<b>461,625</b>
<b>Changes in taxpayers' equity for 2014/15</b>					
Net gain/(loss) on revaluation/indexation of property, plant and equipment	<a href="#">11</a>	0	33,757	0	33,757
Net gain/(loss) on revaluation of available for sale financial asset		0	0	4,900	4,900
Impairment of property, plant and equipment	<a href="#">11</a>	0	(14,780)	0	(14,780)
Revaluation & impairments taken to operating costs	<a href="#">3</a>	0	10,012	0	10,012
Transfers between reserves		9,526	(9,526)	0	0
Transfer of non current assets from other bodies		0	1,115	0	1,115
Transfer from Foundation reserves to operating costs		0	0	(474)	(474)
Net operating cost for the year		(1,473,872)	0	(2,889)	(1,476,761)
<b>Total recognised income and expense for 2014/15</b>		<b>(1,464,346)</b>	<b>20,578</b>	<b>1,537</b>	<b>(1,442,231)</b>
Funding:					
Drawn down	<a href="#">CFS</a>	1,502,305	0	0	1,502,305
Movement in General Fund (Creditor) / Debtor		641	0	0	641
<b>Balance at 31 March 2015</b>	<a href="#">BS</a>	<b>249,926</b>	<b>201,926</b>	<b>70,488</b>	<b>522,340</b>
<b>Balance at 31 March 2013</b>		241,730	166,351	68,556	476,637
Prior Year Adjustments for changes in accounting policy and material errors	<a href="#">25</a>	(48,195)	0	0	(48,195)
<b>Restated balance at 1 April 2013</b>		<b>193,535</b>	<b>166,351</b>	<b>68,556</b>	<b>428,442</b>
<b>Changes in taxpayers' equity for 2013/14</b>					
Net gain/(loss) on revaluation/indexation of property, plant and equipment	<a href="#">11</a>	0	24,742	0	24,742
Net gain/loss on revaluation of available for sale financial assets		0	0	1,805	1,805
Impairment of property, plant and equipment	<a href="#">11</a>	0	(3,718)	0	(3,718)
Impairment of intangible assets	<a href="#">10</a>	0	(116)	0	(116)
Revaluation & impairments taken to operating costs	<a href="#">3</a>	0	3,235	0	3,235
Transfers between reserves		9,116	(9,116)	0	0
Other non-cash costs – Revaluation of Carbon liabilities		0	(30)	0	(30)
Net operating cost for the year		(1,424,911)	0	(1,410)	(1,426,321)
<b>Total recognised income and expense for 2013/14</b>		<b>(1,415,795)</b>	<b>14,997</b>	<b>395</b>	<b>(1,400,403)</b>
Funding:					
Drawn down		1,433,345	0	0	1,433,345
Movement in General Fund (Creditor) / Debtor		241			241
<b>Balance at 31 March 2014</b>	<a href="#">BS</a>	<b>211,326</b>	<b>181,348</b>	<b>68,951</b>	<b>461,625</b>

The Notes to the Accounts numbered 1 to 32 form an integral part of these Accounts

NOTES TO THE ACCOUNTS

FOR YEAR ENDED 31 MARCH 2015

1. ACCOUNTING POLICIES

**(1) Authority**

In accordance with the accounts direction issued by Scottish Ministers under section 19(4) of the Public Finance and Accountability (Scotland) Act 2000 appended, these Accounts have been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury, which follows International Financial Reporting Standards as adopted by the European Union (IFRS as adopted by the EU), IFRIC Interpretations and the Companies Act 2006 to the extent that they are meaningful and appropriate to the public sector. They have been applied consistently in dealing with items considered material in relation to the accounts.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in section 30 below.

**(a) Standards, amendments and interpretations effective in 2014-15**

There are no new standards, amendments or interpretations effective for the first time in 2014-15.

**(b) Standards, amendments and interpretation early adopted in 2014 - 15**

There are no new standards, amendments or interpretations early adopted in 2014 -15.

**(2) Basis of Consolidation**

In accordance with IAS 27 – Separate Financial Statements, the Financial Statements consolidate the Lothian Health Board Endowment Fund operating under the name of the Edinburgh & Lothian's Health Foundation.

NHS Endowment Funds were established by the NHS (Scotland) Act 1978. The legal framework under which charities operate in Scotland is the Charities and Trustee Investment (Scotland) Act 2005. Under the 1978 Act Endowment Trustees are also members of the NHS Board. The Board members (who are also Trustees) are appointed by Scottish Ministers.

The Edinburgh & Lothian's Health Foundation is a Registered Charity with the Office of the Charity Regulator of Scotland (OSCR) and is required to prepare and submit Audited Financial Statements to OSCR on an annual basis.

The basis of consolidation used is Merger Accounting. Any intragroup transactions between the Board and the Endowment Fund have been eliminated on consolidation.

Note 32 to the Annual Accounts, details how these consolidated Financial Statements have been calculated.

**(3) Prior Year Adjustments**

The prior year adjustments relate to a retrospective restatement of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)

CNORIS is a risk transfer and financing scheme for NHS Scotland, and further details are set out at Note 17a.

The change in accounting treatment in 2014/15 relates to the recognition of the Board's respective share of the total liability of NHS Scotland as advised by the Scottish Government and based on information prepared by NHS Boards and the Central Legal Office.

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**(4) Going Concern**

The Accounts are prepared on the going concern basis, which provides that the entity will continue in operational existence for the foreseeable future.

**(5) Accounting Convention**

The Accounts are prepared on a historical cost basis, as modified by the revaluation of property, plant and equipment, intangible assets, inventories, available-for-sale financial assets and financial assets and liabilities (including derivative instruments) at fair value.

**(6) Funding**

Most of the expenditure of the Health Board as Commissioner is met from funds advanced by the Scottish Government within an approved revenue resource limit. Cash drawn down to fund expenditure within this approved revenue resource limit is credited to the general fund.

All other income receivable by the board that is not classed as funding is recognised in the year in which it is receivable.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Non discretionary funding out with the RRL is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, dental or ophthalmic services identified by the Scottish Government. Non discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the RRL in the Resource Outturn Statement.

Funding for the acquisition of capital assets received from the Scottish Government is credited to the general fund when cash is drawn down.

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in the Statement of Consolidated Comprehensive Net Expenditure except where it results in the creation of a non-current asset such as property, plant and equipment.

**(7) Property, plant and equipment**

The treatment of capital assets in the accounts (capitalisation, valuation, depreciation, particulars concerning donated assets) is in accordance with the NHS Capital Accounting Manual.

Title to properties included in the accounts, other than PFI/PPP or finance lease properties, is held by Scottish Ministers.

**(7.1) Recognition**

Property, Plant and Equipment is capitalised where: it is held for use in delivering services or for administrative purposes; it is probable that future economic benefits will flow to, or service potential be provided to, the Board; it is expected to be used for more than one financial year; and the cost of the item can be measured reliably.

All assets falling into the following categories are capitalised:

- 1) Property, plant and equipment assets which are capable of being used for a period which could exceed one year, and have a cost equal to or greater than £5,000.
- 2) In cases where a new hospital would face an exceptional write off of items of equipment costing individually less than £5,000, the Board has the option to capitalise initial revenue equipment costs with a standard life of 10 years.
- 3) Assets of lesser value may be capitalised where they form part of a group of similar assets purchased at approximately the same time and cost over £20,000 in total, or where they are part of the initial costs of equipping a new development and total over £20,000.

### (7.2) Measurement

#### Valuation:

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value as follows:

Specialised NHS Land, buildings, equipment, installations and fittings are stated at depreciated replacement cost, as a proxy for fair value as specified in the FReM.

Non specialised land and buildings, such as offices, are stated at fair value.

Valuations of all land and building assets are reassessed by valuers under a 5-year programme of professional valuations and adjusted in intervening years to take account of movements in prices since the latest valuation. The valuations are carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Scottish Government.

Non specialised equipment, installations and fittings are valued at fair value. The Board values such assets using the most appropriate valuation methodology available (for example, appropriate indices). A depreciated historical cost basis is used as a proxy for fair value in respect of such assets which have short useful lives or low values (or both).

Assets under construction are valued at current cost. This is calculated by the expenditure incurred to which an appropriate index is applied to arrive at current value. These are also subject to impairment review.

To meet the underlying objectives established by the Scottish Government the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

Specialised operational assets are valued on a modified replacement cost basis to take account of modern substitute building materials and locality factors only.

#### Subsequent expenditure:

Subsequent expenditure is capitalised into an asset's carrying value when it is probable the future economic benefits associated with the item will flow to the Board and the cost can be measured reliably. Where subsequent expenditure does not meet these criteria the expenditure is charged to the Statement of Consolidated Comprehensive Net Expenditure. If part of an asset is replaced, then the part it replaces is de-recognised, regardless of whether or not it has been depreciated separately.

#### Revaluations and Impairment:

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in the Statement of Consolidated Comprehensive Net Expenditure, in which case they are recognised as income. Movements on revaluation are considered for individual assets rather than groups or land/buildings together.

Permanent decreases in asset values and impairments are charged gross to the Statement of Consolidated Comprehensive Net Expenditure. Any related balance on the revaluation reserve is transferred to the General Fund.

Gains and losses on revaluation are reported in the Statement of Consolidated Comprehensive Net Expenditure.

### (7.3) Depreciation

Items of Property, Plant and Equipment are depreciated to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Depreciation is charged on each main class of tangible asset as follows:

- 1) Freehold land is considered to have an infinite life and is not depreciated.
- 2) Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Board, respectively.

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- 3) Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification.
- 4) Buildings, installations and fittings are depreciated on current value over the estimated remaining life of the asset, as advised by the appointed valuer. They are assessed in the context of the maximum useful lives for building elements.
- 5) Equipment is depreciated over the estimated life of the asset.
- 6) Property, plant and equipment held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation is charged on a straight line basis.

The following asset lives have been used:

<u>Asset Category/Component</u>	<u>Useful Life</u>
Buildings – Structural	5-40 years
Buildings – Engineering and External Plant	15-35 years
Medical Equipment	3-15 years
Vehicles	7 years
Furniture	10 years
Office & IT Equipment	5-8 years

**(8) Intangible Assets**

**(8.1) Recognition**

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Board's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Board and where the cost of the asset can be measured reliably.

Intangible assets that meet the recognition criteria are capitalised when they are capable of being used in a Board's activities for more than one year and they have a cost of at least £5,000.

The main classes of intangible assets recognised are:

Internally generated intangible assets:

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- 1) The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- 2) The Board intends to complete the asset and sell or use it;
- 3) The Board has the ability to sell or use the asset;
- 4) How the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- 5) Adequate financial, technical and other resources are available to the Board to complete the development and sell or use the asset; and
- 6) The Board can measure reliably the expenses attributable to the asset during development.

Expenditure so deferred is limited to the value of future benefits.

Software:

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Software licences:

Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred.

Carbon Emissions (Intangible Assets):

A cap and trade scheme gives rise to an asset for allowances held and a liability for the obligation to deliver allowances equal to emissions that have been made.

Intangible Assets, such as EU Greenhouse Gas Emission Allowances intended to be held for use on a continuing basis whether allocated by government or purchased are classified as intangible assets. Allowances that are issued for less than their fair value are measured initially at their fair value.

When allowances are issued for less than their fair value, the difference between the amount paid and fair value is revaluation and charged to the general fund. The general fund is charged with the same proportion of the amount of the revaluation, which the amount of the grant bears to the acquisition cost of the asset.

A provision is recognised for the obligation to deliver allowances equal to emissions that have been made. It is measured at the best estimate of the expenditure required to settle the present obligation at the balance sheet date. This will usually be the present market price of the number of allowances required to cover emissions made up to the balance sheet date.

Websites

Websites are capitalised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Board; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

**(8.2) Measurement**

Valuation:

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Where an active (homogeneous) market exists, intangible assets are carried at fair value. Where no active market exists, the intangible asset is revalued, using indices or some suitable model, to the lower of depreciated replacement cost and value in use where the asset is income generating. Where there is no value in use, the intangible asset is valued using depreciated replacement cost. These measures are a proxy for fair value.

Revaluation and impairment:

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in the Statement of Consolidated Comprehensive Net Expenditure, in which case they are recognised in income.

Permanent decreases in asset values and impairments are charged gross to the Statement of Consolidated Comprehensive Net Expenditure. Any related balance on the revaluation reserve is transferred to the General Fund.

Temporary decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to the Statement of Consolidated Comprehensive Net Expenditure.

Intangible assets held for sale are reclassified to 'non-current assets held for sale' measured at the lower of their carrying amount or 'fair value less costs to sell'.

**(8.3) Amortisation**

Intangible assets are amortised to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Amortisation is charged to the Statement of Consolidated Comprehensive Net Expenditure on each main class of intangible asset as follows:

- 1) Internally generated intangible assets. Amortised on a systematic basis over the period expected to benefit from the project.
- 2) Software. Amortised over their expected useful life
- 3) Software licences. Amortised over the shorter term of the licence and their useful economic lives.
- 4) Other intangible assets. Amortised over their expected useful life.
- 5) Intangible assets which has been reclassified as 'Held for Sale' ceases to be amortised upon the reclassification.

Amortisation is charged on a straight line basis.

The following asset lives have been used:

<u>Asset Category/Component</u>	<u>Useful Life</u>
Application Software	4 years

**(9) Non-current assets held for sale**

Non-current assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**(10) Donated Assets**

Non-current assets that are donated or purchased using donated funds are included in the Balance Sheet initially at the current full replacement cost of the asset. The accounting treatment, including the method of valuation, follows the rules in the NHS Capital Accounting Manual.

**(11) Sale of Property, plant and equipment, intangible assets and non-current assets held for sale**

Disposal of non-current assets is accounted for as a reduction to the value of assets equal to the net book value of the assets disposed. When set against any sales proceeds, the resulting gain or loss on disposal will be recorded in the Statement of Consolidated Comprehensive Net Expenditure. Non-current assets held for sale will include assets transferred from other categories and will reflect any resultant changes in valuation.



**(12) Leasing**

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the Board, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. Assets held under finance leases are valued at their fair values and are depreciated over the remaining period of the lease in accordance with IAS17.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The minimum lease payments (annual rental less operating costs e.g. maintenance and contingent rental) are apportioned between the repayment of the outstanding liability and a finance charge. The annual finance charge is allocated to each period during the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability using either the implicit interest rate or another relevant basis of estimation such as the sum of the digits method. Finance charges are recorded as interest payable in the Statement of Consolidated Comprehensive Net Expenditure. Contingent rental and operating costs are charged as expenses on the periods in which they are incurred.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to expenditure on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to expenditure over the life of the lease.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease unless title to the land is expected to transfer.

**(13) Impairment of non-financial assets**

Assets that are subject to depreciation and amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Where an asset is not held for the purpose of generating cash flows, value in use is assumed to equal the cost of replacing the service potential provided by the asset, unless there has been a reduction in service potential. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash flows (cash-generating units). Non-financial assets that suffer an impairment are reviewed for possible reversal of the impairment. Impairment losses charged to the Statement of Consolidated Comprehensive Net Expenditure are deducted from future operating costs to the extent that they are identified as being reversed in subsequent revaluations.

**(14) General Fund Receivables and Payables**

Where the Health Board has a positive net cash book balance at the year end, a corresponding creditor is created and the general fund debited with the same amount to indicate that this cash is repayable to the SGHSCD. Where the Health Board has a net overdrawn cash position at the year end, a corresponding debtor is created and the general fund credited with the same amount to indicate that additional cash is to be drawn down from the SGHSCD.

**(15) Inventories**

Inventories are valued at the lower of cost and net realisable value. Taking into account the high turnover of NHS inventories, the use of average purchase price is deemed to represent current cost.

**(16) Losses and Special Payments**

Operating expenditure includes certain losses which would have been made good through insurance cover had the NHS not been bearing its own risks. Had the NHS provided insurance cover, the insurance premiums would have been included as normal revenue expenditure.

**(17) Employee Benefits**

**Remuneration**

Remuneration of Board members and senior managers disclosed in the remuneration report includes the value of employers' pension scheme contributions.

### Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave and flexible working time entitlement earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

### Pension Costs

The Board participates in the NHS Superannuation Scheme for Scotland providing defined benefits based on final pensionable pay, where contributions are credited to the Exchequer and are deemed to be invested in a portfolio of Government Securities. The Board is unable to identify its share of the underlying notional assets and liabilities of the scheme on a consistent and reasonable basis and therefore accounts for the scheme as if it were a defined contribution scheme, as required by IAS 19 'Employee Benefits'. As a result, the amount charged to the Statement of Consolidated Comprehensive Net Expenditure represents the Board's employer contributions payable to the scheme in respect of the year. The contributions deducted from employees are reflected in the gross salaries charged and are similarly remitted to Exchequer. The pension cost is normally assessed every five years by the Government Actuary and determines the rate of contributions required. The most recent actuarial valuation is published by the Scottish Public Pensions Agency and is available on their website.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the Statement of Consolidated Comprehensive Net Expenditure at the time the Board commits itself to the retirement, regardless of the method of payment.

### (18) Clinical and Medical Negligence Costs

Employing health bodies in Scotland are responsible for meeting medical negligence costs up to a threshold per claim. Costs above this threshold are reimbursed to Boards from a central fund held as part of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) by the Scottish Government.

NHS Lothian provide for all claims notified to the NHS Central Legal Office according to the value of the claim and the probability of settlement. Claims assessed as 'Category 3' are deemed most likely and provided for in full, those in 'Category 2' as 50% of the claim and those in 'Category 1' as nil. The balance of the value of claims not provided for is disclosed as a contingent liability. This procedure is intended to estimate the amount considered to be the liability in respect of any claims outstanding and which will be recoverable from the Clinical Negligence and Other Risks Indemnity Scheme in the event of payment by an individual health body. The corresponding recovery in respect of amounts provided for is recorded as a debtor and that in respect of amounts disclosed as contingent liabilities are disclosed as contingent assets.

### (19) Related Party Transactions

Material related party transactions are disclosed in the Note 28 in line with the requirements of IAS 24. Transactions with other NHS bodies for the commissioning of health care are summarised in Note 4.

### (20) Value Added Tax

Most of the activities of the Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### (21) PFI/HUB/NPD Schemes

Transactions financed as revenue transactions through the Private Finance Initiative or alternative initiatives such as HUB or the Non Profit Distributing Model (NPD) are accounted for in accordance with the HM Treasury application of IFRIC 12, *Service Concession Arrangements*, outlined in the FReM.

Schemes which do not fall within the application of IFRIC 12 are deemed to be off-balance sheet. Where the Board has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Statement of Consolidated Comprehensive Net Expenditure. Where, at the end of the PFI contract, a property reverts to the Board, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up on the balance sheet over the life of the contract by capitalising part of the unitary charge each year.

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Transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' by the Board. The underlying assets are recognised as Property, Plant and Equipment and Intangible Assets at their fair value. An equivalent liability is recognised in accordance with IAS 17. Where it is not possible to separate the finance element from the service element of unitary payment streams this has been estimated from information provided by the operator and the fair values of the underlying assets. Assets are subsequently revalued in accordance with the treatment specified for their applicable asset categories.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge and the finance cost interest element are charged in the Statement of Consolidated Comprehensive Net Expenditure.

**(22) Provisions**

The Board provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated cash flows are discounted using the discount rate prescribed by HM Treasury.

**(23) Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Board's control) are not recognised as assets, but are disclosed in note 19 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

**(24) Corresponding Amounts**

Corresponding amounts are shown for the primary statements and notes to the financial statements. Where the corresponding amounts are not directly comparable with the amount to be shown in respect of the current financial year, IAS 1 'Presentation of Financial Statements', requires that they should be adjusted and the basis for adjustment disclosed in a note to the financial statements.

**(25) Financial Instruments**

**Financial assets**

Classification

The Board classifies its financial assets in the following categories: at fair value through profit or loss, loans and receivables, and available for sale. The classification depends on the purpose for which the financial assets were acquired. Management determines the classification of its financial assets at initial recognition.

(a) Financial assets at fair value through profit or loss

Financial assets at fair value through profit or loss comprise derivatives. Assets in this category are classified as current assets. The Board does not trade in derivatives and does not apply hedge accounting.

(b) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the balance sheet date. These are classified as non-current assets. Loans and receivables comprise trade and other receivables and cash at bank and in hand in the balance sheet.

(c) Available-for-sale financial assets

Available-for-sale financial assets are non-derivatives that are either designated in this category or not classified in any of the other categories. They are included in non-current assets unless management intends to dispose of the investment within 12 months of the balance sheet date. Available for sale financial assets comprise investments.

Recognition and measurement

Financial assets are recognised when the Board becomes party to the contractual provisions of the financial instrument.

Financial assets are derecognised when the rights to receive cash flows from the asset have expired or have been transferred and the Board has transferred substantially all risks and rewards of ownership.

(a) Financial assets at fair value through profit or loss

Financial assets carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the Statement of Consolidated Comprehensive Net Expenditure.

Financial assets carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Consolidated Comprehensive Net Expenditure.

(b) Loans and receivables

Loans and receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, less provision for impairment. A provision for impairment of loans and receivables is established when there is objective evidence that the Board will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 30 days overdue) are considered indicators that the loan and receivable is impaired. The amount of the provision is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the Statement of Consolidated Comprehensive Net Expenditure. When a loan or receivable is uncollectible, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are credited in the Statement of Consolidated Comprehensive Net Expenditure.

(c) Available-for-sale financial assets

Available-for-sale financial assets are initially recognised and subsequently carried at fair value. Changes in the fair value of financial assets classified as available for sale are recognised in equity in other reserves. When financial assets classified as available for sale are sold or impaired, the accumulated fair value adjustments recognised in equity are included in the Statement of Consolidated Comprehensive Net Expenditure. Dividends on available-for-sale equity instruments are recognised in the Statement of Consolidated Comprehensive Net Expenditure when the Board's right to receive payments is established.

Investments in equity instruments that do not have a quoted market price in an active market and whose fair value cannot be reliably measured are measured at cost less impairment.

The Board assesses at each balance sheet date whether there is objective evidence that a financial asset or a group of financial assets is impaired. In the case of equity securities classified as available for sale, a significant or prolonged decline in the fair value of the security below its cost is considered as an indicator that the securities are impaired. If any such evidence exists for available-for-sale financial assets, the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss – is removed from equity and recognised in the Statement of Consolidated Comprehensive Net Expenditure. Impairment losses recognised in the Statement of Consolidated Comprehensive Net Expenditure on equity instruments are not reversed through the income statement.

**Financial Liabilities**

Classification

The Board classifies its financial liabilities in the following categories: at fair value through profit or loss, and other financial liabilities. The classification depends on the purpose for which the financial liabilities were issued. Management determines the classification of its financial liabilities at initial recognition.

(a) Financial liabilities at fair value through profit or loss

Financial liabilities at fair value through profit or loss comprise derivatives. Liabilities in this category are classified as current liabilities. The NHS Board does not trade in derivatives and does not apply hedge accounting.

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(b) Other financial liabilities

Other financial liabilities are included in current liabilities, except for maturities greater than 12 months after the balance sheet date. These are classified as non-current liabilities. The NHS Board's other financial liabilities comprise trade and other payables in the balance sheet.

Recognition and measurement

Financial liabilities are recognised when the NHS Board Scotland becomes party to the contractual provisions of the financial instrument.

A financial liability is removed from the balance sheet when it is extinguished, that is when the obligation is discharged, cancelled or expired.

(a) Financial liabilities at fair value through profit or loss

Financial liabilities carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the Statement of Consolidated Comprehensive Net Expenditure.

Financial liabilities carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Consolidated Comprehensive Net Expenditure.

(b) Other financial liabilities

Other financial liabilities are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

**(26) Segmental reporting**

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments. This has been identified as the executive management team within the Board.

Operating segments are unlikely to directly relate to the analysis of expenditure shown in notes 4 to 7 for Hospital & Community, Family Health and Other Service and Administration Costs, the basis of which relates to Scottish Government funding streams and the classification of which varies depending on Scottish Government reporting requirements.

**(27) Cash and cash equivalents**

Cash and cash equivalents includes cash in hand, deposits held at call with banks, cash balances held with the Government Banking Service, balances held in commercial banks and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the balance sheet. Where the Government Banking Service is using Citi and Royal Bank of Scotland Group to provide the banking services, funds held in these accounts should not be classed as commercial bank balances.

**(28) Foreign exchange**

The functional and presentational currencies of the Board are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Board has assets or liabilities denominated in a foreign currency at the balance sheet date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the balance sheet date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**(29) Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Board has no beneficial interest in them.

However, they are disclosed in Note 30 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

**(30) Key sources of judgement and estimation uncertainty**

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The Board makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The Board makes judgements in applying accounting policies. The estimates, assumptions and judgements that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the financial statements within the next financial year are addressed below.

- Estimates and assumptions regarding estimated impairment.
- Estimates and assumptions underlying the likelihood, outcome and the timing of outcome of material provisions, clinical negligence claims, and potential back-payments in respect of Agenda for Change.
- Estimates and assumptions regarding the fair value of property, plant and equipment, and intangible assets.
- Estimates and assumptions in respect of the sampling of employee benefits for accrual calculations attributable to the whole population of employees.
- Estimated actuarial assumptions in respect of post-employment benefits.
- Judgements on whether the significant risks and rewards of ownership of financial assets and leased assets are transferred to other entities.

**NHS Lothian**

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**2.(a) STAFF NUMBERS AND COSTS**

	<b>Executive Board Members</b>	<b>Non Executive Members</b>	<b>Permanent Staff</b>	<b>Inward Secondees</b>	<b>Other Staff</b>	<b>Outward Secondees</b>	<b>2015 Total</b>	<b>2014 Total</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
<b>STAFF COSTS</b>								
Salaries & Wages	769	258	696,332	-	-	(2,609)	694,750	667,117
Social security costs	96	16	56,546	-	-	-	56,658	54,376
NHS scheme employers' costs	53	2	83,756	-	-	-	83,811	80,064
Inward Secondees	-	10	-	615	-	-	625	622
Agency & recharged Univ. Staff	-	-	-	-	25,700	-	25,700	26,679
	918	286	836,634	615	25,700	(2,609)	861,544	828,858
Compensation for loss of office	-	-	815	-	-	-	815	759
<b>TOTAL</b>	<b>918</b>	<b>286</b>	<b>837,449</b>	<b>615</b>	<b>25,700</b>	<b>(2,609)</b>	<b>862,359</b>	<b>829,617</b>

**STAFF NUMBERS**

**(EMPLOYEES BY WHOLE TIME EQUIVALENT)**

	<b>ANNUAL MEAN</b>	<b>ANNUAL MEAN</b>
Administration staff included in Note 6	140.5	139.4
Hospital and Community Services staff included in Note 4	20,404.6	19,371.0
Non Clinical Services staff included in Note 7	95.5	94.2
Inward Secondees	9.5	8.7
Agency Staff	423.2	375.2
Outward Secondees	(50.3)	(62.7)
Board Total Average Staff	21,023	19,926
Staff with a registered disability	280.3	248.4

Note: Staff pension benefits are provided through the NHS Superannuation Scheme for Scotland. Details of the scheme are in Note 24.

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2.(b) HIGHER PAID EMPLOYEES' REMUNERATION

Other employees, not being directors or senior employees disclosed within the remuneration report on pages 27 - 32, whose remuneration fell within the following ranges:

		Clinical Staff		Other Staff		
		2015	2014	2015	2014	
		Number	Number	Number	Number	
£50,000	to	£60,000	455	376	67	65
£60,001	to	£70,000	209	213	20	20
£70,001	to	£80,000	142	122	19	18
£80,001	to	£90,000	146	136	12	10
£90,001	to	£100,000	124	115	4	4
£100,001	to	£110,000	124	127	6	4
£110,001	to	£120,000	89	102	1	1
£120,001	to	£130,000	90	90	0	0
£130,001	to	£140,000	70	68	0	1
£140,001	to	£150,000	67	37	0	0
£150,001	to	£160,000	46	41	1	1
£160,001	to	£170,000	20	21	0	0
£170,001	to	£180,000	9	7	0	0
£180,001	to	£190,000	4	4	0	0
£190,001	to	£200,000	5	2	0	0
£200,001	and above		3	6	0	1

Clinicians' remuneration includes only that which arises from their NHS Lothian work.

3. OTHER OPERATING COSTS

2013-14			
£'000	Expenditure Not Paid In Cash	Note	£'000
35,627	Depreciation on Purchased Assets	<a href="#">11a</a>	36,906
3,541	Amortisation	<a href="#">10</a>	2,299
556	Depreciation on Donated Assets		663
3,235	Impairments and revaluation loss on property, plant and equipment charged to statement of comprehensive net expenditure		12,076
0	Reversal of impairments and revaluation gains on property, plant and equipment charged to statement of comprehensive net expenditure	<a href="#">11a</a>	(2,064)
0	Loss/(Profit) on disposal of property, plant and equipment		(35)
550	Loss on measurement of non current assets held for sale		0
0	Other non Cash costs		0
(752)	Funding of Donated assets	<a href="#">11b</a>	(968)
0	Other: transfer of assets		1,115
0	Other		1
<b>42,757</b>	<b>Total Expenditure Not Paid In Cash</b>	<a href="#">CFS</a>	<b>49,993</b>
	<b>Interest Payable</b>		
29,493	PFI Finance Lease charges allocated in year	<a href="#">23</a>	28,949
33	Unwinding of Discount		23
<b>29,526</b>	<b>Total</b>		<b>28,972</b>
	<b>Statutory Audit</b>		
<b>384</b>	External auditor's remuneration and expenses		<b>388</b>



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## 4. HOSPITAL AND COMMUNITY HEALTH SERVICES

2013-14		£'000
BY PROVIDER		£'000
1,237,287	Treatment in Board area of NHS Scotland Patients	1,286,476
7,529	Other NHS Scotland Bodies	8,700
3,766	Health Bodies outside Scotland	2,015
16,626	Private sector	17,845
<b>Community Care</b>		
34,861	Resource Transfer	35,552
17,407	Payments made to Voluntary Bodies and Charities	16,261
<b>1,317,476</b>	<b>Total NHS Scotland Patients</b>	<b>1,366,849</b>
3,865	Treatment of UK residents based outside Scotland	3,431
<b>1,321,341</b>	<b>Total Hospital &amp; Community Health Service</b>	<b>1,370,280</b>

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## 5. FAMILY HEALTH SERVICE EXPENDITURE

2013-14		Unified Budget	Non Disc	TOTAL
£'000		£'000	£'000	£'000
121,817	Primary Medical Services	118,750	0	118,750
156,015	Pharmaceutical Services	140,199	23,114	163,313
61,225	General Dental Services	6,308	55,084	61,392
15,073	General Ophthalmic Services	280	14,872	15,152
<b>354,130</b>	<b>Total</b>	<b>265,537</b>	<b>93,070</b>	<b>358,607</b>

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## 6. ADMINISTRATION COSTS

2013-14		Note	£'000
£'000			£'000
1,192	Board members' remuneration	<a href="#">Note 2 (a)</a>	1,204
353	Administration of Board Meetings and Committees		379
761	Corporate Governance and Statutory Reporting		777
5,984	Health Planning, Commissioning and Performance Reporting		5,136
365	Treasury Management and Financial Planning		415
607	Public Relations		695
590	Other		600
<b>9,852</b>	<b>Total administration costs</b>	<a href="#">SOCNE</a>	<b>9,206</b>

## 7. OTHER NON CLINICAL SERVICES (RESTATED)

2013-14			
£'000		Note	£'000
43	Nurse Teaching		64
23,185	Compensation payments – Clinical		(18,712)
430	Compensation payments - Other		923
3,924	Pension enhancement & redundancy		2,189
161	Patients' Travel Attending Hospitals		160
1,428	Health Promotion		1,844
4,563	Public Health		4,196
182	Public Health Medicine Trainees		161
54	Emergency Planning		55
424	Shared Services		413
4,508	Endowment expenditure		2,263
9,005	Other		11,304
<b>47,907</b>	<b>Total Other Non Clinical Services</b>	<a href="#">SOCNE</a>	<b>4,860</b>

There have been significant movements in the CNORIS provision due to reassessment and finalisation of a number of significant cases. This is reflected in the negative expenditure figure shown above for clinical compensation payments.

## 8. OPERATING INCOME

2013-14			
£'000		Note	£'000
	<b>HCH Income</b>		
	<b>NHSScotland Bodies</b>		
1,836	SGHSCD		1,426
218,618	Boards		221,120
6,731	NHS Non-Scottish Bodies		5,931
	<b>Non NHS</b>		
2,492	Private Patients		2,350
1,918	Compensation Income		2,172
17,862	Other HCH Income		17,530
<b>249,457</b>	<b>Total HCH Income</b>	<a href="#">SOCNE</a>	<b>250,529</b>
	<b>FHS Income</b>		
333	Unified		415
	<b>Non Discretionary</b>		
10,645	General Dental Services		11,033
8	General Ophthalmic Services		8
<b>10,986</b>	<b>Total FHS Income</b>	<a href="#">SOCNE</a>	<b>11,456</b>
	<b>Other Operating Income</b>		
23,194	Contributions in respect of Clinical/medical negligence claims		(10,549)
614	Profit on disposal of non current assets		0
765	Donated Asset Additions		968
596	Shared Services		598
3,098	Endowment income		(626)
18,199	Other		13,816
<b>46,466</b>	<b>Total Other Operating Income</b>	<a href="#">SOCNE</a>	<b>4,207</b>
<b>306,909</b>	<b>Total Income</b>		<b>266,192</b>
<b>227,185</b>	<b>Of the above, the amount derived from NHS bodies is</b>		<b>228,477</b>

There have been significant movements in the CNORIS provision and associated debtor due to reassessment and finalisation of a number of significant cases. This is reflected in the negative income figure shown above for contributions in respect of clinical negligence claims

## 9. CAPITAL EXPENDITURE

2013-14 £'000	EXPENDITURE	Note	£'000	
298	Acquisition of Intangible Assets	<a href="#">10</a>	930	
29,509	Acquisition of Property, plant and equipment	<a href="#">11</a>	45,261	
752	Donated Asset Additions	<a href="#">11b</a>	968	
0	Hub enabling expenditure		1,232	
<b>30,559</b>	<b>Gross Capital Expenditure</b>		<b>48,391</b>	
<b>INCOME</b>				
149	Net book value of disposal of Property, plant and equipment	<a href="#">11a</a>	250	
2	Net book value of disposal of Donated Assets	<a href="#">11b</a>	0	
2,764	Value of disposal of Non-Current Assets held for sale	<a href="#">11c</a>	560	
765	Donated Asset Capital income	<a href="#">8</a>	968	
<b>3,680</b>	<b>Capital Income</b>		<b>1,778</b>	
<b>26,879</b>	<b>Net Capital Expenditure</b>		<b>46,613</b>	
<b>SUMMARY OF CAPITAL RESOURCE OUTTURN</b>				
The summary outturn against core and non-core allocations of capital expenditure was as follows:				
		<b>Core</b>	<b>Non Core</b>	<b>Total</b>
26,879	Net capital expenditure as above	28,798	17,815	46,613
26,879	Capital Resource Limit	28,798	17,815	46,613
<b>0</b>	<b>Saving/(excess) against Capital Resource Limit</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 10. INTANGIBLE ASSETS – CONSOLIDATED

	Note	Software Licences £'000	EC Carbon Emissions £'000	Total £'000
<b>Cost or Valuation:</b>				
As at 1 April 2014		17,487	0	17,487
Additions	9	930	0	930
Donations		0	0	0
Transfers		715	0	715
Disposals		0	0	0
Transfers (to)/from non-current assets held for sale		0	0	0
Revaluation		0	0	0
Impairment Charge		0	0	0
Impairment Reversal		0	0	0
<b>As at 31 March 2015</b>		<b>19,132</b>	<b>0</b>	<b>19,132</b>
<b>Amortisation</b>				
As at 1 April 2014		14,863	0	14,863
Provided during the year	3	2,299	0	2,299
Transfers		(198)	0	(198)
Disposals		0	0	0
Transfers (to)/from non-current assets held for sale		0	0	0
Revaluation		0	0	0
Impairment Charge		0	0	0
Impairment Reversal		0	0	0
<b>At 31 March 2015</b>		<b>16,964</b>	<b>0</b>	<b>16,964</b>
<b>Net Book Value at 1 April 2014</b>		<b>2,624</b>	<b>0</b>	<b>2,624</b>
<b>Net Book Value at 31 March 2015</b>	<u>BS</u>	<b>2,168</b>	<b>0</b>	<b>2,168</b>

## PRIOR YEAR – CONSOLIDATED

	Note	Software Licences £'000	EC Carbon Emissions £'000	Total £'000
<b>Cost or Valuation:</b>				
As at 1 April 2013		18,294	116	18,410
Additions	9	298	0	298
Donations		0	0	0
Transfers		0	0	0
Disposals		(1,105)	0	(1,105)
Transfers (to)/from non-current assets held for sale		0	0	0
Revaluation		0	0	0
Impairment Charge		0	(116)	(116)
Impairment Reversal		0	0	0
<b>As at 31 March 2014</b>		<b>17,487</b>	<b>0</b>	<b>17,487</b>
<b>Amortisation</b>				
As at 1 April 2013		12,427	0	12,427
Provided during the year	3	3,541	0	3,541
Transfers		0	0	0
Disposals		(1,105)	0	(1,105)
Transfers (to)/from non-current assets held for sale		0	0	0
Revaluation		0	0	0
Impairment Charge		0	0	0
Impairment Reversal		0	0	0
<b>At 31 March 2014</b>		<b>14,863</b>	<b>0</b>	<b>14,863</b>
<b>Net Book Value at 31 March 2013</b>		<b>5,867</b>	<b>116</b>	<b>5,983</b>
<b>Net Book Value at 31 March 2014</b>	<u>BS</u>	<b>2,624</b>	<b>0</b>	<b>2,624</b>

NHS Lothian

ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31<sup>ST</sup> MARCH 2015

11(a) PROPERTY, PLANT AND EQUIPMENT (Purchased Assets) – CONSOLIDATED

	Note	Land (including under buildings) £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Transport Equipment £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Assets Under Construction £'000	Total £'000
<b>Cost or valuation</b>										
At 1 April 2014		60,832	648,159	2,763	361	117,150	24,466	2,257	27,527	883,515
Additions	9	0	0	0	0	0	0	0	45,261	45,261
Completions		304	10,592	0	0	8,849	1,992	0	(21,737)	0
Transfers		(961)	1,454	(763)	0	246	(714)	0	0	(738)
Transfers (to)/from non-current assets held for sale	11c	(770)	(55)	0	0	0	0	0	0	(825)
Revaluation		2,186	13,628	77	0	0	0	0	0	15,891
Impairment Charge		(1,012)	(11,694)	0	0	0	0	0	(2,531)	(15,237)
Impairment Reversal		0	2,064	0	0	0	0	0	0	2,064
Disposals	9	(50)	0	(207)	0	(244)	0	0	0	(501)
<b>At 31 March 2015</b>		<b>60,529</b>	<b>664,148</b>	<b>1,870</b>	<b>361</b>	<b>126,001</b>	<b>25,744</b>	<b>2,257</b>	<b>48,520</b>	<b>929,430</b>
<b>Depreciation</b>										
At 1 April 2014		0	25,108	1	358	66,636	17,214	1,245	0	110,562
Provided during the year	3	0	19,784	107	3	13,098	3,700	214	0	36,906
Transfers		0	(8)	(2)	0	357	(142)	0	0	205
Transfers (to)/from non-current assets held for sale	11c	0	0	0	0	0	0	0	0	0
Revaluation		0	(17,214)	(97)	0	0	0	0	0	(17,311)
Impairment Charge		0	0	0	0	0	0	0	0	0
Impairment Reversal		0	1,607	0	0	0	0	0	0	1,607
Disposals	9	0	0	(9)	0	(242)	0	0	0	(251)
<b>At 31 March 2015</b>		<b>0</b>	<b>29,277</b>	<b>0</b>	<b>361</b>	<b>79,849</b>	<b>20,772</b>	<b>1,459</b>	<b>0</b>	<b>131,718</b>
<b>Net book value at 1 April 2014</b>		<b>60,832</b>	<b>623,051</b>	<b>2,762</b>	<b>3</b>	<b>50,514</b>	<b>7,252</b>	<b>1,012</b>	<b>27,527</b>	<b>772,953</b>
<b>Net book value at 31 March 2015</b>	11d	<b>60,529</b>	<b>634,871</b>	<b>1,870</b>	<b>0</b>	<b>46,152</b>	<b>4,972</b>	<b>798</b>	<b>48,520</b>	<b>797,712</b>
<b>Open Market Value of Land, buildings and Dwellings Included Above</b>	11d	<b>11,310</b>	<b>55</b>	<b>0</b>						
<b>Asset financing:</b>										
Owned		47,582	419,692	1,870	0	46,132	4,972	798	48,520	569,566
Finance leased		450	4,756	0	0	20	0	0	0	5,226
On-balance sheet PFI contracts		12,497	210,423	0	0	0	0	0	0	222,920
<b>Net Book Value at 31 March 2015</b>	11d	<b>60,529</b>	<b>634,871</b>	<b>1,870</b>	<b>0</b>	<b>46,152</b>	<b>4,972</b>	<b>798</b>	<b>48,520</b>	<b>797,712</b>

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11(a) PROPERTY, PLANT AND EQUIPMENT (Purchased Assets)- PRIOR YEAR – CONSOLIDATED

Note	Land (including under buildings) £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Transport Equipment £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Assets Under Construction £'000	Total £'000
<b>Cost or valuation</b>									
At 1 April 2013	61,603	630,333	2,790	361	135,363	23,617	2,257	28,128	884,452
Additions <u>9</u>	0	0	0	0	0	0	0	29,509	29,509
Completions	39	12,270	0	0	13,384	2,536	0	(28,229)	0
Transfers	0	0	0	0	0	0	0	0	0
Transfers (to)/from non-current assets held for sale <u>11c</u>	0	0	0	0	0	0	0	0	0
Revaluation	999	7,955	7	0	0	0	0	0	8,961
Impairment Charge	(1,809)	(2,399)	(34)	0	0	0	0	(1,881)	(6,123)
Impairment Reversal	0	0	0	0	0	0	0	0	0
Disposals <u>9</u>	0	0	0	0	(31,597)	(1,687)	0	0	(33,284)
<b>At 31 March 2014</b>	<b>60,832</b>	<b>648,159</b>	<b>2,763</b>	<b>361</b>	<b>117,150</b>	<b>24,466</b>	<b>2,257</b>	<b>27,527</b>	<b>883,515</b>
<b>Depreciation</b>									
At 1 April 2013	0	23,037	0	335	86,565	15,318	1,001	0	126,256
Provided during the year <u>3</u>	0	20,182	76	23	11,519	3,583	244	0	35,627
Transfers	0	0	0	0	0	0	0	0	0
Transfers (to)/from non-current assets held for sale <u>11c</u>	0	0	0	0	0	0	0	0	0
Revaluation	0	(15,712)	(69)	0	0	0	0	0	(15,781)
Impairment Charge	0	(640)	(6)	0	0	0	0	0	(646)
Impairment Reversal	0	(1,759)	0	0	0	0	0	0	(1,759)
Disposals <u>9</u>	0	0	0	0	(31,448)	(1,687)	0	0	(33,135)
<b>At 31 March 2014</b>	<b>0</b>	<b>25,108</b>	<b>1</b>	<b>358</b>	<b>66,636</b>	<b>17,214</b>	<b>1,245</b>	<b>0</b>	<b>110,562</b>
<b>Net book value at 1 April 2013</b>	<b>61,603</b>	<b>607,296</b>	<b>2,790</b>	<b>26</b>	<b>48,798</b>	<b>8,299</b>	<b>1,256</b>	<b>28,128</b>	<b>758,196</b>
<b>Net book value at 31 March 2014</b> <u>11d</u>	<b>60,832</b>	<b>623,051</b>	<b>2,762</b>	<b>3</b>	<b>50,514</b>	<b>7,252</b>	<b>1,012</b>	<b>27,527</b>	<b>772,953</b>
<b>Open Market Value of Land, buildings and Dwellings Included Above</b> <u>11d</u>	<b>8,850</b>	<b>0</b>	<b>0</b>						
<b>Asset financing:</b>									
Owned	48,147	424,935	2,762	3	50,514	7,252	1,012	27,527	562,152
Finance leased	450	4,629	0	0	0	0	0	0	5,079
On-balance sheet PFI contracts	12,235	193,487	0	0	0	0	0	0	205,722
<b>Net Book Value at 31 March 2014</b> <u>11d</u>	<b>60,832</b>	<b>623,051</b>	<b>2,762</b>	<b>3</b>	<b>50,514</b>	<b>7,252</b>	<b>1,012</b>	<b>27,527</b>	<b>772,953</b>

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## 11(b) PROPERTY, PLANT AND EQUIPMENT (Donated Assets) – CONSOLIDATED

Note	Land (land holdings and land underlying buildings) £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Transport Equipment £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Assets Under Construction £'000	Total £'000
<b>Cost or valuation</b>									
At 1 April 2014	45	9,315	0	75	3,341	5	0	2,251	15,032
Additions <u>9</u>	0	0	0	0	0	0	0	968	968
Completions	0	2,225	0	0	700	0	0	(2,925)	0
Transfers	0	268	0	0	(245)	0	0	0	23
Transfers (to)/from non-current assets held for sale	0	0	0	0	0	0	0	0	0
Revaluation	0	590	0	0	0	0	0	0	590
Impairment Charge	0	0	0	0	0	0	0	0	0
Impairment Reversal	0	0	0	0	0	0	0	0	0
Disposals <u>9</u>	0	0	0	0	0	0	0	0	0
<b>At 31 March 2015</b>	<b>45</b>	<b>12,398</b>	<b>0</b>	<b>75</b>	<b>3,796</b>	<b>5</b>	<b>0</b>	<b>294</b>	<b>16,613</b>
<b>Depreciation</b>									
At 1 April 2014	0	325	0	75	2,254	2	0	0	2,656
Provided during the year	0	369	0	0	293	1	0	0	663
Transfers	0	8	0	0	(15)	0	0	0	(7)
Transfers (to)/from non-current assets held for sale	0	0	0	0	0	0	0	0	0
Revaluation	0	35	0	0	0	0	0	0	35
Impairment Charge	0	0	0	0	0	0	0	0	0
Impairment Reversal	0	0	0	0	0	0	0	0	0
Disposals <u>9</u>	0	0	0	0	0	0	0	0	0
<b>At 31 March 2015</b>	<b>0</b>	<b>737</b>	<b>0</b>	<b>75</b>	<b>2,532</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>3,347</b>
<b>Net book value at 1 April 2014</b>	<b>45</b>	<b>8,990</b>	<b>0</b>	<b>0</b>	<b>1,087</b>	<b>3</b>	<b>0</b>	<b>2,251</b>	<b>12,376</b>
<b>Net book value at 31 March 2015</b>	<b>45</b>	<b>11,661</b>	<b>0</b>	<b>0</b>	<b>1,264</b>	<b>2</b>	<b>0</b>	<b>294</b>	<b>13,266</b>
<b>Open Market Value of Land in Land and Dwellings Included Above</b>	<b>0</b>		<b>0</b>						
<b>Asset financing:</b>									
Owned	45	11,661	0	0	1,264	2	0	294	13,266
Finance leased	0	0	0	0	0	0	0	0	0
On-balance sheet PFI contracts	0	0	0	0	0	0	0	0	0
<b>Net Book Value at 31 March 2015</b>	<b>45</b>	<b>11,661</b>	<b>0</b>	<b>0</b>	<b>1,264</b>	<b>2</b>	<b>0</b>	<b>294</b>	<b>13,266</b>



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## 11(b) PROPERTY, PLANT AND EQUIPMENT (Donated Assets)- PRIOR YEAR – CONSOLIDATED

Note	Land (land holdings and land underlying buildings) £'000	Buildings (excluding dwellings) £'000	Dwellings £'000	Transport Equipment £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Assets Under Construction £'000	Total £'000
<b>Cost or valuation</b>									
At 1 April 2013	45	9,315	0	75	4,825	172	0	1,831	16,263
Additions <u>9</u>	0	0	0	0	0	0	0	752	752
Completions	0	0	0	0	332	0	0	(332)	0
Transfers	0	0	0	0	0	0	0	0	0
Transfers (to)/from non-current assets held for sale	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Impairment Charge	0	0	0	0	0	0	0	0	0
Impairment Reversal	0	0	0	0	0	0	0	0	0
Disposals <u>9</u>	0	0	0	0	(1,816)	(167)	0	0	(1,983)
<b>At 31 March 2014</b>	<b>45</b>	<b>9,315</b>	<b>0</b>	<b>75</b>	<b>3,341</b>	<b>5</b>	<b>0</b>	<b>2,251</b>	<b>15,032</b>
<b>Depreciation</b>									
At 1 April 2013	0	22	0	72	3,819	168	0	0	4,081
Provided during the year	0	303	0	3	249	1	0	0	556
Transfers	0	0	0	0	0	0	0	0	0
Transfers (to)/from non-current assets held for sale	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Impairment Charge	0	0	0	0	0	0	0	0	0
Impairment Reversal	0	0	0	0	0	0	0	0	0
Disposals <u>9</u>	0	0	0	0	(1,814)	(167)	0	0	(1,981)
<b>At 31 March 2014</b>	<b>0</b>	<b>325</b>	<b>0</b>	<b>75</b>	<b>2,254</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>2,656</b>
<b>Net book value at 1 April 2013</b>	<b>45</b>	<b>9,293</b>	<b>0</b>	<b>3</b>	<b>1,006</b>	<b>4</b>	<b>0</b>	<b>1,831</b>	<b>12,182</b>
<b>Net book value at 31 March 2014</b>	<b>45</b>	<b>8,990</b>	<b>0</b>	<b>0</b>	<b>1,087</b>	<b>3</b>	<b>0</b>	<b>2,251</b>	<b>12,376</b>
<b>Open Market Value of Land in Land and Dwellings Included Above</b>	<b>0</b>		<b>0</b>						
<b>Asset financing:</b>									
Owned	45	8,990	0	0	1,087	3	0	2,251	12,376
Finance leased	0	0	0	0	0	0	0	0	0
On-balance sheet PFI contracts	0	0	0	0	0	0	0	0	0
<b>Net Book Value at 31 March 2014</b>	<b>45</b>	<b>8,990</b>	<b>0</b>	<b>0</b>	<b>1,087</b>	<b>3</b>	<b>0</b>	<b>2,251</b>	<b>12,376</b>

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11(c) NON CURRENT ASSETS HELD FOR SALE – CONSOLIDATED

2014 £'000		Note	£'000
1,511	Property, plant and equipment		1,776
<b>1,511</b>			<b>1,776</b>
<b>4,855</b>	At 1 April		<b>1,511</b>
0	Transfers (to)/from property, plant and equipment	11a	825
(580)	Gains/(losses) recognised on re-measurement of non-current assets held for sale		
(2,764)	Disposals of non-current assets held for sale	9	(560)
<b>1,511</b>	As at 31 March		<b>1,776</b>

West Calder Clinic, 13 Craiglea Place, 5 Mill Lane and Flat 2f1 6 Cambridge Street Flat were sold during the financial year.

The following property assets have been classified in the Balance Sheet as held for sale following approval for disposal by the Board. Completion dates for sale are expected to be during financial year 2015/16.

Property	Disposal Approved Date
Eastern General Hospital	12 <sup>th</sup> October 2005
Rosslynlee Hospital	13 <sup>th</sup> November 2008
Polbeth Clinic, West Lothian	6 <sup>th</sup> February 2013
Longstone Clinic	8 <sup>th</sup> April 2014

11(d) PROPERTY, PLANT AND EQUIPMENT DISCLOSURES - CONSOLIDATED

2014 £'000	Net book value of Property, plant and equipment at 31 March	Note	£'000
772,953	Purchased	11a	797,712
12,376	Donated	11b	13,266
<b>785,329</b>	<b>Total</b>	<b>BS</b>	<b>810,978</b>
8,850	Net book value related to land valued at open market value at 31 March		11,310
0	Net book value related to buildings valued at open market value at 31 March		55
	<b>Total value of assets held under:</b>		
5,079	Finance Leases	11a	5,226
205,722	PFI and PPP Contracts	11a	222,920
<b>210,801</b>			<b>228,146</b>
	<b>Total depreciation charged in respect of assets held under:</b>		
231	Finance leases		238
5,767	PFI and PPP contracts		5,212
<b>5,998</b>			<b>5,450</b>

A sample of land and buildings were revalued by a consortium led by James Barr Limited at 31 March 2015 on the basis of existing use or market value (where no longer in use) and Depreciated Replacement Cost (where the specialist nature of properties precludes an assessment of open market value). Other land and buildings assets were revalued on the basis of indices at 31 March 2015. The net impact was an increase in value of £33,757 which was credited to the Statement of Consolidated Comprehensive Net Expenditure.

Assets Under Construction disclosed in Note 11a includes £17,815k relating to construction costs for revenue funded schemes.

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12. INVENTORIES – BOARD & CONSOLIDATED

2013	2014		Note	£'000
£'000	£'000			
13,435	14,393	Raw Materials and Consumables	<a href="#">B S</a>	16,183
<b>13,435</b>	<b>14,393</b>	<b>Total Inventories</b>		<b>16,183</b>

13. TRADE AND OTHER RECEIVABLES

Consolidated 2013 £'000	Board 2013 £'000	Consolidated 2014 £'000	Board 2014 £'000		Note	Consolidated £'000	Board £'000
<b>Receivables due within one year</b>							
<b>NHS Scotland</b>							
960	960	340	340	SGHSCD		293	293
6,900	6,900	9,771	9,771	Boards		16,127	16,127
<b>7,860</b>	<b>7,860</b>	<b>10,111</b>	<b>10,111</b>	<b>Total NHS Scotland Receivables</b>		<b>16,420</b>	<b>16,420</b>
1,199	1,199	301	301	NHS Non-Scottish Bodies		769	769
4,065	4,065	1,511	1,511	VAT recoverable		4,421	4,421
30,570	30,570	20,630	19,872	Prepayments		33,662	33,329
10,455	10,222	9,874	9,874	Accrued income		10,337	10,337
9,821	9,816	8,271	8,341	Other Receivables		11,608	11,608
13,956	13,956	23,321	23,321	Reimbursement of provisions		6,735	6,735
1,443	1,443	3,139	3,139	Other Public Sector Bodies		3,029	3,029
<b>79,369</b>	<b>79,131</b>	<b>77,158</b>	<b>76,470</b>	<b>Total Receivables due within one year</b>	<a href="#">B S</a>	<b>86,981</b>	<b>86,648</b>
<b>Receivables due after more than one year</b>							
2	2	81	81	Prepayments		338	338
0	0	5	5	Other Receivables		5	5
23,076	23,076	25,062	25,062	Reimbursement of Provisions		21,891	21,891
<b>23,078</b>	<b>23,078</b>	<b>25,148</b>	<b>25,148</b>	<b>Total Receivables due after more than one year</b>	<a href="#">B S</a>	<b>22,234</b>	<b>22,234</b>
<b>102,447</b>	<b>102,209</b>	<b>102,306</b>	<b>101,618</b>	<b>TOTAL RECEIVABLES</b>		<b>109,215</b>	<b>108,882</b>
127	127	398	398	The total receivables figure above includes a provision for bad debts of :		354	354

Movements on the provision for impairment of receivables are as follows:

Consolidated 2014 £'000	Board 2014 £'000		Consolidated £'000	Board £'000
127	127	At 1 April	398	398
603	603	Provision for receivables impairment	235	235
(299)	(299)	Receivables written off during the year as uncollectible	1	1
(33)	(33)	Unused amounts reversed	(280)	(280)
<b>398</b>	<b>398</b>	At 31 March	<b>354</b>	<b>354</b>

13. TRADE AND OTHER RECEIVABLES (continued)

The receivables assessed as individually impaired were mainly individuals and small organisations, which are in unexpected difficult economic situations and it was assessed that not all of the receivable balance may be recovered.

Receivables that are less than three months past their due date are not considered impaired. As at 31 March 2015, receivables of carrying value of £7,447,499 (2014: £3,795,347) were past their due date but not impaired. The ageing of receivables which are past due but not impaired is as follows:

Consolidated 2014 £'000	Board 2014 £'000		Consolidated £'000	Board £'000
2,110	2,110	Up to 3 months past due	4,329	4,329
883	883	3 to 6 months past due	508	508
802	802	Over 6 months past due	2,610	2,610
<b>3,795</b>	<b>3,795</b>	Total at 31 March	<b>7,447</b>	<b>7,447</b>

The receivables assessed as past due but not impaired were mainly NHS bodies and there is no history of default from these customers recently.

Concentration of credit risk is limited due to the customer base being largely NHS Boards and other public bodies. Due to this, management believe that there is no future credit risk provision required in excess of the normal provision for doubtful receivables.

The credit quality of receivables that are neither past due nor impaired is assessed by reference to external credit ratings where available. Where no external credit rating is available, historical information about counterparty default rates is used.

Trade receivables that are neither past due nor impaired are shown by their credit risk below.

Consolidated 2014 £'000	Board 2014 £'000		Consolidated £'000	Board £'000
27,320	27,320	Existing customers with no defaults in the past	33,399	33,399
<b>27,320</b>	<b>27,320</b>	Total neither past due or impaired	<b>33,399</b>	<b>33,399</b>
		The maximum exposure to credit risk is the fair value of each class of receivable. The NHS Board does not hold any collateral as security.		
		The carrying amount of receivables are denominated in the following currencies:		
102,306	101,618	Pounds	108,882	108,882
<b>102,306</b>	<b>101,618</b>		<b>108,882</b>	<b>108,882</b>

All non-current receivables are estimated as recoverable within 6 years (2013-14: 6 years) from the balance sheet date.

The carrying amount of short term receivables approximates their fair value.

The fair value of long term other receivables is £26.5m (2013-14: £25m).

The effective interest rate on non-current other receivables is Nil% (2013-14: Nil%).

14. AVAILABLE FOR SALE FINANCIAL ASSETS

Consolidated 2013 £'000	Board 2013 £'000	Consolidated 2014 £'000	Board 2014 £'000		Note	Consolidated £'000	Board £'000
26,567	0	24,889	0	UK equities & investment trusts		20,181	0
14,382	0	14,086	0	Non UK equities & investment trusts		29,140	0
10,120	0	7,048	0	Fixed Interest securities		8,459	0
14,233	34	21,476	34	Other		14,566	1,266
<b>65,302</b>	<b>34</b>	<b>67,499</b>	<b>34</b>	<b>TOTAL</b>	<b>B.S.</b>	<b>72,346</b>	<b>1,266</b>
60,068	34	65,302	34	At 1 April		67,499	34
11,474	0	14,366	0	Additions		39,141	1,233
(11,564)	0	(14,254)	0	Disposals		(39,110)	(1)
5,324	0	2,085	0	Revaluation surplus/(deficit) transferred to equity		4,816	0
<b>65,302</b>	<b>34</b>	<b>67,499</b>	<b>34</b>	<b>At 31 March</b>		<b>72,346</b>	<b>1,266</b>
0	0	0	0	Current	<b>B.S.</b>	0	0
65,302	34	67,499	34	Non-current	<b>B.S.</b>	72,346	1,266
<b>65,302</b>	<b>34</b>	<b>67,499</b>	<b>34</b>	<b>At 31 March</b>		<b>72,346</b>	<b>1,266</b>
				Other Financial Assets available for sale comprise:			
	1		1	Shares in TMRI Limited			0
	0		0	Shares in Hub South East Scotland Limited			0
	<b>33</b>		<b>33</b>	Loans to Hub South East Scotland Limited			<b>33</b>
	<b>34</b>		<b>34</b>				<b>33</b>

The Edinburgh & Lothian Health Foundation (ELHF) has a pooled investment portfolio with NHS Lanarkshire which is managed by independent investment managers, Schroders. Only the ELHF share of the investments is recorded within the Foundations' Financial Statements and is included within the consolidated Board statements. At year end 2014/15 there were investments of £57,780k and cash awaiting investment £15k. The NHS Lanarkshire share was 7.65% of the total portfolio managed by Casenove (Schroders). ELHF also holds investment properties of £13,285k these are solely owned by ELHF.

The investments in the shares of Hub South East Scotland Limited are unlisted and are denominated in UK pounds sterling. The loan to Hub South East Scotland Limited is also denominated in UK pounds sterling.

The Board owns 11.11% of the share capital of Hub South East Scotland Limited and holds its shares alongside 9 public and private sector partners, including the Scottish Futures Trust, a company controlled by Scottish Ministers. The Board has made a loan of £33k to Hub South East Scotland Limited, and also advanced a further £267k to its public sector partners, to enable them to finance the initial working capital requirements of Hub South East Scotland Limited.

NHS Lothian is entitled to recover the full economic cost of activity in support of Hub South East Scotland and has no requirement to under-write any reported trading losses of these companies. The carrying value of the investment is cost less impairment as there is no active market for the equity investment in Hub South East Scotland Limited.

Shares held in TMRI Ltd at 31<sup>st</sup> March 2014 are no longer operational and the value of £1k has been written off in 2014/15.

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## 15. CASH AND CASH EQUIVALENTS

	Note	At 01/04/14 £'000	Cash Flow £'000	At 31/03/15 £'000
Government Banking Service account balance		108	246	354
Cash at bank and in hand		1,025	(887)	138
Endowments		4,712	(138)	4,574
<b>Total cash – balance sheet</b>	<b>BS</b>	<b>5,845</b>	<b>(779)</b>	<b>5,066</b>

Prior Year		At 01/04/13 £'000	Cash Flow £'000	At 31/03/14 £'000
Government Banking Service account balance		1,186	(1,078)	108
Cash at bank and in hand		188	837	1,025
Endowment cash		4,157	555	4,712
<b>Total cash – balance sheet</b>		<b>5,531</b>	<b>314</b>	<b>5,845</b>

Cash at bank is with major UK banks. The credit risk associated with cash at bank is considered to be low.

## 16. TRADE AND OTHER PAYABLES

Consolidated 2013 £'000	Board 2013 £'000	Consolidated 2014 £'000	Board 2014 £'000		Note	Consolidated £'000	Board £'000
<b>Payables due within one year</b>							
<b>NHS Scotland</b>							
1,994	1,994	(323)	(323)	SGHSCD		865	865
6,672	6,672	8,837	8,837	Boards		6,960	6,960
<b>8,666</b>	<b>8,666</b>	<b>8,514</b>	<b>8,514</b>	<b>Total NHS Scotland Payables</b>		<b>7,825</b>	<b>7,825</b>
1,072	1,072	2,369	2,369	NHS Non-Scottish Bodies		4,182	4,182
1,374	1,374	1,133	1,133	General Fund Payable		492	492
33,483	33,483	30,391	30,391	FHS Practitioners		21,304	21,304
28,047	28,004	5,433	5,433	Trade Payables		21,232	21,225
91,546	90,482	76,367	72,453	Accruals		57,069	51,577
13,104	13,104	16,757	16,757	Deferred Income		17,960	17,960
38	38	14	14	Net obligations under Finance Leases	<a href="#">22</a>	9	9
3,668	3,668	4,149	4,149	Net obligations under PPP/PFI Contracts		4,695	4,695
16,128	16,128	16,151	16,151	Income tax and social security		16,612	16,612
9,830	9,830	11,359	11,359	Superannuation		12,095	12,095
195	195	(110)	(110)	Other Public Sector Bodies		662	662
1,458	1,458	2,171	2,171	Other payables		3,378	3,378
11,996	11,996	11,836	11,836	Employee Benefits		11,886	11,886
9,765	9,765	9,137	9,137	Pay and Conditions Accrual		8,148	8,148
3,437	3,437	5,708	5,708	Capital Accruals		6,491	6,491
<b>233,807</b>	<b>232,700</b>	<b>201,379</b>	<b>197,465</b>	<b>Total Payables due within one year</b>	<b>BS</b>	<b>194,040</b>	<b>188,541</b>
<b>Payables due after more than one year</b>							
14	14	4	4	Net obligations under Finance Leases due within 1-2 years	<a href="#">22</a>	4	4
5	5	1	1	Net obligations under Finance Leases due after 2 years but within 5 years	<a href="#">22</a>	1	1
0	0	0	0	Net obligations under Finance Leases due after 5 years	<a href="#">22</a>	0	0
4,149	4,149	4,695	4,695	Net obligations under PPP/PFI Contracts due within 1-2 years		5,320	5,320
16,048	16,048	18,193	18,193	Net obligations under PPP/PFI Contracts due after 2 years but within 5 years		20,641	20,641
175,018	175,018	168,176	168,176	Net obligations under PPP/PFI Contracts due after 5 years		160,409	160,409
619	619	388	388	Other – Strathbrock Partnership Centre & NPDs		17,964	17,964
<b>195,853</b>	<b>195,853</b>	<b>191,457</b>	<b>191,457</b>	<b>Total Payables due after more than one year</b>	<b>BS</b>	<b>204,339</b>	<b>204,339</b>
<b>429,660</b>	<b>428,553</b>	<b>392,836</b>	<b>388,922</b>	<b>TOTAL PAYABLES</b>		<b>398,379</b>	<b>392,880</b>

16. TRADE AND OTHER PAYABLES (continued)

Consolidated 2014 £'000	Board 2014 £'000		Consolidated £'000	Board £'000
		Borrowings included above comprise:		
19	19	Finance Leases	14	14
<u>195,213</u>	<u>195,213</u>	PFI Contracts	<u>191,065</u>	<u>191,065</u>
<b><u>195,232</u></b>	<b><u>195,232</u></b>		<b><u>191,079</u></b>	<b><u>191,079</u></b>
		The carrying amount and fair value of the non-current borrowings are as follows:		
		<b>Carrying amount</b>		
5	5	Finance Leases	5	5
<u>191,064</u>	<u>191,064</u>	PFI Contracts	<u>186,370</u>	<u>186,370</u>
<b><u>191,069</u></b>	<b><u>191,069</u></b>		<b><u>186,375</u></b>	<b><u>186,375</u></b>
		<b>Fair value</b>		
5	5	Finance Leases	5	5
<u>191,064</u>	<u>191,064</u>	PFI Contracts	<u>186,370</u>	<u>186,370</u>
<b><u>191,069</u></b>	<b><u>191,069</u></b>		<b><u>186,375</u></b>	<b><u>186,375</u></b>
		The carrying amount of short term payables approximates to their fair value.		
		The carrying amount of payables are denominated in the following currencies:		
<u>392,836</u>	<u>388,922</u>	Pounds	<u>398,379</u>	<u>392,880</u>
<b><u>392,836</u></b>	<b><u>388,922</u></b>		<b><u>398,379</u></b>	<b><u>392,880</u></b>

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## 17. PROVISION – CONSOLIDATED

2014		Pensions & similar obligations	Clinical & Medical Negligence	Participation in CNORIS	Other	Total
£'000		£'000	£'000	£'000	£'000	£'000
109,829	At 1 April 2014	23,420	50,195	50,896	535	125,046
39,904	Arising during the year	1,975	12,428	0	1,316	15,719
(14,005)	Utilised during the year	(1,773)	(9,368)	(7,658)	(592)	(19,391)
33	Unwinding of discount	23	0	0	0	23
(10,715)	Reversed unutilised	(596)	(23,603)	0	(185)	(24,384)
<b>125,046</b>	<b>At 31 March 2015</b>	<b>23,049</b>	<b>29,652</b>	<b>43,238</b>	<b>1,074</b>	<b>97,013</b>

The amounts shown above are stated gross and the amount of any expected reimbursements are separately disclosed as receivables in Note 13.

Other provisions include an amount of £986k for non medical CNORIS and £88k in respect of the Board's estimated liability arising from equal pay claims.

Analysis of expected timing of discounted cash flows:

2014		Pensions & similar obligations	Clinical & Medical Negligence	Participation in CNORIS	Other	Total
£'000		£'000	£'000	£'000	£'000	£'000
56,515	Payable within one year	1,751	6,893	25,510	942	35,096
68,531	Payable between 2 -5 years	21,298	16,802	17,728	132	55,960
0	Payable between 6 – 10 years	0	1,272	0	0	1,272
0	Thereafter	0	4,685	0	0	4,685
<b>125,046</b>	<b>At 31 March 2015</b>	<b>23,049</b>	<b>29,652</b>	<b>43,238</b>	<b>1,074</b>	<b>97,013</b>

**Pensions and similar obligations**

The board meets the additional cost of benefits beyond the normal National Health Service Superannuation Scheme for Scotland benefits in respect of employees who retire early by paying the required amounts annually to the National Health Service Superannuation Scheme for Scotland over the period between early departure and normal retirement date. The Board provides for this in full when the early retirement programme becomes binding by establishing a provision for the expected share of payments over the remaining lives of the former employees, discounted by the Treasury discount rate of 1.3% (2013/14: 1.8 %). The Board expects expenditure to be charged to this provision for a period of up to 30 years.

**Clinical & Medical Negligence**

The Board holds a provision to meet the costs of all outstanding and potential clinical and medical negligence claims. All legal claims notified to the Board are processed by the Scottish NHS Central Legal Office who will decide upon risk liability and likely outcome of each case. The provision contains sums for settlement awards, legal expenses and third party costs. Clinical and medical negligence cases lodged can be extremely complex. It is expected that expenditure will be charged to this provision for up to 10 years. The amounts disclosed are stated gross and the amount of any expected reimbursements from the Clinical Negligence and Other Risks Insurance Scheme (CNORIS) is shown separately as receivables in Note 13 to the accounts. Reimbursements yet to be received are included in current and long term trade receivables.



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## 17a) CLINICAL NEGLIGENCE AND OTHER RISKS INDEMNITY SCHEME (CNORIS)

2013	2014		Note	2015
£'000	£'000			£'000
39,260	50,730	Provision recognising individual claims against the NHS Board as at 31 March		30,638
(37,032)	(48,383)	Associated CNORIS receivable at 31 March	13	(28,626)
48,195	50,896	Provision recognising the NHS Board' liability from participating in the scheme at 31 March	17	43,238
<b>50,423</b>	<b>53,243</b>	<b>Net Total Provision relating to CNORIS at 31 March 2015</b>		<b>45,250</b>

The Clinical Negligence and Other Risks Scheme (CNORIS) has been in operation since 2000. Participation in the scheme is mandatory for all NHS boards in Scotland. The scheme allows for risk pooling of legal claims in relation to clinical negligence and other risks and works in a similar manner to an insurance scheme. CNORIS has an agreed threshold of £25k and any claims with a value less than this are met directly from within boards' own budgets. Participants e.g. NHS boards contribute to the CNORIS pool each financial year at a pre-agreed contribution rate based on the risks associated with their individual NHS board. If a claim is settled the board will be reimbursed by the scheme for the value of the settlement, less a £25k "excess" fee. The scheme allows for the risk associated with any large or late in the financial year legal claims to be managed and reduces the level of volatility that individual boards are exposed to.

When a legal claim is made against an individual board, the board will assess whether a provision or contingent liability for that legal claim is required. If a provision is required then the board will also create an associated receivable recognising reimbursement from the scheme if the legal claim settles. The provision and associated receivable are shown in the first two lines above. The receivable has been netted off against the provision to reflect reimbursement from the scheme.

As a result of participation in the scheme, boards should also recognise that they will be required to make contributions to the scheme in future years. Therefore a second provision that recognises the board's share of the total CNORIS liability of NHSScotland has been made and this is reflected in third line above.

Therefore there are two related but distinct provisions required as a result of participation in the scheme. Both of these provisions as well as the associated receivable have been shown in the note above to aid the reader's understanding of CNORIS.

Further information on the scheme can be found at: <http://www.clo.scot.nhs.uk/our-services/cnoris.aspx>

18. MOVEMENT ON WORKING CAPITAL

2014 £'000		Note	Opening Balances £'000	Closing Balances £'000	Net Movement £'000
	<b>INVENTORIES</b>				
(958)	Balance Sheet	<a href="#">12</a>	14,393	16,183	
<b>(958)</b>	<b>Net Decrease/(Increase)</b>				<b>(1,790)</b>
	<b>TRADE AND OTHER RECEIVABLES</b>				
2,661	Due within one year	<a href="#">13</a>	76,470	86,648	
(2,070)	Due after more than one year	<a href="#">13</a>	25,148	22,234	
			101,618	108,882	
(980)	Less: Property, Plant & equipment included in above		(780)	(20)	
			100,838	108,862	
<b>(389)</b>	<b>Net Decrease/(Increase)</b>				<b>(8,024)</b>
	<b>TRADE AND OTHER PAYABLES</b>				
(35,235)	Due within one year	<a href="#">16</a>	197,465	188,541	
(4,396)	Due after more than one year	<a href="#">16</a>	191,457	204,339	
(2,271)	Less: Property, Plant & Equipment (Capital) included in above		(5,708)	(6,491)	
241	Less: General Fund Creditor included in above	<a href="#">16</a>	(1,133)	(492)	
3,708	Less: Lease and PFI Creditors included in above	<a href="#">16</a>	(195,232)	(191,079)	
			186,849	194,818	
<b>(37,953)</b>	<b>Net (Decrease)/Increase</b>				<b>7,969</b>
	<b>PROVISIONS</b>				
11,150	Due within one year	<a href="#">17</a>	56,515	35,096	
4,067	Due after more than one year	<a href="#">17</a>	68,531	61,917	
			125,046	97,013	
<b>15,217</b>	<b>Net (Decrease)/Increase</b>				<b>(28,033)</b>
<b>(24,083)</b>	<b>NET MOVEMENT Decrease/(Increase)</b>				<b>(29,878)</b>

19. CONTINGENT LIABILITIES/ASSETS – CONSOLIDATED

The following contingent liabilities have not been provided for in the Accounts:

2014

£'000		£'000
62,924	Clinical and medical compensation payments	60,459
1,202	Other	1,253

The following contingent assets have not been provided for in the Accounts:

2014

£'000		£'000
(61,188)	Clinical and medical negligence contingent assets	(58,745)

In the normal course of business, medical incidents may have occurred but may not yet be reported to the Board and so cannot be quantified with sufficient degree of certainty to allow an assessment to be made as to whether or not provision is required. Accordingly no provision has been reported in these Accounts.

Rates Review

A rates review is ongoing and expected to be finalised in mid summer 2015. NHS Lothian expect to receive income in relation to back dated rates, the final quantum has not been quantified.

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So far as the members are aware, the Board has not entered into any guarantee arrangement, indemnity nor provided any letter of comfort which would give rise to a contingent liability within the meaning of IAS 37.

**20. POST BALANCE SHEET EVENTS**

There were no Post Balance Sheet date events having a material effect on the accounts.

**21. COMMITMENTS – CONSOLIDATED****(a) Capital Commitments**

The Board have the following capital commitments which have not been provided for in the accounts:

2014 £'000	Contracted	£'000
0	Royal Hospital for Sick Children enablement	45
0	Aseptic Pharmacy Modernisation	50
531	Tranent Health Centre Extension	0
1,904	MRI Scanner STJ	0
1,479	REH Infrastructure	0
1,306	Other Commitments	1,717
<b>5,220</b>		<b>1,812</b>
	<b>Authorised but not Contracted</b>	
0	Royal Hospital for Sick Children and DCN project	32,899
0	Endoscopy Decon Unit WGH	3,046
0	Aseptic Pharmacy Modernisation	910
4,970	Radiotherapy Development Phase 8 & 9	2,375
0	Medical Equipment	7,500
5,000	Premises' upgrading	5,000
12	Tranent Health Centre Extension	0
465	MRI Scanner STJ	0
447	REH Infrastructure	0
46,829	Other	5,105
<b>57,723</b>	<b>Total</b>	<b>56,835</b>

**(b) Other financial commitments**

The Board has no other financial commitments

**(c) Financial Guarantees, Indemnities and Letters of Comfort**

The Board has not entered into any quantifiable guarantee, or indemnity or letter of comfort arrangement which would require evaluation under IAS 39.

## 22. LEASES – CONSOLIDATED

Total future minimum lease payments under operating and finance leases are given in the table below for the each of the following periods.

2014

£'000	Operating Leases	£'000
	<b>Obligations under operating leases comprise:</b>	
	<b>Land</b>	
215	Not later than one year	218
215	Later than one year but no later than two years	218
644	Later than two years, but no later than five years	655
2,306	Later than five years	2,178
	<b>Buildings</b>	
3,180	Not later than one year	2,434
2,434	Later than one year but not later than two years	2,434
7,302	Later than two but not later than five years	7,302
22,802	Later than five years	20,201
	<b>Other</b>	
1,256	Not later than one year	1,212
1,500	Later than one year but no later than two years	1,510
3,979	Between two and five years (inclusive)	3,701
134	After five years	0
	<b>Amounts charged to Operating Costs in year were:</b>	
5,833	Hire of equipment (including vehicles)	6,229
5,817	Other operating leases	5,868
<b>11,650</b>		<b>12,097</b>
	<b>Finance Leases</b>	
	<b>Obligations under Finance leases comprise:</b>	
	<b>Buildings</b>	
0	Rentals due within one year	0
0	Rentals due between one and two years (inclusive)	4
0	Rentals due between two and five years (inclusive)	1
0	Rentals due after five years	0
0		5
0	Less interest element	0
<b>0</b>		<b>5</b>
	<b>Other</b>	
15	Rentals due within one year	4
4	Rentals due between one and two years (inclusive)	3
1	Rentals due between two and five years (inclusive)	2
0	Rentals due after five years	0
20		9
(1)	Less interest element	0
<b>19</b>		<b>9</b>

## 23. PFI CONTRACTS – CONSOLIDATED

The Board has entered into the following PFI contracts.

## ON BALANCE SHEET

Description of Scheme		Start Date	End Date	Estimated capital value £'000
<b>Royal Infirmary of Edinburgh Midlothian Community Hospital Ferryfield</b>	Acute teaching hospital facilities	01/11/01	30/06/53	174,619
	This hospital provides 88 beds for frail elderly and dementia patients, outpatient clinics and a base for CHP led community activities.	01/09/10	31/08/40	17,293
	This service provides a 30 bedded facility for frail elderly and dementia patients and replaced the 100 year old Northern General Hospital	01/10/96	01/10/21	3,233
<b>Ellens Glen</b>	This service provides a 60 bedded facility for frail elderly and dementia patients	01/11/99	01/11/29	3,681
<b>Findlay House</b>	This service provides a 60 bedded facility for frail elderly and dementia patients in the grounds of the Eastern General Hospital	13/06/03	12/06/33	3,798
<b>Tippethill</b>	This service provides a 60 bedded facility for frail elderly and dementia patients at Whitburn	06/09/00	05/09/25	3,293
<b>Bathgate Primary Care Centre</b>	This service provides a Primary Care Centre which accommodates 3 GP Practices and the CHP's community activities in the locality	01/10/01	30/09/26	2,136

The balance of the risks and rewards of ownership of on balance sheet PFI/PPP property are borne by the Board and included in the Board's accounts as property. The liability to pay for the property is in substance a finance lease obligation. Contractual payments therefore comprise two elements; imputed finance lease charges and service charges. The imputed finance lease obligations are as follows:

2014		
£'000	Imputed finance lease obligation under on-balance-sheet PFI/PPP contracts comprises:	£'000
33,175	Rentals due within 1 year	33,610
33,175	Rentals due within 1 to 2 years	33,610
99,526	Rentals due within 2 to 5 years	100,830
459,366	Rentals due thereafter	431,899
625,242		599,949
(430,029)	Less interest element	(408,884)
<b>195,213</b>	<b>Total</b>	<b>191,065</b>

The amount charged to the Statement of Comprehensive Net Expenditure in respect of costs relating to on balance sheet PFI contracts was as follows:

2014		
£'000		£'000
19,673	Service charges	20,671
29,493	Interest charges on finance lease debt	28,949
5,767	Depreciation	5,212
<b>54,933</b>	<b>Total</b>	<b>54,832</b>

Contingent rents included within the interest charges were £4,667,000 (2013-14: £4,233,000)

## 24. PENSION COSTS

The NHS Board participates in the NHS Superannuation Scheme (Scotland). The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and from those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations. The rate of employer contributions is set with reference to a funding valuation undertaken by the scheme actuary. The last four-yearly valuation was undertaken as at 31 March 2012. The next valuation will be as at 31 March 2016 and this will set contribution rates from 1 April 2019.

The NHS board has no liability for other employers obligations to the multi-employer scheme.

As the scheme is unfunded there can be no deficit or surplus to distribute on the wind-up of the scheme or withdrawal from the scheme.

The scheme is an unfunded multi-employer defined benefit scheme.

It is accepted that the scheme can be treated for accounting purposes as a defined contribution scheme in circumstances where the NHS board is unable to identify its share of the underlying assets and liabilities of the scheme.

The employer contribution rate for the period from 1 April 2015 will be 14.9% of pensionable pay. While the employee rate applied is a variable it will provide an actuarial yield of 9.8% of pensionable pay.

At the last valuation a shortfall of 1.4 billion was identified in the notional fund which will be repaid by a supplementary rate of 2.6% of employers pension contributions for fifteen years from 1 April 2015. This contribution is included in the 14.9% employers contribution rate.

The NHS board level of participation in the scheme is 13% based on the proportion of employer contributions paid in 2013-14.

For the current year, normal employer contributions of £83.8m were payable to the SPPA (2013/14 £80.1m) at the rate of 13.5% (2013/14 13.5%) of total pensionable salaries. In addition, during the accounting period the NHS board incurred additional costs of £0 (2013/14 £0) arising from the early retirement of staff.

The expected contribution for 2015/16 are £92.5m based on a rate of 14.9%.

NHS Lothian contribute to SPPA pension scheme, the total NHS employer contribution received for the scheme in the year to 31<sup>st</sup> March 2015 was £640.5m of which 13.1% were NHS Lothian's employers contributions.

Provisions amounting to £23.1m (2013/14 £23.4m) are included in the Balance Sheet and reflect the difference between the amounts charged to the Statement of Consolidated Comprehensive Net Expenditure and the amounts paid directly.

Changes to the scheme were implemented from 1 April 2008. Existing staff, and those joining the scheme up to 31 March 2008, will keep the benefits of the existing scheme but will be given the choice to transfer to the new scheme.

### Existing scheme:

The scheme provides benefits on a "final salary" basis at a normal retirement age of 60. Annual benefits are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. Members pay tiered contribution rates ranging from 5% to 13.3% of pensionable earnings. Pensions are increased in line with the Consumer Prices Index.

On death, pensions are payable to the surviving spouse at a rate of half the member's pension. On death in service, the scheme pays a lump-sum benefit of twice pensionable pay and also provides a service enhancement on computing the spouse's pension. The enhancement depends on length of service and cannot exceed 10 years. Child allowances are payable according to the number of dependant children and whether there is a surviving parent who will get a scheme widow/widower's pension. Medical retirement is

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possible in the event of serious ill health. In this case, pensions are brought into payment immediately where the member has more than 2 years service. Where service exceeds 5 years, the pension is calculated using specially enhanced service, with a maximum enhancement of 10 years.

Members aged 50 or above may take voluntary early retirement and receive a reduced pension. Alternatively, if the employer agrees to this the member will be able to retire on the full pension and lump sum which they have earned.

**Arrangements from 2008:**

The scheme provides benefits on a “final salary” basis at a normal retirement age of 65. Pension will have an accrual rate of 1/60th and be calculated on the basis of the average of the best consecutive three years pensionable pay in the ten years before retirement. There is an option to exchange part of Pension benefits for a cash lump sum at retirement, up to 25% of overall Pension Value.

Members pay tiered contribution rates ranging from 5% to 13.3% of pensionable earnings. Pensions and allowances are index linked to protect their value.

Members aged 55 or above may take voluntary early retirement and receive a reduced pension. Alternatively, if the employer agrees to this the member will be able to retire on the full pension and lump sum which they have earned.

<b>2014</b>		
<b>£'000</b>		<b>£'000</b>
80,064	Pension cost charge for the year	83,812
23,420	Provisions/Liabilities/Pre-payments included in the Balance Sheet	23,050

**25. PRIOR YEAR ADJUSTMENTS**

Prior year adjustments which have been recognised in these Accounts are:

		<b>Dr.</b>	<b>Cr.</b>
		<b>£'000</b>	<b>£'000</b>
<b>Adjustment 1</b>	<b>CNORIS future provision</b>		
	General Fund	50,896	
	CNORIS future provision	<u>17</u>	(50,896)

The accounts reflect £50m adjustment as £48,195k in 2012/13 and £2,701k in 2013/14. This discloses the provision as at 31<sup>st</sup> March 2013 and the in year movement of £2,701 that occurred in 2013/14. This can be seen in the Statement of Changes in Taxpayers’ Equity (SOCTE).

Note 26 shows the restatement of the primary statements as disclosed 31th March 2014. Note 17 shows the detail of the CNORIS provision.

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## 26 (a) RESTATED STATEMENT OF CONSOLIDATED COMPREHENSIVE NET EXPENDITURE

	Previous Accounts 2014 £'000	Adjustment £'000	Restated 2014 £'000
<b>Total Clinical Services Costs</b>	<b>1,415,028</b>		<b>1,415,028</b>
Administration Costs	9,852		9,852
Other Non Clinical Services costs	45,206	2,701	47,907
Other Operating Income	(46,466)		(46,466)
<b>Net Operating Costs</b>	<b>1,423,620</b>	<b>2,701</b>	<b>1,426,321</b>

## 26(b) RESTATED BALANCE SHEET

	Note	Previous Accounts 2014 £'000	Adjustments 2014 £'000	Restated 2014 £'000
<b>Total assets</b>		<b>979,507</b>	<b>0</b>	<b>979,507</b>
<b>Total current liabilities</b>		<b>(227,865)</b>	<b>0</b>	<b>(227,865)</b>
<b>Non-current assets less liabilities</b>		<b>751,642</b>	<b>0</b>	<b>751,642</b>
<b>Non-current liabilities</b>				
Provisions	<u>17</u>	(47,664)	(50,896)	(98,560)
Financial liabilities:				
Trade and other payables	<u>16</u>	(191,457)		(191,457)
<b>Total non-current liabilities</b>		<b>(239,121)</b>	<b>(50,896)</b>	<b>(290,017)</b>
<b>Assets less liabilities</b>		<b>512,521</b>	<b>(50,896)</b>	<b>461,625</b>
<b>Taxpayers' Equity</b>				
General fund	<u>SOCTE</u>	262,222	(50,896)	211,326
Revaluation reserve	<u>SOCTE</u>	181,348		181,348
Other reserves	<u>SOCTE</u>	68,951		68,951
<b>Total taxpayers' equity</b>		<b>512,521</b>	<b>(50,896)</b>	<b>461,625</b>

The detail of the prior year adjustment in relation to the CNORIS participation provision can be seen in Note 17 and 17a.



## 27. FINANCIAL INSTRUMENTS – Consolidated

2014	AT 31 MARCH 2015	Note	Loans and Receivables £'000	Available for sale £'000	Total £'000
£'000					
	<b>Assets per balance sheet</b>				
67,499	Investments	<a href="#">14</a>		72,346	72,346
21,590	Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable.		25,748		25,748
5,845	Cash and cash equivalents	<a href="#">15</a>	5,066		5,066
<b>94,934</b>			<b>30,814</b>	<b>72,346</b>	<b>103,160</b>
2014				<b>Other Financial Liabilities £'000</b>	<b>Total £'000</b>
£'000					
	<b>Liabilities per balance sheet</b>				
19	Finance lease liabilities	<a href="#">16</a>		14	14
195,213	PFI Liabilities	<a href="#">16</a>		191,065	191,065
144,435	Trade and other payables excluding statutory liabilities (VAT and income tax and social security)			134,844	134,844
<b>339,667</b>				<b>325,923</b>	<b>325,923</b>

## FINANCIAL INSTRUMENTS – Board

2014	AT 31 MARCH 2015	Note	Loans and Receivables £'000	Available for sale £'000	Total £'000
£'000					
	<b>Assets per balance sheet</b>				
34	Investments	<a href="#">14</a>		1,266	1,266
21,660	Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable.		25,748		25,748
1,133	Cash and cash equivalents	<a href="#">15</a>	492		492
<b>22,827</b>			<b>26,240</b>	<b>1,266</b>	<b>27,506</b>
2014				<b>Other Financial Liabilities £'000</b>	<b>Total £'000</b>
£'000					
	<b>Liabilities per balance sheet</b>				
19	Finance lease liabilities	<a href="#">16</a>		14	14
195,213	PFI Liabilities	<a href="#">16</a>		191,065	191,065
140,521	Trade and other payables excluding statutory liabilities (VAT and income tax and social security)			129,345	129,345
<b>335,753</b>				<b>320,424</b>	<b>320,424</b>

## 27 (b) Financial Risk Factors

**Exposure to Risk**

The NHS Board's activities expose it to a variety of financial risks:

- Credit risk - the possibility that other parties might fail to pay amounts due
- Liquidity risk - the possibility that the NHS Board might not have funds available to meet its commitments to make payments
- Market risk - the possibility that financial loss might arise as a result of changes in such measures as interest rates, stock market movements of foreign exchange rates.

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Because of the largely non-trading nature of its activities and the way in which government departments are financed, the NHS Board is not exposed to the degree of financial risk faced by business entities.

The Board provides written principles for overall risk management, as well as written policies covering:

**i) Credit Risk**

Credit risk arises from cash and cash equivalents, deposits with banks and other institutions, as well as credit exposures to customers, including outstanding receivables and committed transactions. For banks and other institutions, only independently rated parties with a minimum rating of 'A' are accepted. Customers are assessed, taking into account their financial position, past experience and other factors, with individual credit limits being set in accordance with internal ratings in accordance with parameters set by the NHS Board. The utilisation of credit limits is regularly monitored. No credit limits were exceeded during the reporting period and no losses are expected from non-performance by any counterparties in relation to deposits.

**ii) Liquidity Risk**

The Scottish Parliament makes provision for the use of resources by the NHS Board for revenue and capital purposes in a Budget Act for each financial year. Resources and accruing resources may be used only for the purposes specified and up to the amounts specified in the Budget Act. The Act also specifies an overall cash authorisation to operate for the financial year. The NHS Board is not therefore exposed to significant liquidity risks.

The table below analyses the financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet to contractual maturity date. The amounts disclosed in the table are the contractual undiscounted cash flows.

	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years	Over 5 years	TOTAL
PFI Liabilities	4,695	5,320	20,641	160,409	191,065
Finance lease liabilities	9	4	1	0	14
Trade and other payables excluding statutory liabilities	29,454				29,454
<b>At 31 March 2015 (£'000)</b>	<b>34,158</b>	<b>5,324</b>	<b>20,642</b>	<b>160,409</b>	<b>220,533</b>
<b>At 31 March 2014 (£'000)</b>	<b>14,027</b>	<b>4,699</b>	<b>18,194</b>	<b>168,176</b>	<b>205,096</b>

**iii) Market Risk**

The NHS Board has no powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities and are not held to manage the risks facing the NHS Board in undertaking its activities.

**Cash flow and fair value interest risk**

The NHS Board has no significant interest bearing assets or liabilities and as such income and expenditure cash flows are substantially independent of changes in market interest rates.

**Foreign Currency Risk**

The NHS Board is not exposed to foreign exchange rates except through occasional ad-hoc settlement of purchase liabilities denominated in non £ sterling currencies. The Foundation holds non Sterling equities and bonds and is therefore exposed to foreign currency risk.

**Price risk**

The NHS Board is not exposed to equity security price risk. The Foundation holds equities and bonds and is therefore exposed to equity price risk. This risk is managed by the investment managers.

**27(c) Fair Value Estimation**

The fair value of financial instruments that are not traded in an active market is determined using valuation techniques based on future projected cash flows.

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The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair value.

The fair value of financial liabilities for disclosure purposes is estimated by discounting the future contractual cash flows at the current HM Treasury interest rate that is available for similar financial instruments

**27(d) Derivative Financial Instruments And Forward Currency Exchange Contracts**

At 31 March 2015 there were no principal amounts outstanding in respect of forward currency exchange contracts and there were no amounts credited or charged to the Statement of Consolidated Comprehensive Net Expenditure in respect of gains or losses on such contracts in the year ended 31 March 2015.

**28. RELATED PARTY TRANSACTIONS**

(a) Dr Richard Williams is a non-executive member of NHS Lothian and is a salaried GP in Restalrig Park Medical Centre, Edinburgh. In 2014/15, NHS Lothian's Family Health Services' and other payments to Restalrig Park Medical Centre amounted to £1,315,132 (2013/14: £1,325,673). Dr. Williams' personal remuneration is disclosed in the remuneration report on pages 26 - 32.

(b) By virtue of their membership of the Board, executive and non-executive members are Trustees of the Lothian NHS Endowment Fund, which is a registered Scottish Charity and which expends donations for any NHS purpose and in accordance with the donor of the funds. During 2014/15 the funds spent a total of £6.55mm (2013/14: £6.91m), in support and in addition to, NHS funded supplies and services, including capital projects. NHS Lothian had a trading balance due from the Lothian NHS Endowment Fund of £68,804 as at 31 March 2015 (31 March 2014: £74,732).

(c) The Board enters into transactions with other Scottish Government and United Kingdom Government agencies and publicly funded bodies (such as Councils and educational institutions) in the ordinary course of its operations. These transactions take place at arms length. Scottish Ministers issue instructions and guidance on special transactions between publicly funded bodies in areas such as property transfers and joint venture investments.

(d) As stated in Note 14, NHS Lothian owns 11.11% share of the share capital of Hub South East Scotland Limited. The Board has made a loan of £33k to Hub South East Scotland Limited, and also advanced a further £267k to its public sector partners, to enable them to finance the initial working capital requirements of Hub South East Scotland Limited. The shareholders of Hub South East Scotland Limited are public authorities and the Scottish Futures Trust who, in conjunction with a private sector partner are participating in a planned programme of investments in shared premises and related facilities services. NHS Lothian transactions with Hub South East Scotland Limited during the financial year ended 31 March 2015 were £3.7m (13/14 £2.9m)

**29. SEGMENT INFORMATION**

The net operating costs of the Board are analysed on the basis of Individual Business Units reported to the Board for performance management purposes. The acute specialist hospital services are split between the Business Units of Scheduled and Unscheduled Care. Community Health Partnerships and the West Lothian Community Health and Care Partnership (CHCPs) Business Units are responsible for delivery of Family and Community health services and include Child and Adult Mental Health, Learning Disabilities and acute adult and child mental health services at the Royal Edinburgh Hospital. Corporate Department budgets include the non-clinical support services performed to support the Board's core operations and Strategic Budgets represent the Board's commissioning of services, and central overhead costs of the Board. As responsibilities for care shift from the acute sector the segmental analysis and comparatives will reflect these changes.

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The segments that have been used to report performance management this year are as follows:

- Scheduled Care
- Unscheduled Care
- East Lothian; Mid Lothian; West Lothian and City of Edinburgh CH(C)Ps
- Corporate and Strategic Departments
- Endowments

Assets and liabilities are not reported as part of performance management arrangements so this information is not provided.

	Scheduled £'000	Unscheduled £'000	CHCPs £'000	Corporate £'000	Endowments £'000	Total £'000
<b>Net operating cost 2014/15</b>	320,213	297,695	646,877	209,087	2,889	<b>1,476,761</b>
<b>Net operating cost 2013/14 – Restated</b>	298,038	285,806	637,281	203,786	1,410	<b>1,426,321</b>

30. THIRD PARTY ASSETS

The Board holds funds on behalf of those inpatients that are highly dependent and not capable of handling their financial affairs when admitted to and during their stay in hospital. Transactions made on behalf of such patients and residual funds are subject to regular audit. These are not departmental assets and are not included in the accounts. The assets held at the reporting period date to which it was practical to ascribe monetary values comprised monetary assets, such as bank balances and monies on deposit. The amounts and movements in year are set out in the table immediately below.

	At 31 March 2014 £'000	Gross Inflows £'000	Gross Outflows £'000	At 31 March 2015 £'000
Bank balances and monies on deposit	1,264	1,446	(1,663)	1,047
<b>Total Monetary Assets</b>	<b>1,264</b>	<b>1,446</b>	<b>(1,663)</b>	<b>1,047</b>

## 31. REDUNDANCY COSTS

The Board has throughout the financial year agreed, with a number of employees, voluntary severance arrangements and other non-compulsory early retirement arrangements. The pension element of these costs in 2014/15 was nil (2013/14- nil). The cost of such arrangements is summarised below:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	1	1
£10,000 - £25,000	0	5	5
£25,000 - £50,000	0	20	20
£50,000 - £100,000	0	13	13
£100,000- £150,000	0	1	1
£150,000- £200,000	0	0	0
>£200,000	0	0	0
<b>Total number exit packages by type</b>	<b>0</b>	<b>40</b>	<b>40</b>
<b>Total resource cost (£'000)</b>	<b>0</b>	<b>1,888</b>	<b>1,888</b>

## PRIOR YEAR

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	1	1
£10,000 - £25,000	0	1	1
£25,000 - £50,000	0	13	13
£50,000 - £100,000	0	3	3
£100,000- £150,000	0	2	2
£150,000- £200,000	0	0	0
>£200,000	0	0	0
<b>Total number exit packages by type</b>	<b>0</b>	<b>20</b>	<b>20</b>
<b>Total resource cost (£'000)</b>	<b>0</b>	<b>1,144</b>	<b>1,144</b>

## 32. LINKED STATEMENT OF CONSOLIDATED COMPREHENSIVE NET EXPENDITURE (RESTATED)

## (a) Group SOCNE

Group 2014 £'000		Board £'000	Endowments £'000	Intra Group adjustment £'000	Consolidated £'000
	<b>Clinical Services Costs</b>				
1,321,341	Hospital and Community	1,370,579		(299)	1,370,280
(249,457)	Hospital and Community Income	(250,529)			(250,529)
1,071,884		1,120,050	0	(299)	1,119,751
354,130	Family Health	358,607			358,607
(10,986)	Family Health Income	(11,456)			(11,456)
<b>1,415,028</b>	<b>Total Clinical Services Costs</b>	<b>1,467,201</b>	<b>0</b>	<b>(299)</b>	<b>1,466,902</b>
9,852	Administration Costs	9,206			9,206
9,852		9,206	0	0	9,206
47,907	Other Non Clinical Services	2,597	6,536	(4,273)	4,860
(46,466)	Other Operating Income	(5,132)	(3,647)	4,572	(4,207)
<b>1,426,321</b>	<b>Net Operating Costs</b>	<b>1,473,872</b>	<b>2,889</b>	<b>0</b>	<b>1,476,761</b>

The intercompany adjustments relate to removal of intercompany rental income to endowments from NHS Lothian £299k, and removal of grants to NHS Lothian £4,273k.

Realised gains from Foundation investments of £474k have been recognised in the Endowment 'Other operating income' line above.

## 32 LINKED CONSOLIDATED GROUP BALANCE SHEET (RESTATED)

## (b) Group Balance Sheet

Group 2014 £'000	Note	Board £'000	Endowment £'000	Intra Group adjustment £'000	Group £'000
<b>Non-current assets:</b>					
785,329	Property, plant and equipment	<u>11</u>	810,978		810,978
2,624	Intangible assets	<u>10</u>	2,168		2,168
Financial assets:					
67,499	Available for sale financial assets	<u>14</u>	1,266	71,080	72,346
25,148	Trade and other receivables	<u>13</u>	22,234		22,234
<b>880,600</b>	<b>Total non-current assets</b>		<b>836,646</b>	<b>71,080</b>	<b>907,726</b>
<b>Current Assets:</b>					
14,393	Inventories	<u>12</u>	16,183		16,183
Financial assets:					
77,158	Trade and other receivables	<u>13</u>	86,648	402 (69)	86,981
5,845	Cash and cash equivalents	<u>15</u>	492	4,574	5,066
1,511	Assets classified as held for sale	<u>11c</u>	1,776		1,776
<b>98,907</b>	<b>Total current assets</b>		<b>105,099</b>	<b>4,976 (69)</b>	<b>110,006</b>
<b>979,507</b>	<b>Total assets</b>		<b>941,745</b>	<b>76,056 (69)</b>	<b>1,017,732</b>
<b>Current liabilities</b>					
(56,515)	Provisions	<u>17</u>	(35,096)		(35,096)
Financial liabilities:					
(201,379)	Trade and other payables	<u>16</u>	(188,541)	(5,568) 69	(194,040)
<b>(257,894)</b>	<b>Total current liabilities</b>		<b>(223,637)</b>	<b>(5,568) 69</b>	<b>(229,136)</b>
<b>721,613</b>	<b>Non-current assets plus/(less) net current assets/(liabilities)</b>		<b>718,108</b>	<b>70,488 0</b>	<b>788,596</b>
<b>Non-current liabilities</b>					
(68,531)	Provisions	<u>17</u>	(61,917)		(61,917)
Financial liabilities:					
(191,457)	Trade and other payables	<u>16</u>	(204,339)		(204,339)
<b>(259,988)</b>	<b>Total non-current liabilities</b>		<b>(266,256)</b>		<b>(266,256)</b>
<b>461,625</b>	<b>Assets less liabilities</b>		<b>451,852</b>	<b>70,488 0</b>	<b>522,340</b>
<b>Taxpayers' Equity</b>					
211,326	General fund	SOCTE	249,926		249,926
181,348	Revaluation reserve	SOCTE	201,926		201,926
68,951	Funds held on Trust	SOCTE	0	70,488	70,488
<b>461,625</b>	<b>Total taxpayers' equity</b>		<b>451,852</b>	<b>70,488 0</b>	<b>522,340</b>

There are unrealised gain reserves of £7,029k that are included within the Funds held on Trust figure of £70,488k.

## 32. LINKED CONSOLIDATED GROUP CASHFLOWS (RESTATED)

## c) Group Cashflows

2014	2014	2014		Board	Endowment	Group
Board	Endowment	Group	Cash flows from operating activities	Board	Endowment	Group
£'000	£'000	£'000		£'000	£'000	£'000
(1,424,911)	(1,410)	(1,426,321)	Net operating cost	(1,473,872)	(2,889)	(1,476,761)
42,757	0	42,757	Adjustments for non-cash transactions	49,993	0	49,993
29,526	0	29,526	Add back: interest payable recognised in net operating cost	28,972	0	28,972
0	(2,768)	(2,768)	Deduct: interest receivable recognised in net operating cost	0	(1,631)	(1,631)
0	(332)	(332)	Investment income	0	(310)	(310)
(389)	(439)	(828)	(Increase) / decrease in trade and other receivables	(8,024)	361	(7,663)
(958)	0	(958)	(Increase) / decrease in inventories	(1,790)	0	(1,790)
(37,953)	2,796	(35,157)	Increase / (decrease) in trade and other payables	7,969	1,580	9,549
15,217	0	15,217	Increase / (decrease) in provisions	(28,033)	0	(28,033)
<b>(1,376,711)</b>	<b>(2,153)</b>	<b>(1,378,864)</b>	<b>Net cash outflow from operating activities</b>	<b>(1,424,785)</b>	<b>(2,889)</b>	<b>(1,427,674)</b>
			<b>Cash flows from investing activities</b>			
(27,238)	0	(27,238)	Purchase of property, plant and equipment	(44,478)	0	(44,478)
(298)	0	(298)	Purchase of intangible assets	(930)	0	(930)
0	0	0	Investment Additions	(1,233)	0	(1,233)
3,895	0	3,895	Proceeds of disposal of property, plant and equipment	1,605	913	2,518
0	(392)	(392)	Receipts from sale of investment	0	(103)	(103)
0	3,100	3,100	Interest and dividends received	0	1,941	1,941
<b>(23,641)</b>	<b>2,708</b>	<b>(20,933)</b>	<b>Net cash outflow from investing activities</b>	<b>(45,036)</b>	<b>2,751</b>	<b>(42,285)</b>
			<b>Cash flows from financing activities</b>			
1,433,586	0	1,433,586	Funding	1,502,946	0	1,502,946
(241)	0	(241)	Movement in general fund working capital	(641)	0	(641)
1,433,345	0	1,433,345	Cash drawn down	1,502,305	0	1,502,305
(3,708)	0	(3,708)	Capital element of payments in respect of finance leases and on-balance sheet PFI contracts	(4,153)	0	(4,153)
(33)	0	(33)	Interest paid	(23)	0	(23)
(29,493)	0	(29,493)	Interest element of finance leases and on-balance sheet PFI/PPP contracts	(28,949)	0	(28,949)
<b>1,400,111</b>	<b>0</b>	<b>1,400,111</b>	<b>Net Financing</b>	<b>1,469,180</b>	<b>0</b>	<b>1,469,180</b>
(241)	555	314	<b>Net Increase / (decrease) in cash and cash equivalents in the period</b>	(641)	(138)	(779)
1,374	4,157	5,531	<b>Cash and cash equivalents at the beginning of the period</b>	1,133	4,712	5,845
<b>1,133</b>	<b>4,712</b>	<b>5,845</b>	<b>Cash and cash equivalents at the end of the period</b>	<b>492</b>	<b>4,574</b>	<b>5,066</b>
			<b>Reconciliation of net cash flow to movement in net debt/cash</b>			
(241)	555	314	Increase/(decrease) in cash in year	(641)	(138)	(779)
1,374	4,157	5,531	Net debt/cash at 1 April	1,133	4,712	5,845
<b>1,133</b>	<b>4,712</b>	<b>5,845</b>	<b>Net debt/cash at 31 March</b>	<b>492</b>	<b>4,574</b>	<b>5,066</b>





Lothian Health Board

**DIRECTION BY THE SCOTTISH MINISTERS**

1. The Scottish Ministers, in pursuance of sections 86(1), (1B) and (3) of the National Health Services (Scotland) Act 1978, hereby give the following direction.
2. The statement of accounts for the financial year ended 31 March 2006, and subsequent years, shall comply with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (FRM) which is in force for the year for which the statement of accounts are prepared.
3. Subject to the foregoing requirements, the accounts shall also comply with any accounts format, disclosure and accounting requirements issued by the Scottish Ministers from time to time.
4. The accounts shall be prepared so as to give a true and fair view of the income and expenditure and cash flows for the financial year, and of the state of affairs as at the end of the financial year.
5. This direction shall be reproduced as an appendix to the statement of accounts. The direction given on 30 December 2002 is hereby revoked.

Signed by the authority of the Scottish Ministers

Dated 10/2/2006



Lothian NHS Board

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2-4 Waterloo Place  
Edinburgh  
EH1 3EG  
Telephone 0131 536 9000  
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[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

Date 17 June 2015  
Your Ref  
Our Ref

Enquiries to  
Direct Line 0131 465 5804  
Email [Elaine.watters@nhslothian.scot.nhs.uk](mailto:Elaine.watters@nhslothian.scot.nhs.uk)

David McConnell  
Assistant Director  
Audit Scotland  
4th Floor, South Suite  
The Athenaeum Building  
8 Nelson Mandela Building  
Glasgow  
G2 1BT

Dear David

## **NHS Lothian**

### **Annual Accounts 2014/15**

This representation letter is provided in connection with your audit of the financial statements of NHS Lothian for the year ended 31 March 2015 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the state of affairs of the board and its group as at 31 March 2015 and of their net operating costs for the year then ended.

I confirm to the best of my knowledge and belief, and having made appropriate enquiries of the Executive Management Team and the Board, the following representations given to you in connection with your audit of NHS Lothian for the year ended 31 March 2015.

#### **General**

I acknowledge my responsibility and that of NHS Lothian for the financial statements. All the accounting records requested have been made available to you for the purposes of your audit. All material agreements and transactions undertaken by NHS Lothian have been properly reflected in the financial statements. All other records and information have been made available to you, including minutes of all management and other meetings.

The information given in the Management Commentary in the financial statements, including the Strategic Report, Directors' Report and Remuneration Report, presents a balanced picture of NHS Lothian and is consistent with the financial statements.

I confirm that the effects of uncorrected misstatements are immaterial, individually and in aggregate, to the financial statements as a whole. I am not aware of any uncorrected misstatements other than those identified in the Annual Audit Report for the Board of NHS Lothian and the Auditor General for Scotland.

### **Regularity of Financial Transactions**

The financial transactions of NHS Lothian are in accordance with the relevant legislation and regulations governing its activities and expenditure and income were incurred or applied in accordance with applicable enactments and guidance issued by the Scottish Ministers.

### **Financial Reporting Framework**

The financial statements have been prepared in accordance with 2014/15 Government Financial Reporting Manual, and in accordance with the requirements of the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers including all relevant presentation and disclosure requirements.

Disclosure has been made in the financial statements of all matters necessary for them to show a true and fair view of the transactions and state of affairs of NHS Lothian and its group for the year ended 31 March 2015.

### **Accounting Policies & Estimates**

All material accounting policies adopted are as shown in the Accounting Policies included in the financial statements. The continuing appropriateness of these policies has been reviewed since the introduction of IAS 8 and on a regular basis thereafter, and takes account of the requirements set out in the 2014/15 Government Financial Reporting Manual.

The significant assumptions used in making accounting estimates are reasonable and properly reflected in the financial statements. There are no changes in estimation techniques which should be disclosed due to their having a material impact on the accounting disclosures.

### **Going Concern**

The Accountable Officer has assessed NHS Lothian's ability to carry on as a going concern, as identified in the Accounting Policies, and have disclosed, in the financial statements, any material uncertainties that have arisen as a result.

### **Related Party Transactions**

All transactions with related parties have been disclosed in the financial statements. I have made available to you all the relevant information concerning such transactions, and I am not aware of any other matters that require disclosure in order to comply with the requirements of IAS24, as interpreted by the 2014/15 Government Financial Reporting Manual.

## **Post Balance Sheet Events**

There have been no material events since the date of the Consolidated Balance Sheet which necessitate revision of the figures in the financial statements or notes thereto including contingent assets and liabilities.

Since the date of the Consolidated Balance Sheet no events or transactions have occurred which, though properly excluded from the financial statements, are of such importance that they should be brought to your notice.

## **Corporate Governance**

I acknowledge as Accountable Officer my responsibility for the corporate governance arrangements. I confirm that I have disclosed to the auditor all deficiencies in internal control of which I am aware.

The corporate governance arrangements have been reviewed and the disclosures I have made are in accordance with the 2014/15 Government Financial Reporting Manual. There have been no changes in the corporate governance arrangements or issues identified, since the 31 March 2015, which require disclosure.

## **Fraud**

I have considered the risk that the financial statements may be materially misstated as a result of fraud. I have disclosed to the auditor any allegations of fraud or suspected fraud affecting the financial statements. There have been no irregularities involving management or employees who have a significant role in internal control or that could have a material effect on the financial statements.

## **Assets**

The assets shown in the Consolidated Balance Sheet at 31 March 2015 were owned by NHS Lothian, other than assets which have been purchased under operating leases. Title to properties included in the books and accounts at 31 March 2015 was held by the Central legal Office, a division of NHS National Services Scotland, on behalf of Scottish Ministers. Assets are free from any lien, encumbrance or charge except as disclosed in the financial statements.

## **Liabilities**

All liabilities have been provided for in the books of account, including the liabilities for all purchases to which title has passed prior to 31 March 2015.

## Carrying Value of Assets and Liabilities

The assets and liabilities have been recognised, measured, presented and disclosed in accordance with the 2014/15 Government Financial Reporting Manual. There are no plans or intentions that are likely to affect the carrying value of classification of the assets and liabilities within the financial statements.

## Provisions

Provisions have been made in the financial statements for all material liabilities which have resulted or may be expected to result, by legal action or otherwise, from events which had occurred by 31 March 2015 and of which NHS Lothian could reasonably be expected to be aware. The amount recognised as a provision is the best estimate of the expenditure likely to be required to settle the present obligation at 31 March 2015.

Yours sincerely

**Tim Davison**  
**Accountable Officer**



**Headquarters**  
Waverley Gate  
2-4 Waterloo Place  
Edinburgh EH1 3EG

**Chair Brian G. Houston**  
**Chief Executive Tim Davison**

*Lothian NHS Board is the common name of Lothian Health Board*

Board Meeting  
24 June 2015

Medical Director/Director of Human Resources & OD/Director of Nursing

### SUMMARY PAPER - WORKFORCE RISK ASSESSMENT

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"> <li>Obstetrics &amp; Gynaecology – From February 2015 7 out of 8 new posts created in 2012/13 have been filled. The service continues to look at options for increasing resident on-call consultant cover, where vacancies occur they will be filled on the basis of participation on the on-call rota. Recruitment to 4 International Medical Training Fellowship (IMTF) posts is underway with one appointment made thus far.</li> <li>The findings and recommendations of a review of Women's services undertaken by the Royal College of Obstetricians in February are being considered by The Maternity Services Programme Board who will consider the recommendations and take forward necessary actions that may be required.</li> </ul>	3.21
<ul style="list-style-type: none"> <li>Paediatrics – The situation at SJH previously detailed remains unchanged, with only four of the nine out of hours slots filled on a substantive basis.</li> </ul>	3.22
<ul style="list-style-type: none"> <li>MOE – Trainee gaps are very difficult to fill, with only 1 of 5 recent Locum for Training (LAT) posts being filled resulting in reliance on locum staffing.</li> <li>Recent consultant recruitment did not fill a post based at Roodlands Hospital which now has only 1wte of an establishment of 4wte filled substantively and is almost entirely reliant on RIE staff working additional shifts, staff bank and agency staffing.</li> </ul>	3.2.3
<ul style="list-style-type: none"> <li>Following recent recruitment to 4 out of 5 vacancies the consultant workforce is now close to full capacity. A further 4 new posts are under recruitment as part of the Head and Neck Capacity plan.</li> </ul>	3.2.4
<ul style="list-style-type: none"> <li>There are significant recruitment problems within Psychiatry at St John's hospital within General, Rehabilitation and Perinatal Psychiatry with 3 recent vacancies receiving no applicants and require to be covered by agency locums.</li> </ul>	3.2.5
<ul style="list-style-type: none"> <li>General Practices are having difficulty in filling Partner vacancies whilst there are increasing gaps in recruitment to GP training.</li> </ul>	3.3
<ul style="list-style-type: none"> <li>NHS Lothian is substantially increasing health visitor training to ensure compliance with the Named Person and Child Statutory Planning Service legislation from August 2016. However there are also significant risk demographic pressures and replacing retirees may absorb additional trainees. The expansion of the training of advanced nurse practitioners has increased from 49 in April 2014 to 56 in April 2015 and potentially a further 16-20 in September to support general practice.</li> </ul>	3.5

Nick McAlister  
Head of Workforce Planning  
9 June 2015

**WORKFORCE RISK ASSESSMENT**

**1 Purpose of the Report**

The purpose of this report is to update the Board on the actions currently underway to ameliorate risks to service sustainability within certain specialties where high levels of risk have been identified. The scope of the paper has been widened to consider risk within the wider workforce as well as the medical specialities.

**2 Recommendations**

- 2.1 Recognise the steps that are being taken to both sustain the trained obstetric medical workforce in the medium term and enhance patient safety with 24/7 resident consultant cover.
- 2.2 Recognise staffing for the paediatric unit at SJH continues to be heavily reliant on a small number of staff doing additional night and weekend shifts to cover rota gaps.
- 2.3 Acknowledge that recruitment to Medicine for the Elderly vacancies at Roodlands hospital has been unsuccessful and as such the service is almost entirely reliant upon cover by RIE staff or supplementary staffing.
- 2.4 Note the successful recruitment that has been achieved within Anaesthetics at the 3 adult acute sites and the recruitment underway to expand the Consultant workforce at St John's Hospital as part of the Head and Neck capacity plan.
- 2.5 Note the recruitment difficulties within psychiatric specialties within St John's Hospital and West Lothian mental health services.
- 2.6 Support the actions being taken forward to appoint Acute Clinical Development Fellows and International Development Fellows to support services where there are medical trainee gaps.
- 2.7 Note the actions that are underway at a national level to improve medical workforce planning for the medium to long terms.
- 2.8 Note the workforce challenges that are being faced by general practice workforces and support participation in the Primary Care Workforce Survey 2015, which will help inform Scottish Government planning for the GP workforce.
- 2.9 Support the work that is underway to develop trainee rotas that will ensure no trainees will work more than 7 days in a row as required by recent Scottish Government direction and note the challenge this may represent for some services.
- 2.10 Support the actions that are being taken forward to increase health visitor training capacity to enable growth of the workforce to ensure compliance with the Named Person and Child Statutory Planning Service legislation from August 2016.

### **3 Discussion of Key Issues**

#### **3.1 Background**

The overall in-post consultant workforce has increased from 711wte to 792wte between 2011 and 2014, an increase of 81wte (9.7%). This investment has been made to help respond to increasing demand from a growing population and provide additional capacity to reduce treatment times. It has also been in response to a reduction in trainee numbers in some areas and a move to become less reliant on trainees for service delivery. The main areas of increase have been in Paediatrics, Surgery, Anaesthetics, Emergency Medicine and Obstetrics & Gynaecology. During this period the level of retirements within the consultant workforce decreased from 26 in 2011/12 to 17 in 2013/14 but in 2014/15 the level has again increased to 24.

There have also been a number of areas, as detailed in this paper, where it has not been possible to grow the workforce to the extent that has been identified by capacity planning and where posts have not been able to be filled where staff have retired. This represents one of the key workforce risks faced by NHS Lothian (NHSL) along with other Health Boards in Scotland.

Since June 2013 a Medical Workforce Risk Assessment paper has been taken to the NHS Lothian Board to highlight the areas of high risk and the actions underway to reduce the level of risk. Over this time there have been on-going updates around Emergency Medicine, Paediatrics and O&G as these were identified as key areas of risk as part of the medical workforce risk assessment process.

This paper also provides detail around other areas of significant risk where NHS Lothian has been unable to provide additional capacity and improve patient flow in areas such as Anaesthetics, Medicine of the Elderly (MoE) and Ophthalmology due to recruitment difficulties.

Many of the workforce challenges that are faced within the medical workforce are faced across NHS Scotland and this paper details the range of work streams and actions that are underway nationally to address them.

Whilst many of the workforce supply challenges that are faced by the Board relate to the medical workforce there are also challenges within other areas of the workforce. This paper also provides detail in relation to Health Visiting where there are demographic challenges with significant anticipated retirements and also the need to grow the workforce to respond to the requirements of the Named Person and Child Statutory Planning Service legislation.

#### **3.2 Progress in addressing key medical workforce risks**

##### **3.2.1 Obstetrics & Gynaecology**

The South East Scotland O&G training programme experiences a high level of gaps due to trainees going Out of Programme (OOP) for research/experience, maternity leave and less than full time working. Recruitment of competent Locums Appointed for Training (LATs) to cover these gaps is often unsuccessful. There is an ongoing requirement for internal locum usage including consultants covering resident middle grade OOH shifts several times a month with a consequent impact on day time availability.



In 2012/13 the Board made funding available for eight new consultant posts to contribute to the resident middle grade rota at RIE and from February 2015 seven of these posts were filled substantively and one filled on a fixed term basis. However, recruitment has been difficult and ongoing turnover is anticipated. The service continues to look at options for increasing resident on-call consultant cover and where vacancies occur they will be filled on the basis of participation on the on-call rota. Without further expansion however it may take longer to increase the consultant presence on the labour ward. Where gaps arise these will be covered by internal locums.

Attempts to recruit four fixed term clinical fellows (including making use of the Scottish Government International Medical Training Fellowship initiative) continue. Only one appointment has been made to date.

Within elective gynaecology services sickness absence and two resignations have presented challenges for planned outpatient and inpatient work this year. A locum consultant was appointed from December 2014 for one year and two consultant posts in gynaecology will be advertised shortly.

The findings and recommendation of a review of Women's Services undertaken by the Royal College of Obstetricians in February 2015 at NHS Lothian's request has recently been considered by the Healthcare Governance Committee. The Maternity Services Programme Board will now consider the recommendations and take forward necessary actions that may be required.

### **3.2.2 Paediatrics**

As detailed in previous papers there have been considerable efforts made to sustain paediatric and neonatal rotas across Lothian in the face of considerable gaps.

The situation at SJH detailed in previous Board papers however remains unchanged, with only four of the nine out of hours slots filled on a substantive basis. The staffing situation for the combined Paediatric and Neonatal Service remains very difficult, heavily reliant on a small number of people doing additional night and weekend shifts (making use of a waiver from the European Working Time Directive) and prone to short notice difficulties because of sickness or other unplanned absence.

One clinical fellow has recently been appointed making use of the International Medical Training Fellowship programme. However, a start date depends on the doctor obtaining a visa. The doctor will also need to undergo a period of induction and assessment before they can be considered for the out of hours rota. In two previous cases the doctors have not been considered to have attained the necessary competencies to work in the middle grade out of hours rota thus failing to alleviate the situation.

At St John's for the last six months there are also gaps (currently two out of six) in the FY/GPST rota which further impacts the service. These have been managed by a series of short term locums. Two junior clinical fellow posts will be advertised shortly to try and cover these gaps.

### **3.2.3 Medicine of the Elderly (MOE)**

Within MOE services in Lothian there are trainees placed as part of both core medical training and specialty training. There can be significant variability in the number of trainees in a given rotation and there are can also be gaps following the annual

recruitment process. The most substantial pressure however is the number of gaps that arise as a result of maternity leave and less than full-time training. These gaps are very difficult to fill and a recent attempt to recruit to 5 Locum for Training (LAT) posts resulted in only 1 post being filled.

Clinical development fellows as outlined in Section 3.26 have been and continue to be very important in providing cover for some of these gaps; they do however require a greater level of supervision. There is also significant reliance on bank and agency locums to provide adequate cover.

There are also significant challenges associated with the recruitment of trained doctors and the following section provides detail on recent recruitment activity in this speciality.

#### Western General Hospital (WGH)

There was partially successful recruitment to 2 full-time consultants and 2 part-time consultants at the WGH which provided the consultant workforce element required to support COMPASS initiative in North Edinburgh aimed at improving assessment and subsequent clinical case management, monitoring and review of frail elderly patients. The 1.5wte Specialty Doctors element was however unsuccessful.

A recent attempt to recruit to a 12 month maternity leave 0.8wte locum consultant post was also unsuccessful and attracted no applicants.

#### RIE & Liberton

A recruitment exercise to recruit 4 Consultants at the beginning of February 2015 was successful in filling 3 posts, with 1 successful candidate taking up post in June 2015 and the other 2 commencing in August 2015. The post that remained unfilled is based at Roodlands Hospital and represents the latest in a number of unsuccessful recruitment attempts at this site. As a consequence only 1 wte of an establishment of 4 wte consultant posts is filled on a substantive basis at Roodlands Hospital. These gaps are currently being covered by a range of ad-hoc staffing measures including consultants from the RIE working additional shifts, staff bank shifts and external agency staffing. Should it not be possible to fill gaps then it may be necessary to close Roodlands to admissions at the weekend. It is clear that these measures do not represent a sustainable solution in the medium to long term and alternative staffing models are currently under consideration.

Recruitment to a permanent replacement specialty doctor post covering the RIE and Liberton sites in February was unsuccessful in attracting any suitable applicants and is once again under recruitment. A subsequent recruitment process for 1 new and 1 replacement permanent specialty doctor positions was successful with the applicants anticipated to take up post in June/July.

There is recruitment currently underway for a further 2 specialty doctors/fellows covering the RIE and Liberton sites with interviews planned in June 2015.

### **3.2.4 Anaesthetics**

Sufficient anaesthetic consultant staffing is key to ensuring optimum theatre utilisation and ensuring a consistent flow in activity.

Within Anaesthetics in NHS Lothian and many Health Boards in Scotland there have however been long standing difficulties in filling consultant posts. This is as a result of increased demand associated with increasing activity and the introduction of treatment times guarantees. As a consequence recruitment is highly dependent on the numbers of higher specialty trainees completing their training as the majority of applicants are from within Scotland.

There have been partial successes in recruitment; at the end of 2013 the 3 main adult acute sites were successful in filling 8 out of 13 posts. This however left a number of positions unfilled.

There was further recruitment undertaken for 3 full time new consultant posts at SJH; 2 wte permanent and 1 wte 12 month locum position all of which were filled and commenced in early 2015.

In order to fill the 5 remaining vacant consultant posts covering emergency, obstetric and cardio-thoracic anaesthesia adverts were placed in February 2015. All these posts were filled with the exception of 1 in emergency anaesthesia with the successful candidates taking up post at the end of August and early September. Consequently there is now close to full capacity within the anaesthetics workforce at the RIE, WGH and SJH.

There are however 4 additional new consultant posts under recruitment at SJH as part of the Head and Neck capacity plan which aims to improve and sustain services to meet treatment time guarantees on an on-going basis.

Within the trainee workforce however there remain a significant number of gaps that emerge within the trainee workforce as a result of maternity leave and emerging gaps as trainees complete training. These posts as with other specialties continue to be very difficult to fill and as a consequence there is continuing reliance of supplementary staffing to cover gaps.

### **3.2.5 Psychiatry**

In-line with other health boards these services are facing increasing difficulties in filling consultant posts. There are on average 6% vacancies within general psychiatry and an average of 12% within old age psychiatry across NHS Scotland (Source ISD Scotland). This represents only posts that are actively under recruitment and there may be other posts that are not being actively recruited due to a lack of applicants.

Nationally Mental Health specialties are a specific concern with a low fill rate of 78% in the core programme and very low fill rates in the Higher Specialty programmes; CAMHS 80%, Forensic 44%, General Psychiatry 31%, Old Age 42% and Learning Disability 50%. There are already gaps in the Higher Specialty programmes and funding had been released from these programmes to fund additional core posts, however these have not been filled. The gaps in these programmes will have an impact both on current services and on the future supply of trained doctors for consultant vacancies.

Recruitment to psychiatry posts in Lothian in general has been relatively good with posts being filled when advertised. However within West Lothian this has not been the case and it has not been possible to fill the following posts based at SJH:

Mother and Baby Unit - Perinatal Psychiatry  
General Adult Psychiatry

## Rehabilitation Psychiatry

In each case the recruitment process attracted no applicants, despite recent success in filling 2 Old age Psychiatry posts.

With a national shortage of Consultant Psychiatrists prospective candidates have a wide range of posts to consider when applying for roles. The posts in West Lothian carry a heavy workload and include a significantly more intense on-call commitment than in other areas and as such may be less attractive.

Further efforts are underway to advertise posts widely and use specialty forums to ensure the widest possible coverage. There is also consideration being given as to whether there could be a more collaborative and integrated approach to psychiatry within Lothian. There has also been contact made with other Boards Medical Directors in the South East Region in relation to regional specialty recruitment and whether this could assist Boards with recruitment and retention.

These unfilled vacancies are being covered currently by agency locums and as such there is not a gap in service, but there is significant financial pressure as a result.

### 3.2.6 Clinical Development Fellows

In response to the significant difficulties that are being faced in filling LAS and LAT posts NHS Lothian introduced the Acute Clinical Development Fellowship (ACDF) role aimed at doctors leaving foundation training who wish to gain further experience in a specialty before committing to a specialty training programme.

Since its introduction in 2013 the programme has helped support service sustainability whilst providing excellent training opportunities in a number of areas where recruitment to LAT/LAS posts is very difficult.

In 2015 the number of ACDF posts has been increased and widened to cover the following areas:

Site	Service	Number of post
St John's Hospital	Emergency Department	6
St John's Hospital	ENT Surgery/Oral Maxillofacial Surgery /Plastic Surgery	3
Royal Infirmary	Emergency Department	3
Royal Infirmary	Acute Medicine	4
Royal Infirmary	Medicine for the Elderly	3
Royal Infirmary	Trauma & Orthopaedics	3
Western General Hospital	Oncology	3

Following interest being expressed by Forth Valley in the NHS Lothian programme 3 posts have been recruited for Forth Valley within Emergency Medicine.

There also 3 posts currently under recruitment for primary care for the first time, which have attracted expressions of interest. Interviews are scheduled for the end of June.

The funding for these ACDF posts has been met through savings associated with vacancies however it is becoming increasingly difficult to sustain funding for these posts due to financial pressures associated with supplementary staffing.

### **3.2.7 National medical workforce planning**

The risk assessment process has consistently flagged up a difficulty in filling posts that arise out with the annual recruitment process either as a result of trainee withdrawal, maternity leave and trainees going out of programme to undertake research PhDs. As detailed previously these gaps can be very difficult to fill other than by using agency or bank locums, as posts may be less than full time and for a relatively short period.

The national Strategy to Attract and Retain Trainees (StART) Alliance led by NES is developing a range of measures aimed at improving recruitment and retention within training programmes.

#### **3.2.7.1 Scottish Shape of Training Transition Group**

Many of the workforce challenges that are faced by Boards require to be tackled at both a local and national level. The planning of training programmes and numbers requires to be carried out nationally in conjunction with Boards to ensure that planning reflects the requirements of services, as well as those of trainees. This group was established in 2014 under the leadership of the Scottish Government along with training leads from NES and stakeholders from Boards. The Regional Workforce Director for SE Scotland is part of the group and liaises closely with the regional medical workforce group. The remit of the group is to:

- Receive and assess representations from stakeholders in relation to specialty training numbers, setting the annual specialty training numbers.
- Gather and analyse workforce data on issues related to the trainee medical workforce.
- Gather and analyse data on service provision issues including trainee rota gaps and acute consultant shortages.
- Identify, assess and work with the Service to mitigate workforce risks relating to the current and future medical trainee workforce.
- Develop and maintain medical workforce supply/demand profiles for each specialty
- Design and support programmes to improve distribution of the medical
- Maintain oversight of Trainee Medical Recruitment processes including providing a forum to ensure consistent standards and for developing and articulating an NHS Scotland position on evolving arrangements for UK national recruitment
- Engagement and connection with all the key organisations.

The key work streams that are currently being progressed include:

- Research to understand the career destinations of foundation trainees through a destination survey.
- Profiling of core medical training including recruitment & retention and flows through to specialty training.
- Understanding gaps in training programmes
- Development of medical specialty profiles
- Coordination of the International Medical Fellowship programme

The SE region and NHS Lothian are currently reviewing and testing some of the planning assumptions that have been used to plan future trainee numbers to help

ensure the accuracy of the planning process. Getting this work right is key in ensuring workforce sustainability in the medium to long term.

### 3.2.7.2 Sustaining Medical Workforce in Scotland – Proposal for International Medical Training Fellowships (IMTF)

The Scottish Government (SG) wrote to all Boards last year detailing a proposal for International Medical Training Fellowships (IMTF), which could be used to help sustain the medical workforce. The objective of the proposal was to provide additional high quality posts to address gaps in the provision of service, using training grade contracts. These posts are for senior trainees that are near to achieving their Certificate of Completion of Training (CCT) and the fellowships provide an opportunity to widen and increase experience.

Submissions were made to the SG for the following areas:

SPECIALTY	BASE
Colorectal	WGH
Transplant Unit	RIE
Oncology	WGH
Acute Medicine	WGH
Oral and Maxillofacial Surgery	SJH
Obstetrics & Gynaecology X2	RIE
Paediatrics X2	RHSC & SJH
Anaesthetics /Critical Care	RIE
Plastic Surgery	SJH
Medicine and Regional Infectious Diseases Unit	WGH

All these proposals were accepted by the SG and NES who reviewed the proposals to ensure they represent high quality training opportunities.

Seven of these posts have now completed the recruitment process and successful candidates will take up post in August and September 2015. All posts with the exception of Infectious Disease attracted applicants and this post will be re-advertised shortly.

### 3.3 General Practice

As mentioned in previous Board papers general practice is facing considerable workforce pressures within both the UK as a whole and across Scotland.

Over the last 10 years the profile of the GP workforce has changed significantly. There are now more female GPs than males, with a lower sessional commitment. In Lothian there is a significantly higher proportion of part-time GPs (61.3%) than the Scottish average (49.5%), the majority of whom are part-time. National research (Primary care workforce survey 2013) has shown that only 25% of females work 8 or more sessions (whole time equivalent). These changes in the average contribution level were not factored in to the national planning of training of numbers until relatively recently.

Demographic change within the GP workforce is also a key factor as the majority of GPs (55%) are aged over 45 years old, with the majority of females aged under 45

and the majority of males approximately 48 years old. Where gaps arise they are typically partners and these posts can be unattractive given the predominance of part-time working.

Within Lothian practices these pressures are evident, for example within Leith Links Practice where 6 partners left over a 3 month period. These departures were unrelated however it was not possible to recruit to the vacancies and employment of locum doctors and changes to practice boundaries were required.

It has been recognised by the Scottish Government that there requires to be an increase to GP training numbers and that these numbers need a replacement factor of 1.8 trainees for each retirement to account for the increase in part time working. There is however a heavy reliance on being able to fill all training slots and the fill rate for current GP programmes is 77%, against a fill rate of 90% in 2014. A reduced fill rate such as this will compromise future recruitment of qualified GPs. NES are currently developing a website and central point of contact for GP's wanting to return to work or those who trained overseas and would like to join the GP workforce in Scotland.

However even if training numbers are successfully increased this may not necessarily mean that it will be possible to fill vacancies on a like for like basis and workforce redesign may be required to provide opportunities that correspond with the desire for part-time working within a large proportion of GPs.

Service redesign based around the needs of patients, the development of technology and fit for purpose premises will also be key to sustaining practices and the GP workforce in the medium to long term.

The SGHD will be running the Primary Care Workforce Survey 2015 between August and October (subject to confirmation). This will ask all GP practices and OOH services to complete a survey looking at the workforce profile of both GPs and practices nurses including demography, retirements and vacancies. It will be important to obtain as full coverage and completion as possible as this forms the only main source of information on the GP workforce and as such is one of the main sources of intelligence upon which the SG can draw upon to make decisions around future training numbers. NHS Lothian will work closely with practices to maximise participation.

### **3.4 Seven Day Working**

In November 2014 the SGHD issued a directive to amend working patterns for Junior Doctors in line with best practice. This included the following commitments:

- End the practice of rostering junior doctors working seven nights in a row by February 2015.
- By February 2016 no junior doctor will work any more than seven days in a row
- Simplify the junior doctors hours monitoring process, removing any barriers to the accurate recording and monitoring of these hours.
- Ensure that all staff have access to appropriate rest facilities

Whilst these requirements did not represent any change to New Deal or WTR legislation, they however represent a move from technical compliance to best practice.

NHS Lothian had already adopted some of the requirements of the CEO letter well before its release. The practice of working 7 consecutive nights was stopped in 2009. The key issue for NHS Lothian now is to ensure that no doctor in training works more than 7 days in a row by February 2016.

The SGHD have also recommended that best practice would be to include a zero hours day prior to a block of nights when revising rotas for maximum 7 day working ensuring that trainees would be well rested before commencing nights.

The Medical Directors Group within Lothian is leading on this piece of work and with the help of the Compliance Team, it has specified rota parameters which detail how rotas are to be configured in future to meet the SGHD's Directive.

The intention is to have the majority of rotas fulfilling all these requirements by the commencement of the new rotation in August 2015, with agreed new rotas in place by the end of June 2015 to ensure trainees are given the required 1 month's notice of a change in working pattern. This will allow a period when rotas can be trialled and further amended if necessary prior to the end of January deadline.

The Compliance team is currently meeting with each specialty to consider possible options for all rotas. Each rota is being risk assessed against the new parameters with a monthly update being provided to the Medical Directors Group.

Whilst the directive relates to trainees only any OOHs cover provided by clinical development fellows on trainee rotas will also require to be in line with the new parameters.

Some departments have however already highlighted that compliance with the new requirements may prove difficult / have adverse impact on Service delivery. These will be considered on a case by case basis.

### **3.5 Nursing and Midwifery Workforce**

The national nursing and midwifery workload and workforce planning tools have been run on an annual basis. The findings have been triangulated with professional judgement and quality indicators and optimum staffing levels identified across speciality groups, and papers brought to previous CMT meetings. Investment has been made to ameliorate the impact of incremental drift on budgets, to ensure safer staffing levels in areas of professional concern and to eliminate variation within specialities across sites. A further paper will be brought to the Board to describe in detail the remaining shortfall in the nurse and midwifery staffing levels and a Board Development Day is planned for September.

Maintaining safe staffing has seen continued and increased use of supplementary staffing to ensure safety for patients across in patient settings. The Francis, Keogh and Vale of Leven reports have all highlighted the impact of staffing levels and skill mix on the quality of care delivered. A risk assessment is carried out for every agency shift requested and whilst there has been a reduction in agency used however agency continues to be pursued where patient safety may be compromised.

The use of nursing and midwifery bank and agency (as reported by ISD) in 2014/15 compared with 2013/14 is detailed in table below.



		2014/15	2013/14
Bank	Wte	718	643
	Cost (£m)	£21.9m	£19.3m
Agency	Wte	60	39
	Cost (£m)	£5.3m	£3.5m

The increased use of supplementary staffing is against a backdrop of a decreased establishment gap, currently 581 wte (5.9% of the total nursing and midwifery funded establishment).

### 3.5.1 Health Visiting Workforce Capacity

As mentioned in previous Board papers the Health Visiting (HV) workforce requires to considerably increase across Scotland to ensure compliance with the Named Person and Child Statutory Planning Service legislation from August 2016.

The Scottish Government have agreed to fund an additional 500 HVs in Scotland by 2018 to support the required workforce expansion. NHS Lothian share will be in the region of an additional 56 fully funded posts this being based on an anticipated 13% share of the national resource. Funding allocation will be recurring and allocated incrementally during 2015-18.

The issues regarding reduced supply and capacity within the Health Visiting workforce across Scotland are well recognised. In Lothian we have carefully risk managed this situation and trained additional HVs during 2013-14 and 2014-15. We have also introduced significant staff nurse skill mix in response to service development and redesign and in mitigation of the growing number of HV vacancies. This ensures the needs of our families are being met and the role of the HV staff nurse is now well embedded within HV teams.

There are however clearly significant risks associated with the current existing Health Visitor workforce including:

- Vacancy rates: At 1<sup>st</sup> April 2015, there were 25 HV vacancies across Lothian. This is despite advertising locally and throughout the UK. Recruitment is also becoming more challenging as HVs move into different posts as part of their career progression.
- Age Profile of existing band 6 HVs: 54% of Band 6 HVs are over 50 years of age (72.3 WTE). Most HVs have retained NHS 'special status' and therefore could potentially retire at 55. Five band 6 staff have notified their intention to retire by September 2015. This potentially reduces the beneficial impact of the additional HV staff being trained during and due to graduate in September 2015.

The additional funding that is anticipated from the Scottish Government will help provide the capacity that is required to increase by approximately 56 wte. Further expansion of numbers by approximately 26 wte is required to comply with the national caseload weighting tool and a further 7 wte for population growth by 2018. These other areas of expansion are as yet unfunded and represent a significant financial pressure for NHS Lothian.

The potential shortage of HVs is included in the NHS Lothian corporate risk register.

### **3.5.2 NHSL Actions and proposed next steps to recruit Health Visitors**

In anticipation of the national review and introduction of the Children and Young People (Scotland) Act, NHS Lothian has used vacancy factor related to under spend to augment the HV training budget. In 2014-15, sixteen nurses were seconded to Queen Margaret University (QMU) (an additional ten places than routinely trained in Lothian) to undertake the HV Specialist Practitioner Qualification (SPQ). NHS Lothian is one of the few Boards that have consistently supported a minimum of 6 HVs to undertake the SPQ course at QMU on an on-going basis.

All 16 of these students need supervision from a Community Practice Teacher (CPT). 11 additional CPTs are currently being supported to undertake the course at QMU which is part-time over 2 years. It is anticipated that 6 will qualify in 2015 and with a further 5 qualifying in 2016.

The implementation of the Named Person Role introduces considerable administration functions for HVs including organising and recording formal GIRFEC Child Planning meetings, coordination of care and drafting and review of statutory child plans. A new role of GIRFEC Administrator to support the HVs with the additional administrative function associated with the Named Person role is being developed.

Options for part time training and other approaches (distance learning) to achieving the HV, SPQ are being explored with education providers at national level. NHS Lothian is working closely with colleagues nationally to ensure that we are able to train staff without draining nursing resource across NHS Scotland.

Retaining existing HVs and HV staff nurses is also a priority. It is envisaged that some of the attached HV staff nurses will apply to undertake HV training. It is imperative that staff nurse vacancies are recruited to in sufficient time to ensure continued operational delivery by HV teams.

### **3.5.3 Advanced Nurse Practitioners**

The training of advanced nurse practitioners (ANPs) is ongoing, 39 began training in April 2014 and a further 17 began in April 2015. These staff are training across a range of specialities including oncology, cardiology, the REACT / IMPACT teams and medicine of the elderly which previously had low numbers of no ANPs, neonates, paediatrics and hospital at night where there is an existing staff cohort of ANPs. A further increase is planned from September with 16-20 entering training to GP practice roles.

The time to train Advanced Nurse Practitioners and the input required from medical colleagues to support the training requires planning and does not provide a quick win to cover existing medical gaps.

### **3.5.4 Revalidation**

The introduction of a model for revalidation by the Nursing and Midwifery Council (the NMC, the regulatory body for nurses and midwives) that includes a third party input will begin in April 2016.

Revalidation includes confirmation of the registrants continued fitness to practise, that the registrant has met the requirements for practice and continuing professional development, have sought and received third party feedback which has informed their

reflection on their practice and have sought and received third party confirmation that they have provided this evidence.

A pan Lothian approach is being taken to the implementation, although registrants are personally accountable for ensuring that they comply with the revalidation requirements on a 3 yearly basis.

### **3.6 Workforce risk assessment update process**

A programme for the review of medical workforce risk assessments has commenced, and will cover all areas covered previously as well as some community areas not specifically covered previously. These will be fed into the Lothian Medical Workforce Group as well as clinical/site management teams and key areas of risk will also be reflected within future board papers.

## **4 Risk Register**

- 4.1 The NHS Lothian risk register contains a 'Medical Workforce Sustainability' risk, which relates the risk that workforce supply pressures in conjunction with activity pressures will impact on service sustainability and/or NHS Lothian's ability to achieve its corporate objectives. The multi-factorial risk assessments that have been carried out will be reviewed and updated where necessary on a 6 monthly basis or where there are significant changes.

## **5 Impact on Inequality, Including Health Inequalities**

The introduction of the medical workforce risk assessment process has been subject to a rapid impact assessment for which a report has been prepared.

## **6 Involving People**

Before any changes in service provision across any site in NHS Lothian are made, there would need to be engagement and consultation with appropriate audiences with the guidance of the Scottish Health Council.

## **7 Resource Implications**

- 7.1 There are potential resource implications, which are identified as part of the planning process within specialties to reduce the level of workforce risk. These will be progressed through the appropriate local management structures to secure necessary support.

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10 June 2014

Board meeting  
24 June 2015

Chief Officer

## ACUTE SERVICES PERFORMANCE UPDATE

### SUMMARY PAPER

The key points of the paper are summarised here.

At the end of April, 500 patients were waiting beyond the 12 week treatment time guarantee. 476 patients were treated in month beyond the guarantee	3
3,467 outpatients were waiting over 12 weeks.	4
18 week performance from referral to treatment remains stable at 85.1%	5
Performance against both the 31 and 62 day cancer standard is provisionally placed at 96.2%, which exceeds the 95% expected standard. Performance against the standards for Colorectal and Urology remains challenging for NHS Lothian	6
Provisional information on diagnostic waiting times shows that 1,448 diagnostic endoscopy patients were waiting longer than the 6 week standard and 146 radiology patients were also waiting longer than the standard	7
Endoscopy Recovery Plan	8.2
19 patients were waiting beyond audiology standards at the end of April 2015	9
NHS Lothian continues to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months	10
NHS Lothian's overall performance against the 4 hour standard for the month of April 2015 was 93.56% (92.61% during March)	11
During April, 48 patients waited longer than 8 hours and 22 patients waited longer than 12 hours in A&E	11.4
The 2015/16 Winter Planning Project Board, chaired by the Chief Officer, has been established	12
The overall number of delayed discharges across NHS Lothian has increased from 148 in March 2015 to 172 in April 2015	13

**ACUTE SERVICES PERFORMANCE UPDATE**

**1 Purpose of the Report**

- 1.1 The purpose of this report is to provide the Board with an update on the performance of Acute Services.
- 1.2 Following the consolidation of management arrangements for Scheduled Care, Unscheduled Care, and Estates and Facilities under a single Chief Officer, we have combined the Scheduled Care and Unscheduled Care reports which the Board previously received.
- 1.3 Any member wishing additional information should contact the Executive Lead in advance of the meeting.

**2 Recommendations**

- 2.1 It is recommended that the Board receives this update on the performance of Acute Services.

**3 Inpatients and Daycases**

- 3.1 At the end of April, 500 patients were waiting beyond the 12 week treatment time guarantee (Table 1). 476 patients were treated in month beyond the guarantee (Table 2).

**Table 1 – Treatment Time Guarantee Patients seen beyond 12 weeks.**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
TTG Seen	443	533	476	388	402	467	448	397	427	406	564	692	476

- 3.2 Figures on list size and unavailability are shown in the following table. The use of unavailability and choice codes in Lothian remains low.

**Table 2 – List Size and Unavailability**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Total List Size (TTG)	9445	9256	9252	9307	9534	9842	9841	9832	9961	9600	9481	9140	8941
Available	8260	8016	7891	8000	8322	8697	8810	8733	8784	8714	8576	8174	7911
Unavailable	1185	1240	1361	1307	1212	1145	1031	1099	1177	886	905	966	1030
Percentage Unavailable	13%	13%	15%	14%	13%	12%	10%	11%	12%	9%	10%	11%	12%

## 4 Outpatients

- 4.1 Across NHS Lothian, 3,467 outpatients were waiting more than the 12 week TTG at the end of April; figures in key specialties are shown in the table below.
- 4.2 Figures on outpatient list size and unavailability are shown in the following table.

**Table 3 – List Size and Unavailability<sup>1</sup>**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Total List Size	40808	42481	42480	43738	43091	42624	43955	43004	42639	41721	42861	43694	46547
Available	39837	41357	41169	42320	41854	41441	42808	42085	41527	41000	41987	42878	45843
Unavailable	971	1124	1311	1418	1237	1183	1147	919	1112	721	694	816	704
Percentage Unavailable	2%	3%	3%	3%	3%	3%	3%	2%	3%	2%	2%	2%	2%

## 5 18 Weeks Referral to Treatment Standard

- 5.1 Performance against the 18 week referral to treatment standard remains stable at 85.1% during April; however NHS Lothian is still below the expected 90% compliance. Table 6 shows the trend for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard.

## 6 Cancer

- 6.1 At the end of March, performance against both the 31 and 62 day cancer standards is provisionally placed at 96.2% which is above the 95% standard.<sup>2</sup>
- 6.2 Performance against cancer standards are shown in table 7 and table 8, October 2014 to March 2015. Delivery has been close to, or slightly above, the 95% expected across each month in the past quarter.
- 6.3 There is a variation in waiting times performance by cancer type. Performance against the standards for Colorectal and Urology remains challenging for NHS Lothian.

<sup>1</sup> Figures may differ from those previously reported. These were drawn from national data warehouse to ensure comparability throughout.

<sup>2</sup> March 2015 data are provisional.

**Table 4 – Trend in Cancer Performance (31 days from diagnosis to treatment)**

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Cancer Type	Percentage that started treatment within 31 days					
<b>All Cancer types</b>	<b>98.2%</b>	<b>95.3%</b>	<b>97.4%</b>	<b>93.3%</b>	<b>94.1%</b>	<b>96.2%</b>
Breast (screened excluded)	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%
Cervical (screened excluded)	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%
Cervical (screened only)	100.0%	n/a	100.0%	100.0%	100.0%	100.0%
Colorectal (screened excluded)	96.9%	96.4%	96.3%	86.4%	94.4%	96.0%
Colorectal (screened only)	100.0%	100.0%	87.5%	75.0%	80.0%	100.0%
Head & Neck	100.0%	92.3%	94.4%	100.0%	100.0%	100.0%
Lung	100.0%	98.4%	100.0%	100.0%	98.6%	98.6%
Lymphoma	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%
Neurological - Brain and CNS	n/a	n/a	n/a	100.0%	n/a	n/a
Ovarian	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	100.0%	100.0%	95.8%	100.0%	95.8%
Urological	90.4%	84.6%	90.7%	75.9%	73.1%	82.4%

**Table 5 – Trend in Cancer Performance (62 days from urgent referral to treatment)**

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Cancer Type	Percentage that started treatment within 62 days					
<b>All Cancer types</b>	<b>96.8%</b>	<b>92.9%</b>	<b>96.5%</b>	<b>94.5%</b>	<b>93.1%</b>	<b>95.6%</b>
Breast (screened excluded)	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%
Cervical (screened excluded)	100.0%	100.0%	50.0%	66.7%	100.0%	100.0%
Cervical (screened only)	n/a	n/a	100.0%	100.0%	100.0%	100.0%
Colorectal (screened excluded)	81.3%	93.8%	93.3%	78.6%	85.7%	87.5%
Colorectal (screened only)	100.0%	100.0%	71.4%	100.0%	66.7%	100.0%
Head & Neck	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%
Lung	100.0%	100.0%	100.0%	100.0%	94.4%	94.1%
Lymphoma	80.0%	71.4%	100.0%	80.0%	100.0%	100.0%
Melanoma	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Neurological - Brain and CNS	n/a	n/a	n/a	100.0%	n/a	n/a
Ovarian	100.0%	50.0%	100.0%	100.0%	n/a	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	91.7%	100.0%	100.0%	90.9%	100.0%
Urological	95.2%	87.5%	94.4%	87.0%	80.0%	82.6%

## 7 Diagnostics waiting times performance

- 7.1 Provisional information on diagnostic waiting times shows that 1,448 diagnostic endoscopy patients were waiting longer than the 6 week standard. This is an increase on the January position (1,006 patients were waiting). We have an endoscopy recovery plan in place to improve our performance which is outlined below at paragraph 8.2.
- 7.2 The number of radiology patients waiting beyond the 6 week standard was 146 in April, which is a significant increase on March's position (20 patients); there have however been

changes to the way in which we record radiology information and this has affected the trend data.<sup>3</sup>

## 8 Surveillance Endoscopy

8.1 End of April's surveillance endoscopy position saw 1,332 patients waiting beyond their due date. This is a significant increase since May 2014 (439 patients). Table 11 shows the trend in patients waiting longer than their planned review date. We have a recovery plan in place to improve our performance.

**Table 6 – Surveillance and Review Patients overdue appointment**

	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Colonoscopy	89	81	83	108	113	96	191	301	447	487	570	614
Upper Endo	53	42	57	55	51	71	99	125	206	279	299	320
Flexi Sig	22	16	18	20	19	17	18	35	58	80	99	109
Flexi Cysto	219	234	180	190	269	334	324	282	263	259	285	196
Other	56	49	33	37	39	59	34	62	105	93	98	93
<b>Total</b>	<b>439</b>	<b>422</b>	<b>371</b>	<b>410</b>	<b>491</b>	<b>577</b>	<b>666</b>	<b>805</b>	<b>1079</b>	<b>1198</b>	<b>1351</b>	<b>1332</b>

### Endoscopy recovery

8.2 The number of patients waiting over six weeks for an Endoscopy procedure in Lothian has increased since the end of October 2014. There are a number of reasons for this including high referral levels on the back of initiatives such as Detecting Cancer Early, and lower than normal capacity levels due to maintenance with our decontamination equipment and the impact of vacancies in key staffing areas.

8.3 We have taken the following actions to improve this position including:

- Weekend work has continued at an increased rate at both WGH & RIE.
- The Regional Endoscopy Unit has increased NHS Lothian sessions to 15 sessions in June, equivalent to 75 patient appointments each month.
- A trained Nurse Endoscopist came into post in June and will perform a minimum of five scoping sessions per week.
- Three new GI Consultants have been appointed with planned start dates in early August 2015.
- The training of the two Trainee Nurse Endoscopists is progressing well with their accelerated training programme due to complete in late 2015.
- Business Cases at both RIE and WGH for new purpose built Decontamination Units have been approved and building work has commenced on each site. Contingency arrangements are progressing at WGH with two new units due to be in use by October 2015. This will provide stability to the service until the new unit is complete in March 2016.
- Housekeeping by Endoscopy Booking Staff and validation by Consultants is continuing.

A recovery trajectory to the end of October 2015 has been formulated using our Demand Capacity Activity Queue (DCAQ) information.

<sup>3</sup> This is the first month that the clock for radiology tests stopped with verification of report rather than attendance date. This change in data recording accounts for most of the cases reported over 6 weeks, apart from ultrasound where delays are continuing in the vascular lab.



## 9 Audiology waiting times

- 9.1 An overall 18 week standard applies to audiology patients and such journeys are included with the 18 week figures covered earlier in the paper. In addition to this pathway standard, audiology services are expected to meet stage of treatment targets for assessment and both treatment and hearing aid fitting.
- 9.2 These standards are set locally within an overall 18 week timeframe. Adult services elected to adopt 9 weeks for both elements, while paediatric services selected timeframes of 12 and 6 weeks.
- 9.3 Performance against these two standards for these services is shown in the tables below for April 2014 to April 2015. Across adult and paediatric audiology services, 19 patients were waiting beyond audiology standards at the end of April 2015.

**Table 7 – Adult Audiology – Performance against Standard**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
<i>Patients waiting for audiology assessment (first contact)</i>													
Number waiting 9 weeks and over	17	14	38	11	3	0	0	0	111	174	5	0	1
Total number waiting	1677	1619	1599	1735	1516	1608	1464	1662	1939	1710	1683	1810	1756
<i>Patients waiting for fitting of hearing aid</i>													
Number waiting 9 weeks and over	33	33	108	45	3	1	0	26	215	177	2	0	1
Total number waiting	944	1001	1051	931	983	995	1007	1024	978	886	789	616	736
<i>Patients waiting for other treatment (excl. hearing aids)</i>													
Number waiting 9 weeks and over	2	0	2	4	4	4	0	8	15	27	6	0	1
Total number waiting	105	42	92	126	96	67	84	116	121	115	117	90	119

**Table 8 – Paediatric Audiology – Performance against Standard**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
<i>Patients waiting for audiology assessment (first contact)</i>													
Number waiting 12 weeks and over	0	0	0	0	0	0	0	0	0	0	0	0	0
Total number waiting	220	264	216	142	144	101	168	238	189	161	229	362	429
<i>Patients waiting for other treatment (excl. hearing aids)</i>													
Number waiting 6 weeks and over	1	0	0	0	0	0	0	1	0	17	29	22	16
Total number waiting	50	3	7	12	6	8	7	38	47	50	71	69	56

## 10 IVF waiting times

- 10.1 NHS Lothian continues to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months. At the end of April, there were no patients waiting over 12 months. Publication of this provisional information has now commenced nationally.
- 10.2 NHS Lothian is using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland. The numbers waiting at month-end since July are outlined below; figures exclude those patients waiting to be seen on behalf of other centres.

**Table 9 – IVF Waiting List**

	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15
Numbers waiting	296	277	252	242	196	192	192	190	194	178
Numbers over 12 months	2	2	2	2	3	2	0	0	0	0

## 11 Accident and Emergency 4 hour standard

- 11.1 NHS Lothian's overall performance against the 4 hour standard for the month of April 2015 was **93.56%** (95.23% MtD as at 18 May).<sup>4</sup> Although this is below national standard of 95%, performance has been improving over the last 3 months.

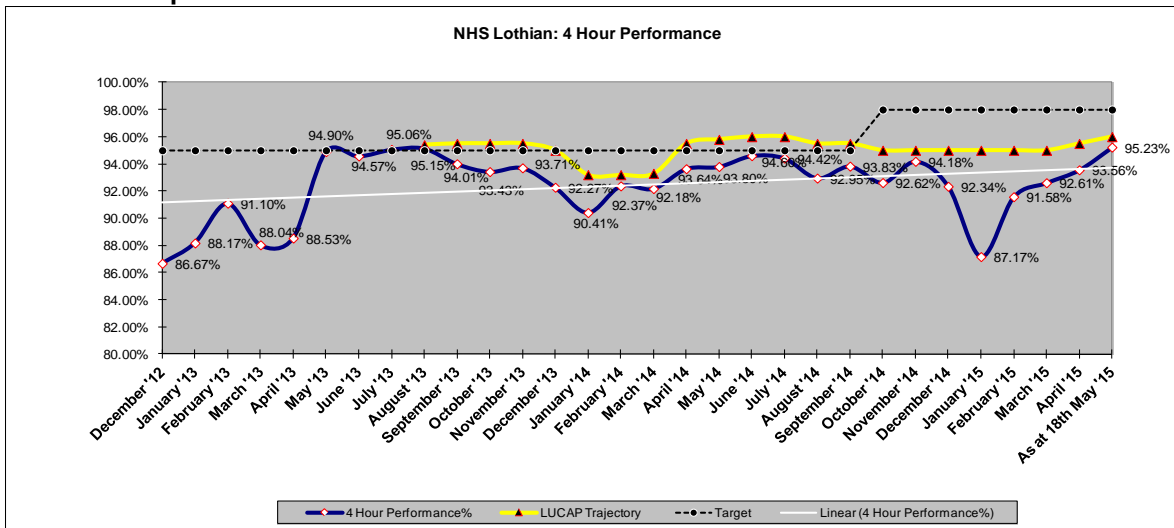
<sup>4</sup> The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter.

11.2 The performance across individual sites for April 2015 was as follows (MtD as at 18 May figures are shown in brackets) and overall trend in performance is shown in graph below.

- RIE **93.63%** (95.97%)
- WGH **88.21%** (89.65%)
- StJ **93.29%** (95.12%)
- RHSC **98.48%** (98.56%)

11.3 Our overall performance at the end of April falls short of the revised agreed LUCAP 2014 trajectory of 95.5%.

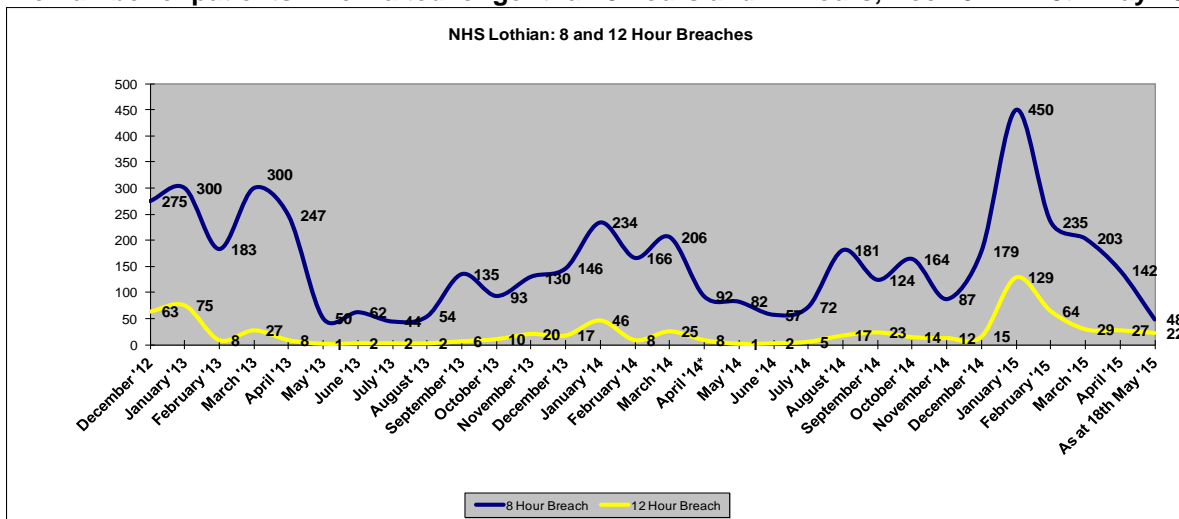
**Trend in A&E performance**



**8 and 12 hour breaches**

11.4 We are striving to continually improve the quality and safety of patient care which includes reducing the number of patients waiting long periods in A&E. There has been significant improvement in the number of patients who waited longer than 8 and 12 hours across NHS Lothian's hospitals: in April, 48 patients waited longer than 8 hours compared with 450 patients in January 2015, and 22 patients waited longer than 12 hours compared with 129 in January.

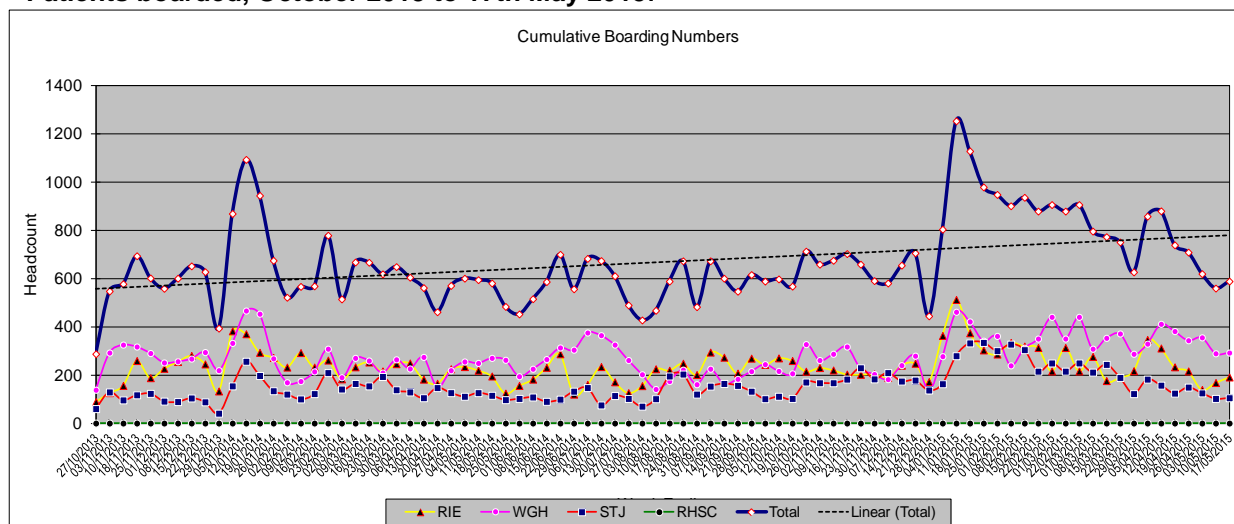
**The number of patients who waited longer than 8 hours and 12 hours, Dec 2012 – 18th May 2015**



## Boarding of patients

- 11.5 The following graph shows the number of patients 'boarded out' across the system on a weekly basis since October 2013. From a high of 1,252 at week ending 11th January 2015, the cumulative boarding number has reduced to 588 at week ending 17th May 2015. We are reviewing how we record boarding data with the aim of ensuring it is recorded consistently. This may impact on trend analysis in future papers.

**Patients boarded, October 2013 to 17th May 2015.**



## 12 Winter planning

- 12.1 Our performance against the 4 hour A&E standard during the winter months averaged out at 90.45%, and the number of 8 and 12 hour breaches reached a high during January 2015.<sup>5</sup> To ensure we robust planning arrangements for winter 15/16, we are establishing a Winter Planning Project Board, which will be chaired by Chief Officer. Membership will be multi-disciplinary with representation across a number of key health service stakeholders/organisations. As part of the winter 2014/15 de-brief process, we identified some common themes across acute, primary care and social care services, which we will use as 'lessons learned' and inform first stage in planning. The group is due to meet on 1st July and will meet on a monthly basis thereafter.

## 13 Delayed discharges

- 13.1 Using the latest Monthly Census data, the overall number of delayed discharges across NHS Lothian was 172.<sup>6</sup> The following tables outline the delayed discharge numbers in more detail. The average monthly number of delayed discharges for the year to March 2015 was 174. Significant numbers of delayed discharges lie within the City and across East Lothian.
- 13.2 We continue to engage with our social care colleagues to develop solutions to capacity issues that impact on flow; this includes a bi-weekly meeting of Executive and senior management colleagues from NHS Lothian and City of Edinburgh.

<sup>5</sup> For the purposes of planning, 'winter' is defined as January, February and March.

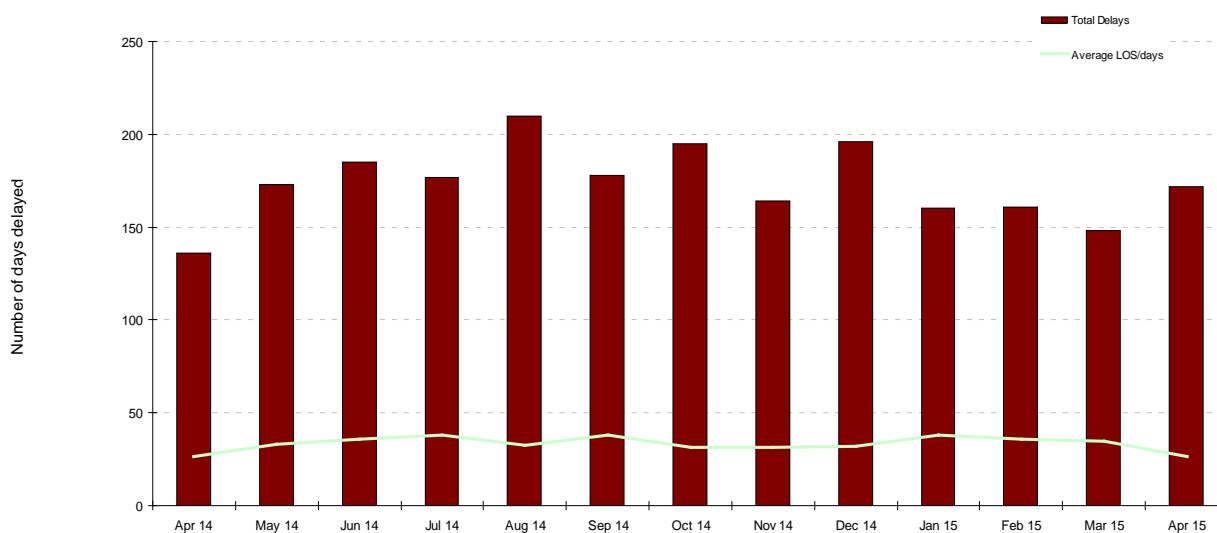
<sup>6</sup> Monthly census at 15 April 2015.

## Lothian Delayed Discharges – overall number of patient delayed, monthly progress 2014/2015.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Overall Total	136	173	185	177	210	178	195	164	196	160	161	148	172
Edinburgh	97	133	139	133	147	114	151	108	141	101	107	99	125
East Lothian	25	19	30	25	30	43	30	37	31	36	29	24	27
Midlothian	7	13	11	13	18	10	3	8	8	6	7	9	5
West Lothian	5	4	4	5	9	8	9	9	12	15	15	12	12
Non-Lothian	2	4	1	1	6	3	2	2	4	2	3	4	3

13.3 The total number of delays along with the average length of delay, by month, is illustrated in the following chart.

**Average length of delay (excluding all X-codes)**



	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	Apr 15
Total Delays	136	173	185	177	210	178	195	164	196	160	161	148	172	172
Average LOS/days	27	33	36	38	33	38	31	31	32	38	36	35	26	26

Jim Crombie  
Chief Officer; NHS Lothian  
University Hospitals & Support Services  
5 June 2015

Board Meeting  
24 June 2015

Medical Director

**SUMMARY PAPER - QUALITY REPORT**

This paper summarise the key points in the full paper.

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

	Para
<ul style="list-style-type: none"> <li>The number of formal complaints remains fairly stable (excluding prisons Graph 3). The response rate at 20 days and 3 days remains a challenge (graphs 1 &amp; 2). The Complaints review is set out in the Person-Centred Culture Paper on the Board Agenda.</li> </ul>	3.1.1 and Graphs 1-4
<ul style="list-style-type: none"> <li>HSMR – None of the three acute hospitals are a statistical outlier; all are below one and have seen reductions from the October-December 2007 baseline.</li> </ul>	3.1.2 and Graphs 7-9
<ul style="list-style-type: none"> <li>Staff absence levels (Graph 6) are over 4% (4.8%) which has been above 4% for a 10-month period.</li> </ul>	3.1.3 and Graph 6
<ul style="list-style-type: none"> <li>The HEAT targets for reduction in <i>C.Difficile</i> and Staph. aureus bacteraemias are not being achieved (see graphs 11&amp;12). Healthcare Associated Infection is a separate agenda item and paper.</li> </ul>	3.1.4 and Graphs 11-12
<ul style="list-style-type: none"> <li>A number of reports on the Board agenda examine in more detail delayed discharges, A&amp;E 4 hour waits, Cancer 62 day waits and compliance with stroke standards which remain a challenge.</li> </ul>	3.1.5 and Graphs 5,17,18 & 19-21

Jo Bennett  
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1 June 2015  
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## **QUALITY REPORT**

### **1 Purpose of the Report**

- 1.1 This report presents the Quality Report for April 2015, to provide assurance on the quality of care NHS Lothian provides.

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

### **2 Recommendations**

- 2.1 Review the quality dashboard and exception reporting to inform assurance requirements, (context and technical appendix are set out in Appendix 1).

### **3 Discussion of Key Issues**

#### **3.1 Exception Reporting – Quality Dashboard**

- 3.1.1 The number of formal complaints remains fairly stable (excluding prisons Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. The response rate at 20 days and 3 days remains a challenge (graphs 1 & 2).

- 3.1.2 Since December 2009, Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP). The aim of the Scottish Patient Safety Programme is to reduce hospital mortality by 20% by December 2015 compared to the baseline of 2007. The publication in April 2015 is for the period October - December 2014.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties (medical and surgical). The calculation takes account of patients who died within 30 days from admission; that is, it includes deaths that occurred in the community (out of hospital deaths) as well as those occurring in-hospital. It excludes deaths that occur more than 30 days after admission whether in hospital or not.

Hospital Standardised Mortality Ratio (HSMR) = Observed Deaths / Predicted Deaths. The prediction is based on data from SMR01 returns. The purpose is to adjust observed mortality for the underlying risk of death at the time of admission (Graphs 7-9).

Key Points:

- The current values and change from baseline are in Table 1 below
- None of the three acute adult hospitals is a statistical outlier and all are below 1.

**Table 1**

	<b>HSMR Oct-Dec 2007</b>	<b>HSMR Oct-Dec 2014</b>	<b>Change from baseline</b>
Scotland	1.00	0.89	-16.1%
RIE	0.87	0.75	-17.6%
St John's	0.88	0.80	-9.3%
WGH	0.74	0.70	-11.1%

- 3.1.3 Staff absence levels (Graph 6) are over 4% (4.8%) which appears to be increasing over a six-month period with significant variation across NHS Lothian.
- 3.1.4 The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see graphs 11&12).
- 3.1.5 Achieving the stroke standards for both admission to unit within 1 day and swallow screen on day of admission remains a challenge. A stroke review is taking place and the review will be reported to HCG in November 2015.
- 3.1.6 NHS Lothian has aligned its reporting of Pressure Ulcers into the Scottish Patient Safety Programme (SPSP) Measurement Framework. The reporting through the Quality Report is currently under review.

## Quality Dashboard – April 2015 (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focussing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.

If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

### QUALITY AMBITION

#### **PERSON-CENTRED - Process Measures**

[20-day Complaints Response Rate](#) \*

[3-day Complaints Response Rate](#) \*

[Delayed Discharges and Average Length of Stay](#) \*

#### **PERSON-CENTRED - Outcome Measures**

[Number of Complaints \(excluding HMP Healthcare\)](#) \*

[Number of Complaints for HMP Healthcare](#) \*

[Staff Absence Levels](#) \*

[Patient Experience](#)

[Staff Experience](#)

#### **SAFE – Outcome Measures**

[Hospital Standardised Mortality Ratios for RIE, WGH & St. John's](#) \*

[Incidents with harm](#) \*

[C. Difficile Numbers](#) \*

[Staph. Aureus Bacteraemia Numbers](#) \*

[Number of Cardiac Arrests](#) \*

[Rate of Cardiac Arrests](#) \*

[Inpatient Falls with Harm](#) \*

#### **EFFECTIVE – Process Measures**

[A&E 4 Hour Wait](#) \*

[Cancer Waits 62 Days from Diagnosis to Treatment](#) \*

[Admission to stroke unit on day or day after admission](#) \*

[Stroke Treatment Measure: CT Scan](#) \*

[Stroke Treatment Measure: Swallow Screen](#) \*

#### **Additional Quality Measures**

Hospital Scorecard: July to September 2014 \*

##### **Indicator**

	<b>Lothian Rate</b>	<b>Scottish Rate</b>
	<b>(Per 1000 admissions)</b>	
Standardised Surgical Readmission rate within 7 days	23.40	21.84
Standardised Surgical Readmission rate within 28 days	45.10	42.00
Standardised Medical Readmission rate within 7 days	52.32	49.58
Standardised Medical Readmission rate within 28 days	120.19	111.33
	<b>Lothian</b>	<b>Scotland</b>
Average Surgical Length of Stay – Adjusted	0.96	1.00
Average Medical Length of Stay – Adjusted	1.08	1.00



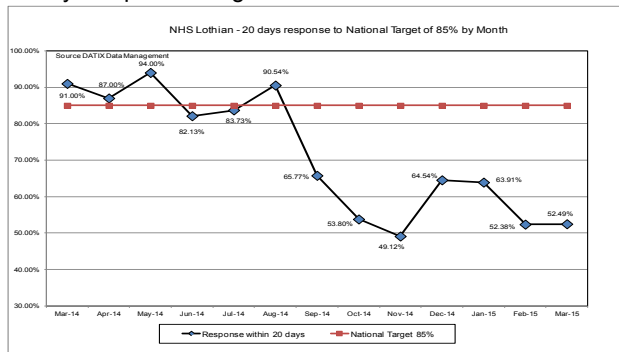
## Person-Centred

“Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.”

Title:	20-day Complaints Response Rate (Graph 1)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	85% of complaints responded to within 20 days

### Process Measure

20-Day Response Target across NHS Lothian

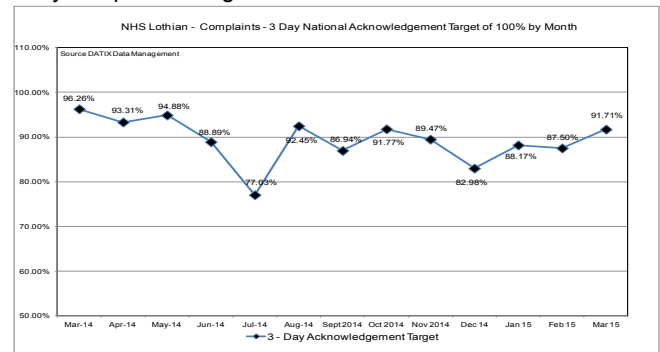


Data Source: Datix Exec Lead: Alan Boyter

Title:	3-day Complaints Response Rate (Graph 2)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	100% formal acknowledgement within 3 working days

### Process Measure

3-Day Response Target across NHS Lothian

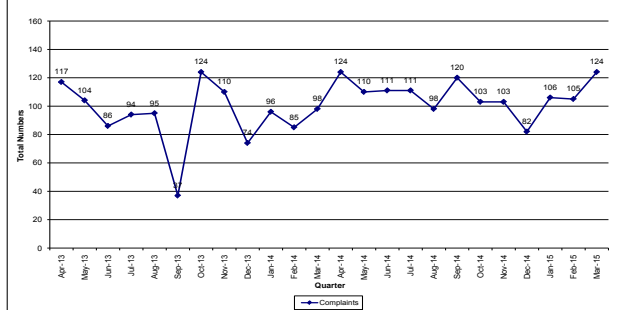


Data Source: Datix Exec Lead: Alan Boyter

Title:	Number of Complaints (excluding Prison Complaints) (Graph 3)
Numerator:	Total number of complaints
Goal:	Reduction in number of formal complaints

### Outcome Measure

NHS Lothian Formal Complaints (excluding HMP)

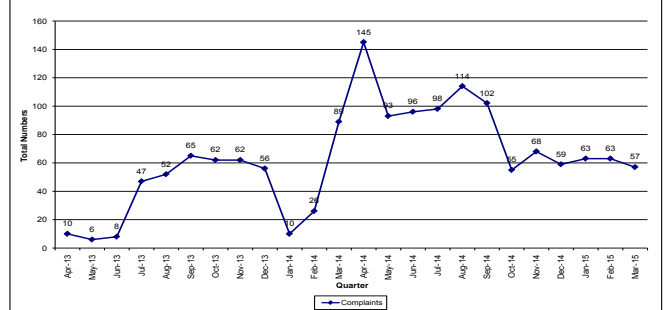


Data Source: Datix Exec Lead: Alan Boyter

Title:	Number of Prison Complaints (Graph 4)
Numerator:	Total number of prison complaints
Goal:	Reduction in number of formal complaints

### Outcome Measure

HMP Healthcare Formal Complaints

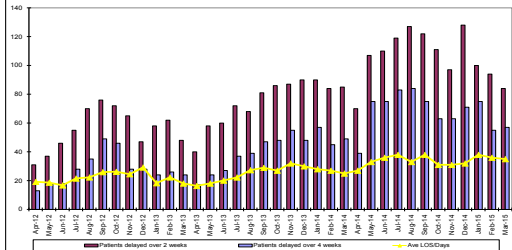


Data Source: Datix Exec Lead: Alan Boyter

Title:	Delayed Discharges & Average Length of Stay (Graph 5)
Goal:	No patient waiting longer than 2 weeks for discharge, by April 2015

### Process Measure

Delayed Discharge and Average LOS/days

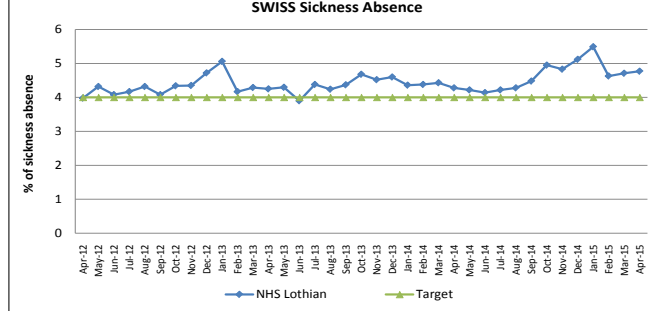


Data Source: Local data captured on EDISON shared data with Health & Social Care Exec Lead: Melanie Johnson

Title:	Staff Absence Levels (Graph 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

### Outcome Measure

SWISS Sickness Absence

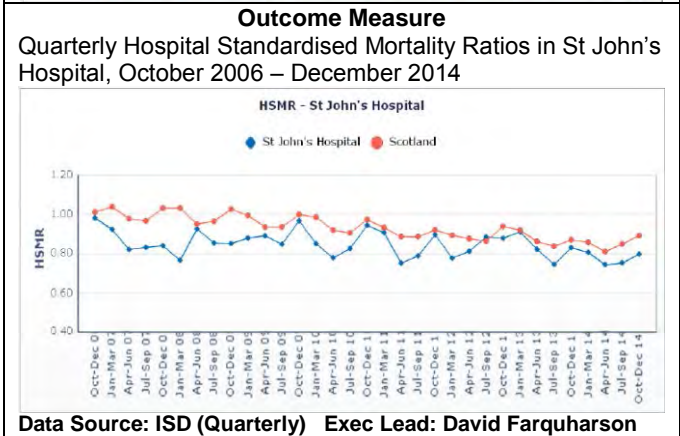
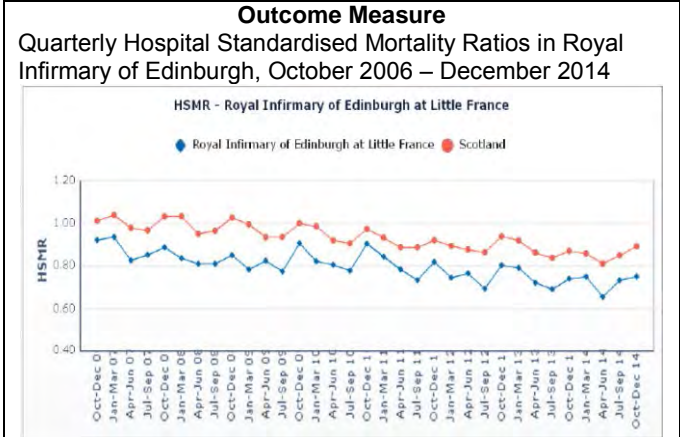


Data Source: Scottish Workforce Information Strategic Systems (SWISS) Exec Lead: Alan Boyter

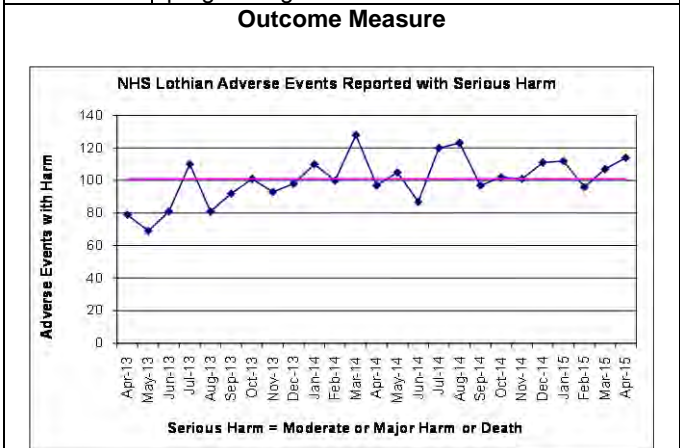
**Safe**

“There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.” Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, HAI indicators, arrest calls, falls with harm and pressure ulcers.

Title:	Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Graphs 7 – 9)
Numerator:	Total number of in-hospital deaths and deaths within 30 days of discharge from hospital
Denominator:	Predicted total number of deaths
Goal:	20% reduction against 2006/07 baseline by December 2015



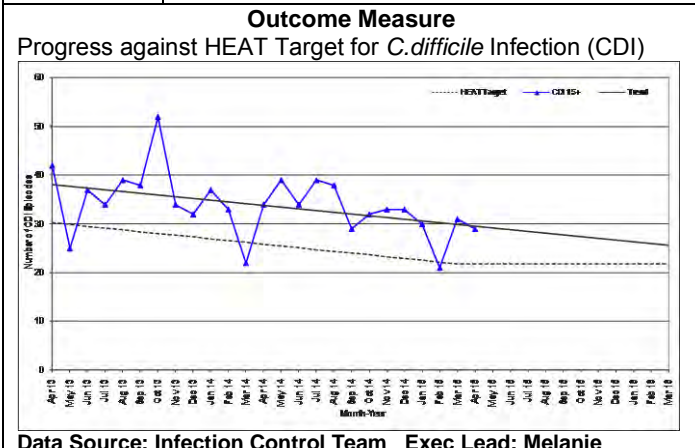
Title:	Incidents with harm (Graph 10)
Numerator:	Number of incidents associated with serious harm reported per month in NHS Lothian (Dec 2011- Nov 2013)
Goal:	There are specific goals for reductions in Falls & Pressure Ulcers. See separate graphs for progress against these.



Data Source: Datix Exec Lead: David Farquharson

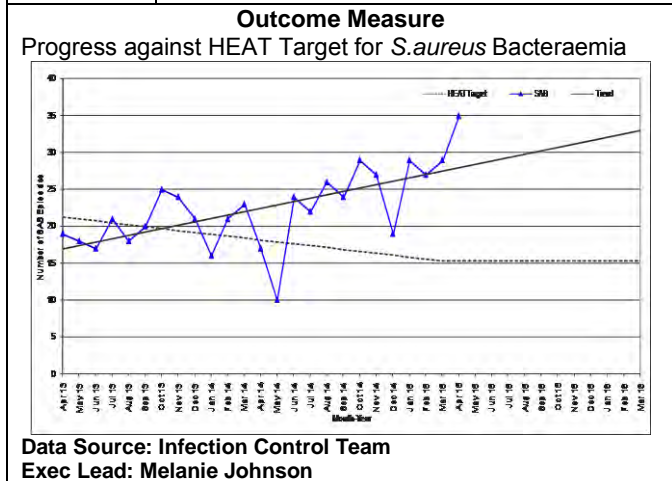
**Safe (cont'd)**

Title:	C. difficile associated disease against HEAT Target 2012-13 (Graph 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve 262 or fewer CDI by March 2015 as shown by trend line.

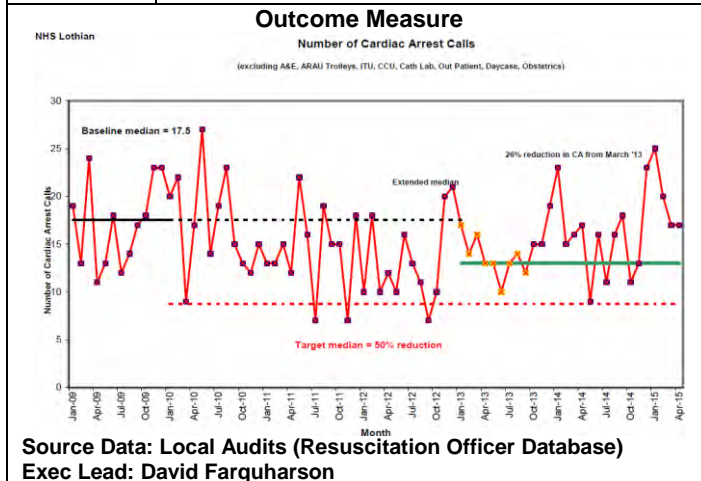


Data Source: Infection Control Team Exec Lead: Melanie Johnson

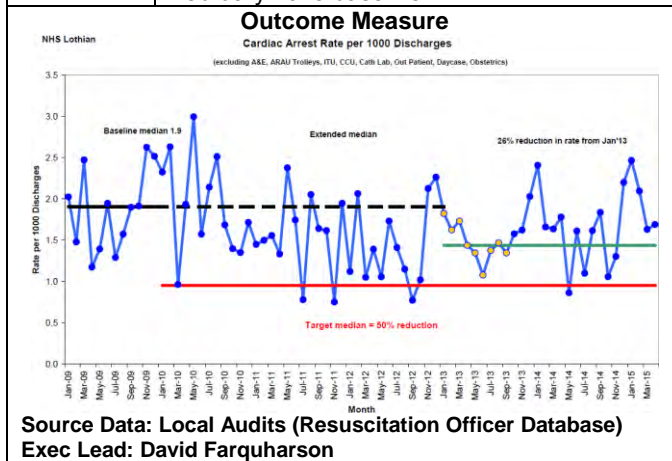
Title:	Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 12)
Numerator:	The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)
Goal:	NHS Lothian is to achieve 184 or fewer SABs by March 2015 as shown by trend line.



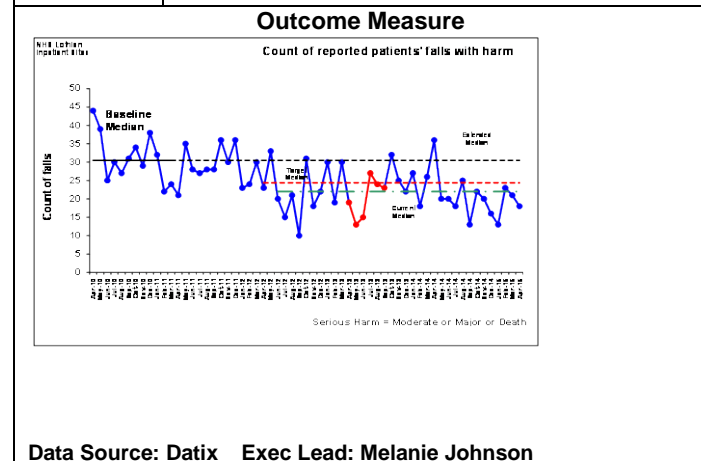
Title:	Number of Cardiac Arrests (Acute Wards) (Graph 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline



Title:	Rate of Cardiac Arrests (Acute Wards) (Graph 14)
Numerator:	Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline



Title:	Patient Falls with Harm (Graph 15)
Numerator:	Number of falls reported resulting in moderate or major harm or death (define moderate/major). Data for NHS Lothian inpatient sites
Goal:	20% reduction in inpatients falls and associated harm by December 2015



**Effective**

“The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.” Progress on this ambition is measured through clinical quality indicators and stroke care.

Title:	A&E 4 Hour Wait (Graph 17)
Numerator:	Number of patients waiting less than 4 hours from arrival to admission or discharge
Denominator:	Number of patients attending
Goal:	98% of patients waiting less than 4 hours from arrival to admission by March 2015

**Process Measure**

**Data Source: Patient Administration System (TRAK)**  
**Exec Lead: Melanie Johnson**

Title:	Cancer Waits 62 Days from Diagnosis to Treatment (Graph 18)
Numerator:	Number of patients waiting 62 days to treatment Please note the scale
Denominator:	Number of cancer patients
Goal:	95% of patients from diagnosis to treatment wait no longer than 62 days

**Process Measure**

**Data Source: SGHD Management Information**  
**Exec Lead: Jim Crombie**

Title:	Admission to Stroke Unit within 1 day of admission (Graph 19)
Numerator:	Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal:	90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

**Process Measure**

Note: 2015 data is not validated and should be treated as provisional

**Lothian = 73.3% (63/86)**  
**Data Source: ISD** **Exec Lead: Jim Crombie**

Title:	Stroke Treatment Measures (Graph 20)
Numerator:	Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

**Process Measure**

Note: 2015 data is not validated and should be treated as provisional

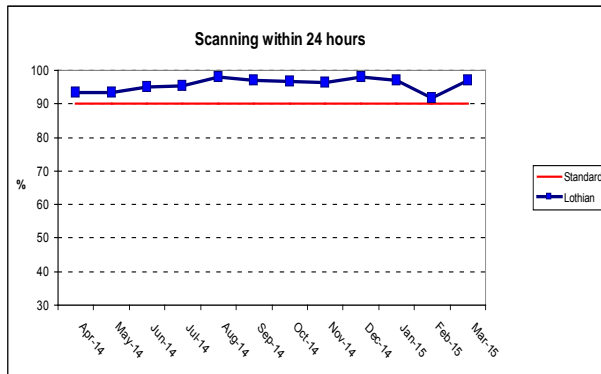
**Lothian = 83.2% (84/101)**  
**Data Source: ISD** **Exec Lead: Jim Crombie**

## Effective (cont'd)

Title:	Stroke Treatment Measures (Graph 21)
Numerator:	Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission

### Process Measure

Note: 2015 data is not validated and should be treated as provisional



Lothian = 97% (98/101)

Data Source: ISD Exec Lead: Jim Crombie

## **4 Key Risks**

- 4.1 Achieving the HAI HEAT target, complaints response times, stroke targets, delayed discharge target and cancer target.
- 4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.
- 4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

## **5 Risk Register**

- 5.1 Achieving HAI targets is also on the Corporate Risk Register (Risk 1076) and its risk grading has been increased to reflect that NHS Lothian is outwith HAI trajectory. Access to Acute Stroke Unit is on the University Hospital Services Risk Register – Medicine and Associated Services (Risk 2444). Compliance with stroke standards is captured in Unscheduled Care on the Corporate Risk Register. Complaints Management is also captured on the Corporate Risk Register.

## **6 Impact on Inequality, Including Health Inequalities**

- 6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.
- 6.2 This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).
- 6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

## **7 Involving People**

- 7.1 No service change.

## **8 Resource Implications**

- 8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.

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## **List of Appendices**

Appendix 1: Supporting Context and Technical Appendix

## Context and Technical Appendix

### Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland's quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian's Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

### Hospital Standardised Mortality Ratio (HSMR)

HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

### *S.aureus* Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.



### **C.difficile Infection (CDI) rate**

New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

### **Incidents associated with harm**

Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

### **Surgical readmissions within 7 days**

This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011. This measure has been standardised by age, sex and deprivation (SIMD 2009).

### **Surgical re-admissions within 28 days**

As for 7 day readmissions.

### **Medical Re-admissions Within 7 Days**

This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.

The data are presented for calendar year 2011.

This measure has been standardised by age, sex and deprivation (SIMD 2009).

### **Medical Re-admissions Within 28 Days**

As for 7 day readmissions.

### **Average Length of Surgical Stay (Adjusted)**

Ratio of 'observed' length of stay over 'expected' length of stay.

This indicator is case mix adjusted by HRG\* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.

A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

### **Average Length of Medical Stay (Adjusted)**

Ratio of observed length of stay over expected length of stay.

This indicator is case mix adjusted by HRG\* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

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

Board Meeting  
24 June 2015

Director of Finance

## FINANCIAL POSITION TO MAY 2015

### 1 Purpose of the Report

- 1.1 The purpose of this report is to provide the Board with an overview of the financial position at period 2. The paper also gives early consideration to the year end outturn and the implications for the remainder of the financial year.
- 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 of the Board are asked to:

- Note that the financial position at period 2 shows an overspend of £4.188m across all services, which includes an overspend against the core baseline position of £2.669m and a shortfall in the total in-year LRP target of £3.018m, offset in part by £1.5m of non recurring corporate savings;
- Recognise the increase in the required LRP delivery from £30m per the Financial Plan to £31.325m, and the impact of the net shortfall of £1.5m in LRP against this target. As LRP acts as a resource in the Financial plan, the Board should note that failure to deliver this level of cash saving will result in a shortfall in available resources to support planned investment;
- Support the arrangements to monitor financial performance throughout this year and ensure actions are implemented to deliver financial balance by year end.

### 3 Discussion of Key Issues

- 3.1 At period 2 of this financial year, NHS Lothian overspent by £4.188m for the year to date against the Revenue Resource Limit. Table 1 shows a summary of the position to date including achievement of efficiency savings. A detailed analysis by expenditure type and business unit is shown in Appendix 1 and by operational unit in Appendix 2

**Table 1: Financial Position to 31 May 2015**

	Mth 1 £000's	Mth 2 £000's	YTD £000's
Core Position	£(657)	£(2,012)	£(2,669)
Efficiency Savings Position	£(1,711)	£(1,308)	£(3,018)
N/R Corporate Savings LRP	£667	£833	£1,500
<b>Total Financial Position</b>	<b>£(1,701)</b>	<b>£(2,487)</b>	<b>£(4,188)</b>

- 3.2 The 2015/16 Financial Plan presented to the Board on 1 April 2015 set out how financial balance could be achieved in this financial year. Within the plan, due recognition was given to pre-existing financial pressures and a total of £14.3m was allocated from within the plan to cover these cost pressures.
- 3.3 Additional recurrent cost pressures of approximately £10m incurred in the last financial year were not funded through the financial plan on the basis these costs would be managed through specific management actions. To ensure these actions deliver the required expenditure reductions, performance management meetings with all business units have begun, led by the Chief Executive, to scrutinise financial performance and the required actions to deliver balance.
- 3.4 At this stage of the financial year, NHS Lothian has not been able to deliver month on month financial balance against its core budget. The key drivers of the £2.669m overspend (before the shortfall in LRP) are as follows:
- **GP Prescribing**  
The year-to-date overspend in Prescribing after two months is shown as £1.598m, based on extrapolated data from the last financial year. This is despite uplift totalling £8m from the Financial Plan, including £4.5m of growth funding in 2015/16 and £3.5m to offset underlying overspend in 2014/15. The position in GP prescribing is the single largest adverse variance so far this year. In recognition of this significant pressure, a detailed report on cost pressures and mitigating actions will be presented to the Finance and Resources Committee in July.
  - **Nursing**  
Nursing is showing an adverse variance of £1.103m year to date, with the main areas of overspend in Acute Services and Edinburgh CHP. Within Edinburgh CHP the costs of Gylemuir were expected to be funded by the reduction in IPCC beds at the RVH, however this resource cannot currently be released to the level expected, partially due to the level of 1:1 nursing required within the IPCC beds and a slower reduction in the bed numbers than anticipated which in turn has created an inability to reduce staffing levels on these wards. Within Acute services, ongoing nursing cost pressures from winter beds open in the first two months are the subject of a detailed review to establish whether a funding stream is available within Unscheduled Care to offset the costs or whether management actions will be required to manage the pressure within existing resources.
  - **Medical Supplies**  
This area is reporting an overspend of £457k to date. The main area of pressures within Unscheduled Care is driven by Cardiology high cost activity despite additional financial plan funding supporting the 14/15 baseline pressure. The pressure is being driven in part by the ratio of Lothian to non Lothian activity which at month 2 is showing 75%:25% compared to the budgeted 40%:60% for some procedures. The number of Lothian TAVI procedures is also ahead of the annual plan currently. In addition there is a new type of valve being utilised with the cost implications currently being reviewed. Activity levels will be monitored closely to ensure a rebalance of occurs during the year.

### **Efficiency and Productivity**

- 3.5 The 2015/16 financial plan required a delivery of £30m in-year to achieve a balanced position, which recognised a carry forward shortfall on LRP in 2014/15. Following the conclusion of the financial year, this carry forward gap has deteriorated, resulting in an

increase to the current year target of £1.325m to £31.325m. Plans identified total £28.249m at this stage leaving a shortfall against both the financial plan target and the total recurring requirement.

- 3.6 Of the £28.2m identified efficiency plans, £2.6m were targeted to be achieved by the end of month 2. With only £1.6m achieved, a shortfall against plans of identified £1m is reported. A further net £513k slippage gap arises due to a shortfall against the total target required. Appendix 3 sets the LRP achievement to date in further detail.
- 3.7 Failure to deliver LRP to the anticipated £31.325m value presents the health board with two challenges: Firstly, this will impact on the board's ability to deliver its statutory target of breakeven this year; Secondly, the financial plan requires efficiency savings as a funding source for investments in the plan, and failure to achieve the full quantum of savings means that the resources in the plan will no longer be available at this level.
- 3.8 Further consideration will be given to the 2015/16 targets for delivering the £31m in-year LRP at business unit level. Any proposed changes will be presented through the F&R committee.

#### **4 Risks and Assumptions**

- 4.1 At this stage, elements of the Financial Plan funding are still to be confirmed. This includes over £5m of assumed income for Waiting Times, and additional funding of £12.5m from PPRS (Pharmacy Price Regulation Scheme) to support drug prescribing across NHS Lothian. Failure to receive this funding to the level anticipated will have a further adverse effect on achievement of year end balance.
- 4.2 In addition, the ability for the board to deliver against other operational targets, including waiting times and delayed discharges as well as the unknown impact of winter may yet impact adversely on the outturn position.

#### **5 Year end forecast**

- 5.1 Forecasting at such an early stage in the year cannot provide absolute certainty around the year-end outturn, however based on the evidence of the first two months it is clear that the conditions required to deliver a breakeven outturn position as set out in the financial plan are not being met. Therefore, corrective actions must now be identified to ensure in year balance can be achieved, and in parallel plans are required to be defined to ensure this can be delivered on a sustainable basis.

#### **6 Actions to ensure achievement of financial balance**

- 6.1 The Board can be assured that NHS Lothian remains fully committed to achieving financial balance this year. In order to achieve this, a number of actions have been introduced, or will be put in place, including:
  - Routine financial performance meetings with the Chief Executive, Director of Finance and the Director of Strategic Planning and relevant leads of Business Units and Services to ensure plans are in place locally to deliver a breakeven outturn including delivery of LRP;
  - A review of all in-year flexibility to support breakeven will be undertaken at an early stage and as part of the Quarter 1 review. The level of flexibility available this year

is significantly lower than in prior years, and it will not be sufficient to achieve financial balance;

- A review of the Financial Plan funding arrangements to establish opportunities to reduce previously agreed expenditure on the basis of a shortfall in delivery of LRP;
- Discussions with the SGHSCD will be initiated at an early stage to confirm current income assumptions and to explore other opportunities for additional in-year and recurrent financial support.

6.2 Actions to deliver a balanced outturn will be detailed and directed through the Finance and Resources Committee in the first instance, with further detail provided at its next meeting on the 8 July.

## **7 Risk Register**

7.1 The Risk register will be considered following the detailed Quarter 1 review and any changes will be made at this stage based on the outcome of this.

## **8 Health and Other Inequalities**

8.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

## **9 Involving People**

9.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

## **10 Resource Implications**

10.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report at this stage.

Susan Goldsmith

Director of Finance

17 June 2015

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## **List of Appendices**

Appendix 1: NHS Lothian Income & Expenditure Summary 31 May 2015

Appendix 2: NHS Lothian Summary by Operational Unit to 31 May 2015

Appendix 3: NHS Lothian Efficiency & Productivity Summary as at Month 2

**NHS Lothian Income & Expenditure Summary to May 2015**

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	228,016	38,694	38,993	(299)	(96)
Nursing	371,724	62,968	64,071	(1,103)	(134)
Administrative Services	78,234	13,347	13,353	(6)	73
Allied Health Professionals	58,426	10,048	9,942	107	140
Health Science Services	36,871	6,073	5,944	129	173
Management	9,791	1,757	1,631	126	89
Support Services	50,232	8,653	9,059	(406)	(242)
Medical & Dental Support	6,714	1,116	1,005	111	57
Other Therapeutic	22,533	3,974	4,141	(167)	(106)
Personal & Social Care	2,729	465	462	3	24
Other Pay	503	(232)	(185)	(47)	(65)
Emergency Services	15	3	6	(4)	(1)
<b>Pay</b>	<b>865,788</b>	<b>146,866</b>	<b>148,423</b>	<b>(1,557)</b>	<b>(89)</b>
Drugs	113,922	18,018	18,017	0	(256)
Medical Supplies	81,618	13,958	14,414	(457)	(393)
Maintenance Costs	5,692	927	852	76	(130)
Property Costs	40,564	7,052	6,520	532	327
Equipment Costs	19,776	3,431	3,674	(244)	(41)
Transport Costs	9,165	1,537	1,653	(116)	(139)
Administration Costs	148,957	14,517	13,536	981	372
Ancillary Costs	14,785	2,474	2,430	44	42
Other	25,004	(1,325)	(1,371)	46	(115)
Service Agreement Patient Serv	82,394	18,291	18,551	(260)	(93)
<b>Non-Pay</b>	<b>541,877</b>	<b>78,879</b>	<b>78,276</b>	<b>603</b>	<b>(426)</b>
Gms2 Expenditure	113,547	16,874	16,762	112	(139)
Ncl Expenditure	3	0	(12)	12	0
Other Primary Care Expenditure	0	0	22	(22)	(10)
Pharmaceuticals	132,332	21,085	22,683	(1,598)	(1,177)
<b>Primary Care</b>	<b>245,882</b>	<b>37,959</b>	<b>39,456</b>	<b>(1,496)</b>	<b>(1,327)</b>
Fhs Non Discret Allocation	(1,914)	(775)	(773)	(2)	(1)
<b>Other</b>	<b>(1,914)</b>	<b>(775)</b>	<b>(773)</b>	<b>(2)</b>	<b>(1)</b>
Income	(1,655,837)	(40,582)	(40,365)	(217)	(169)
<b>Income</b>	<b>(1,655,837)</b>	<b>(40,582)</b>	<b>(40,365)</b>	<b>(217)</b>	<b>(169)</b>
Rrl	(140)	0	0	0	0
<b>Revenue Resource Limit</b>	<b>(140)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>CORE POSITION</b>	<b>(4,345)</b>	<b>222,347</b>	<b>225,016</b>	<b>(2,669)</b>	<b>(2,012)</b>
Savings Target Non-Pay	(3,018)	(3,018)	0	(3,018)	(1,308)
N/R Corp Savings LRP	1,500	1,500	0	1,500	833
<b>TOTAL (see note)</b>	<b>(37,201)</b>	<b>220,829</b>	<b>225,016</b>	<b>(4,187)</b>	<b>(2,487)</b>

NB. The above table relates to Core Services only. There is £37.201m of Non Core Budget not shown above that balances Annual Budget to zero.

## NHS Lothian Summary by Operational Unit to May 2015

Description	Unscheduled Care (£k)	Scheduled Care (£k)	East Lothian Chp (£k)	Edinburgh Chp (£k)	Midlothian Chp (£k)	West Lothian Chp (£k)	Facilities And Consort (£k)	Corporate Services (£k)	Strategic Services (£k)	Total (£k)
<b>Annual Budget</b>	<b>223,983</b>	<b>405,035</b>	<b>83,189</b>	<b>306,254</b>	<b>52,056</b>	<b>113,306</b>	<b>137,656</b>	<b>79,597</b>	<b>(1,438,278)</b>	<b>(37,201)</b>
Medical & Dental	194	(258)	14	(19)	16	(106)	0	(77)	(64)	(299)
Nursing	(549)	(222)	53	(356)	65	(59)	(21)	(7)	(8)	(1,103)
Administrative Services	(13)	(8)	(7)	58	(7)	(44)	9	17	(11)	(6)
Allied Health Professionals	(66)	(36)	(4)	6	34	5	(0)	(66)	232	107
Health Science Services	32	74	(22)	43	(3)	16	0	(9)	0	129
Management	24	11	(21)	35	12	2	(18)	75	4	126
Support Services	7	(35)	(12)	4	0	5	(184)	(190)	(1)	(406)
Medical & Dental Support	0	70	0	(1)	0	31	0	10	0	111
Other Therapeutic	5	19	12	4	(3)	(124)	0	(79)	(1)	(167)
Personal & Social Care	(1)	(12)	(2)	(13)	0	0	(0)	31	0	3
Other Pay	13	(23)	(2)	(11)	0	(15)	(11)	2	0	(47)
Emergency Services	0	0	0	0	0	(1)	0	(3)	0	(4)
<b>Pay</b>	<b>(354)</b>	<b>(418)</b>	<b>8</b>	<b>(249)</b>	<b>115</b>	<b>(289)</b>	<b>(225)</b>	<b>(295)</b>	<b>151</b>	<b>(1,557)</b>
Drugs	(106)	(71)	29	1	(4)	115	(0)	153	(116)	0
Medical Supplies	(306)	(5)	(33)	(124)	(23)	32	(20)	17	5	(457)
Maintenance Costs	(17)	(25)	(4)	(25)	1	(2)	159	(12)	(1)	76
Property Costs	6	(11)	(34)	18	(1)	18	534	5	(2)	532
Equipment Costs	11	(90)	(31)	(44)	(7)	14	(100)	16	(12)	(244)
Transport Costs	(12)	(101)	1	30	11	20	(33)	(31)	(0)	(116)
Administration Costs	112	371	29	123	26	109	(13)	(105)	329	981
Ancillary Costs	23	20	1	(25)	2	12	21	(11)	(0)	44
Other	1	(16)	(30)	1	0	4	(12)	99	0	46
Service Agreement Patient Serv	(13)	10	(12)	(61)	(0)	(13)	0	107	(277)	(260)
<b>Non-Pay</b>	<b>(300)</b>	<b>81</b>	<b>(84)</b>	<b>(107)</b>	<b>4</b>	<b>309</b>	<b>536</b>	<b>239</b>	<b>(75)</b>	<b>603</b>
Gms2 Expenditure	0	(0)	70	(0)	3	40	(1)	(1)	0	112
Ncl Expenditure	0	12	0	(0)	0	0	0	0	0	12
Other Primary Care Expenditure	0	(22)	0	0	0	0	0	0	0	(22)
Pharmaceuticals	0	0	(206)	(745)	(163)	(484)	0	0	0	(1,598)
<b>Primary Care</b>	<b>0</b>	<b>(11)</b>	<b>(135)</b>	<b>(745)</b>	<b>(160)</b>	<b>(444)</b>	<b>(1)</b>	<b>(1)</b>	<b>0</b>	<b>(1,496)</b>
Fhs Non Discret Allocation	0	0	0	(3)	0	1	0	0	0	(2)
<b>Other</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3)</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2)</b>
Income	57	235	34	(52)	(3)	59	(81)	31	(498)	(217)
<b>Income</b>	<b>57</b>	<b>235</b>	<b>34</b>	<b>(52)</b>	<b>(3)</b>	<b>59</b>	<b>(81)</b>	<b>31</b>	<b>(498)</b>	<b>(217)</b>
<b>CORE POSITION</b>	<b>(597)</b>	<b>(112)</b>	<b>(178)</b>	<b>(1,155)</b>	<b>(44)</b>	<b>(363)</b>	<b>229</b>	<b>(25)</b>	<b>(422)</b>	<b>(2,669)</b>
Savings Target Non-Pay	(308)	(1,483)	(103)	(869)	(67)	(26)	(65)	(5)	(92)	(3,018)
N/R Corp Savings LRP	0	0	0	0	0	0	0	0	1,500	1,500
<b>TOTAL</b>	<b>(905)</b>	<b>(1,595)</b>	<b>(281)</b>	<b>(2,025)</b>	<b>(111)</b>	<b>(389)</b>	<b>164</b>	<b>(31)</b>	<b>986</b>	<b>(4,187)</b>

### NHS Lothian Efficiency and Productivity Summary as at Month 2 2015/16

Business Unit	Total Recurring Target	Current Year Plans	Gap on In Year Plans	Current Year Position					Full Year Position		
				April - May					Total Recurring Target	Full Year Plans Identified	Gap on Recurring Plans
				Plans Phased to Date	Actual Delivery	Slippage on Plan	Gap Phased to Date	Total Slippage			
£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	
East Lothian Chp	1,203	1,203	0	88	0	88		88	1,203	1,402	(199)
Midlothian Chp	806	716	90	65	26	39	15	54	806	986	(180)
Edinburgh Chp	7,486	3,790	3,696	494	299	195	616	811	7,486	3,885	3,601
West Lothian Chp	1,328	1,323	5	68	69	(1)	1	0	1,328	1,331	(3)
Prescribing	4,005	3,325	680	391	390	1	113	114	4,005	3,325	680
Scheduled Care	11,563	6,109	5,454	750	176	574	909	1,483	17,563	7,084	10,479
Unscheduled Care	5,556	4,615	941	360	209	151	157	308	8,556	4,849	3,707
Facilities & Consort	3,208	3,126	82	111	59	52	14	66	3,208	4,089	(881)
<b>Total Business Units</b>	<b>35,155</b>	<b>24,207</b>	<b>10,948</b>	<b>2,327</b>	<b>1,228</b>	<b>1,099</b>	<b>1,825</b>	<b>2,924</b>	<b>44,155</b>	<b>26,951</b>	<b>17,204</b>
<b>Corporate Services &amp; Strategic Programmes</b>											
Corporate Services	86	0	86	(0)	0	(0)	14	14	86	0	86
eHealth	1,355	757	598	55	46	9	100	109	1,355	757	598
Finance	408	1,411	(1,003)	68	243	(175)	(167)	(342)	408	411	(3)
Human Resources & Communications	617	511	106	56	16	40	18	58	617	552	65
Medical Director	121	122	(1)	20	20	0	(0)	0	121	122	(1)
Nursing	283	283	0	36	47	(11)	0	(11)	283	292	(9)
Pharmacy	1,012	205	807	35		35	135	169	1,012	205	807
Planning	156	128	28	21	22	(1)	5	4	156	128	28
Public Health	498	501	(3)	18	14	4	(1)	3	498	501	(3)
Strategic Programmes	552	124	428	7		7	85	92	552	124	428
Strategic - Other	82	0	82			0		0	82		82
<b>Total Corporate Dept &amp; Strategic Programmes</b>	<b>5,170</b>	<b>4,042</b>	<b>1,128</b>	<b>316</b>	<b>408</b>	<b>(92)</b>	<b>188</b>	<b>96</b>	<b>5,170</b>	<b>3,092</b>	<b>2,078</b>
<b>Total</b>	<b>40,325</b>	<b>28,249</b>	<b>12,076</b>	<b>2,643</b>	<b>1,636</b>	<b>1,007</b>	<b>2,013</b>	<b>3,020</b>	<b>49,325</b>	<b>30,043</b>	<b>19,282</b>
Financial plan additional non-delivery LRP offset	(9,000)		(9,000)			0	(1,500)	(1,500)			0
<b>Total</b>	<b>31,325</b>	<b>28,249</b>	<b>3,076</b>	<b>2,643</b>	<b>1,636</b>	<b>1,007</b>	<b>513</b>	<b>1,520</b>	<b>49,325</b>	<b>30,043</b>	<b>19,282</b>



NHS Lothian

Board Meeting  
24 June 2015

Director of Strategic Planning, Performance Reporting & Information

## **SUMMARY PAPER - HEALTH AND SOCIAL CARE INTEGRATION - INTEGRATION JOINT BOARDS**

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

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

To agree the formal nomination of voting Board members to the four Integration Joint Boards as set out in Table 1.	3.3
To agree the formal nomination of the three healthcare professionals as non-voting members to each of the four Integration Joint Board as set out in Table 2.	3.7
To agree the formal nomination to the four Strategic Planning Groups as set out in paragraph 3.10.	3.9

Professor Alex McMahon  
Director, Strategic Planning, Performance Reporting and Information  
18 June 2015  
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# NHS Lothian

Board Meeting  
24 June 2015

Director of Strategic Planning, Performance Reporting & Information

## HEALTH AND SOCIAL CARE INTEGRATION - INTEGRATION JOINT BOARDS

### 1 Purpose of the Report

1.1 The purpose of this report is to recommend to the Board:

- a) Who it nominates as voting members of each Integration Joint Board.
- b) Who it appoints as non-voting members of each Integration Joint Board, to fill the health professional positions that the NHS Board is required by law to appoint.
- c) Who it nominates as a member of the Strategic Planning Group for each IJB

1.2 This paper is relevant to the Board's 2015/16 Corporate Objective Four: "Deliver Actions to Enable Change." It specifically relates to action 4.1 - "integration".

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

### 2 Recommendations

- 2.1 To accept this report as assurance that none of the individuals proposed for membership of Integration Joint Boards are disqualified from being a member.
- 2.2 To appoint the Lothian NHS Board members set out in Table 1 as voting members of the respective Integration Joint Boards.
- 2.3 To appoint the healthcare professionals identified in Table 2 as non-voting members of the respective Integration Joint Boards.
- 2.4 To nominate Alex McMahon as the NHS Board's representative on each of the Integration Joint Boards' Strategic Planning Groups.
- 2.5 To note that progress with the development of the senior management structure and recruitment of the Chief Officer in Edinburgh in Edinburgh is underway but a further report on progress will come to the August meeting of the Board.
- 2.6 Note that the first meeting of the Edinburgh Children's Joint Board was held on 10 June. NHS Lothian non Executive representatives are Shulah Allan; Kay Blair and Alison Meiklejohn.

### 3 Discussion of Key Issues

3.1 The Scottish Ministers have approved the Integration Schemes for the City of Edinburgh, East Lothian and Midlothian. The associated Integration Joint Boards will be established on 27 June 2015. The final West Lothian Integration Scheme was

submitted later than the other three, and due to the parliamentary timetable, it is expected that the West Lothian Integration Joint Board will be established in September.

- 3.2 The NHS Board must now focus on implementing those Integration Schemes, whilst complying with the Public Bodies (Joint Working) (Scotland) Act 2014 and the associated orders and regulations. This includes addressing the membership of the Integration Joint Boards and their strategic planning groups.
- 3.3 Board members should note that a process is underway in relation to the appointment of the Chief Officers and the Chief Finance Officers. It had been hoped that a progress report on the wider management structure within Edinburgh would have been available for this meeting. That has not been possible at this stage. However progress is still being made as stated above with the Shadow IJB Chair and Vice Chair and there remains a commitment to focus on the development of the four localities in Edinburgh aligned with wider developments within the City of Edinburgh Council.
- 3.4 Voting Members

Table 1: Proposed NHS Board nominees as voting members of the Integration Joint Boards.

<u>INTEGRATION JOINT BOARD</u>	<u>VOTING MEMBERS</u>
City of Edinburgh  (5 positions)	George Walker (Chair), Dr Richard Williams, Kay Blair, Shulah Allan and Alex Joyce
East Lothian  (4 positions)	Mike Ash (Vice-Chair), John Iredale, Alison Meiklejohn and Alex Joyce.  Note: Councillor Donald Grant will be the Chair of the IJB, as the council currently has the right to determine the chair. Alison Meiklejohn will become a member of this IJB as an interim measure instead of Graeme Warner. It is anticipated that the NHS Board will replace her with one of the new appointments to the NHS Board.
Midlothian  (4 positions)	Peter Johnson (Vice- Chair), Morag Bryce, Melanie Johnson and Alex Joyce.  Note: Councillor Catherine Johnstone will be the Chair of the IJB, as the council currently has the right to determine the chair.
West Lothian  (4 positions)	Julie McDowell (vice-chair), Alison Meiklejohn, David Farquharson and Alex Joyce.  Note: Councillor Frank Toner will be the Chair of the IJB as the council currently has the right to determine the chair.

- 3.5 The Board approved its nominees to the integration joint boards on 14 January 2015. The table has the same members with the exception that Graeme Warner has been replaced with Alison Meiklejohn in East Lothian and George Walker replaced Robert Wilson in Edinburgh.
- 3.6 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 sets out criteria which would disqualify an individual from being a member of an Integration Joint Board. All of the individuals in Tables 1 and 2 (below) have confirmed that they are not disqualified from participating.
- 3.7 Non-Voting Members

The above Order states that it is for the health board to determine who should hold the following non-voting integration joint board membership positions:

- (a) "A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Lothian in accordance with Regulations made under Section 17P of the National Health Service (Scotland) Act 1978;
  - (b) A registered nurse who is employed by NHS Lothian or by a person or body with which NHS Lothian has entered into a general medical services contract; and
  - (c) A registered medical practitioner employed by NHS Lothian and not providing primary medical services."
- 3.8 The Medical Director, Nurse Director, Director of Public Health & Health Policy, the Director of Strategic Planning, Performance & Information and the Corporate Governance Manager met to discuss how to take this forward. It was recognised that being a member of an IJB is different from a role in the operational or management arena, and it is different from being a member of a CHP sub-committee. It will require the individual to have certain knowledge, skills and experience, and he or she will have to comply with the Ethical Standards Act. It is possible that an individual who is appointed may require further support in terms of his or her own development. Another key issue is that the appointments will create a time commitment for each of the individuals, and this is a critical issue. The demands of these appointments will need to be met within the framework of existing job plans and other work commitments.

Following this discussion, it was concluded that a pragmatic approach would be for the NHS Board to appoint individuals from the proposed senior management team of the relevant IJB, and that this should be reviewed in 18 months. The relevant senior management team posts and the individuals concerned are set out in Table 2 below.

Table 2: Proposed Non-Voting (health professional) members of integration joint boards

	East Lothian	Edinburgh	Midlothian	West Lothian
(a) Medical practitioner providing primary medical services	Clinical Director of the IJB	Clinical Director of the IJB	Clinical Director of the IJB	Clinical Director of the IJB
(b) Registered Nurse	Chief Nurse for the IJB	Chief Nurse for the IJB	Chief Nurse for the IJB	Chief Nurse for the IJB
(c) Medical practitioner not providing primary medical services	Associate Medical Director for the Royal Infirmary of Edinburgh	Associate Medical Director for the Royal Infirmary of Edinburgh	Associate Medical Director for the Western General Hospital	Associate Medical Director for St John's Hospital

3.9 The Board may wish to note that there are changes being made to the Chief Nurse posts in Edinburgh and West Lothian due to a move internally and retirement. In the interim the Executive Director of Nursing will ensure representation at any IJB meetings until the positions are filled.

### 3.10 Strategic Planning Groups of Integration Joint Boards

The Act requires an Integration Joint Board to establish a strategic planning group before preparing their first strategic plan. The Act and regulations set out the process and membership of the group. At least one of the members has to be an individual nominated by the health board. This was discussed in the above meeting, and the view was this needs to be an individual with expertise in planning and a sound knowledge of the board's strategies and plans. The Act does not require the person to be a member of the NHS Board. Consequently it is recommended that the Director of Strategic Planning, Performance Reporting and Information be nominated onto all four strategic planning groups.

The Director of Strategic Planning, Performance Reporting and Information will review the membership of all four strategic planning groups in relation to health input with the Joint Directors/Chief Officers. If required additional representation will be agreed.

## 4 Key Risks

4.1 The key risk is that the new Integration Joint Boards could have inadequate or ineffective systems of governance, which in turn lead them to failing to discharge their roles. The knowledge, skills and experience of the membership will be a critical factor in addressing that risk.

## **5 Risk Register**

- 5.1 Health and Social Care Integration is already on the Corporate Risk register and is reviewed frequently and has lately been reduced in significance.

## **6 Impact on Inequality, Including Health Inequalities**

- 6.1 No impact assessment was carried out as part of this paper being produced as the decisions being as asked by the Board. The work of the IJB's and the Strategic Planning Groups will have a direct impact on addressing issues relating to inequality and health inequalities and this will feature within the production of the strategic commissioning plan.

## **7 Involving People**

- 7.1 The nominations being put forward have been discussed with involvement from the Board Chairman, Chief Executive, members of the Corporate Management Team and Shadow Board Chairs and Vice Chairs as appropriate.

## **8 Resource Implications**

- 8.1 The resource implications are that as yet we do not fully understand what the time and costs will be for the three healthcare professionals involved in undertaking a non-voting role and this will be require to be reviewed as the IJB itself develops. There would require to be a discussion at around 18 months with responsible Directors as set out above.
- 8.2 In addition the actual costs of running the IJB proper are not fully understood and therefore there may be a requirement to revisit this again in due course once they are established and operational.

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18 June 2015

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Board Meeting  
24 June 2015

Joint Director of Health & Social Care, East Lothian & Executive Lead for Primary Care Services/Director of Strategic Planning, Performance Reporting & Information

### SUMMARY PAPER - PRIMARY CARE AND Lothian UNSCHEDULED CARE SERVICES

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"> <li>The paper reports on progress with the Primary Care strategic propositions and priorities, and seeks Board support for the resource allocations agreed and further work underway</li> </ul>	3.1
<ul style="list-style-type: none"> <li>Planned current year revenue and capital investments in primary care to support practice capacity are presented for support and approval</li> </ul>	3.2,3.3,3.4
<ul style="list-style-type: none"> <li>Proposals are being developed to assist with difficulties in GP recruitment and retention, along with an emergency fund to support practices at risk</li> </ul>	3.5, 3.8
<ul style="list-style-type: none"> <li>A Primary Care Information Technology Operational Board has been established</li> </ul>	3.6
<ul style="list-style-type: none"> <li>Recommendations developed by GP Sub-committee on a new model for supporting care of the frail elderly in community settings have formed the basis of recent discussions with the four Lothian Health and Social Care Partnerships, and a verbal update will be provided to the Board.</li> </ul>	3.7
<ul style="list-style-type: none"> <li>The review of district nursing services, led by the Nurse Director, will be taken forward alongside the development of the frail elderly model of care</li> </ul>	3.7
<ul style="list-style-type: none"> <li>Consultation on the Lothian Unscheduled Care Service (LUCS) review has concluded and specific recommendations have been agreed by East Lothian CHP sub-committee.</li> </ul>	3.9
<ul style="list-style-type: none"> <li>Proposals to address recruitment and retention of staff in LUCS have been developed and are under consideration, alongside the national review.</li> </ul>	3.10
<ul style="list-style-type: none"> <li>the National Primary Care Out of Hours Review Group will be visiting Lothian in July</li> </ul>	3.10
<ul style="list-style-type: none"> <li>Primary care general practice capacity has been reviewed as an item for inclusion on NHS Lothian Corporate Risk Register, PCCO and Health and Social Care Partnership Risk Registers</li> </ul>	5.1,5.2

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**PRIMARY CARE AND Lothian UNSCHEDULED CARE SERVICES**

**1 Purpose of the Report**

- 1.1 The purpose of this report is to recommend that the Board acknowledge and support progress in the development and delivery of the primary care strategic propositions outlined in Our Health, Our Care, Our Future NHS Lothian's Strategic Plan 2014 - 2024.

**2 Recommendations**

- 2.1 Agree to the 2015/16 NHS Lothian financial plan primary care investment of circa £1.11m to support delivery of a number of primary care propositions outlined in Our Health, Our Care, Our Future
- 2.2 Support the concept of a special measures package framework to meet the needs of practices at significant risk of service disruption. A number of initiatives have been developed to alleviate difficulties associated with general practitioner recruitment and retention and increasing workloads in primary care services which impact on access. It is estimated circa £968,022 investment is required to support these initiatives. This would be an immediate priority against the national primary care funds when distributed.
- 2.3 Acknowledge progress in the enhancement of primary care Information Technology and Management (IT&M) systems – though problems still reported.
- 2.4 Note capital investment in a number of primary care schemes totalling £1,261,814 has been approved through the Lothian Capital Investment Group
- 2.5 Note work is being taken forward within the four Health and Social Care Partnerships to support development of models for care to support the frail elderly in the community
- 2.6 Note work is progressing to review the district nursing service to support the emerging new models of care
- 2.7 Note progress with the implementation of the recommendations associated with the Lothian Unscheduled Care Service (LUCS) and the visit from the National Primary Care Out of Hours Review Group to NHS Lothian in early July 2015
- 2.8 Note the proposals for improving recruitment and retention in LUCS. These would be an immediate priority against the national primary care funds when distributed
- 2.9 To note that primary care general practice capacity has been reviewed as an item for the NHS Lothian Corporate Risk register and will be reviewed continuously.

**3 Discussion of Key Issues**

- 3.1 A progress report relating to NHS Lothian's Strategic Plan 2014-2024 was agreed at the NHS Lothian Board meeting in February 2015. This built on a presentation and discussion



on primary care at the January Board Development session. The report set out the key primary care and community health service priorities to support delivery of the Scottish Government 2020 Vision and shift in the balance of care, key priorities include:

- Access
- Support for the Frail Elderly in the Community
- Shifting the Balance of Care
- Workforce
- IT&M
- Workload and demand

3.2 Additional resource has been provided to NHS Lothian for GMS services in recent years. This additional funding has been provided to reflect general uplift as well as changes in demography. Table 1 below sets out the increases to Lothian relative to Scotland since 2011/12

<b>PMS/GMS Allocation £000's</b>				
	<b>2011-12</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>
Lothian	100,644	101,747	103,635	105,251
Scotland	676,885	680,953	689,944	698,135
Lothian Share %	14.87%	14.94%	15.02%	15.08%
<b>Increases/ Uplifts</b>				
Lothian		1,103	1,888	1,616
Lothian %		1.1%	1.9%	1.6%
Scotland		4,068	8,990	8,191
Scotland %		0.6%	1.3%	1.2%
General Uplift		612	1,368	1,250
Local Demographic Uplift		491	520	367
		<b>1,103</b>	<b>1,888</b>	<b>1,616</b>

3.3 An initial investment of circa £1.1m in revenue for primary care and community health services is included in NHS Lothian's 2015-16 financial plan having been discussed and supported by the Primary Care Forward Group and NHS Lothian Corporate Management Team. Investment priorities are as follows:

<b>Strategic Priority</b>	<b>Description</b>	<b>Investment</b>
Domiciliary Phlebotomy	Further enhancement of the domiciliary phlebotomy service to extend arrangements for phlebotomy in general practice. There is a bigger challenge around wider secondary care tests done by practices which needs to be considered.	£300,000
Type 2 Diabetes	Provision of an enhanced service for Type 2 diabetes to ensure individuals with type 2 diabetes are managed through primary care services rather than referral to secondary care services	£350,000
Very Long acting contraception VLARC	Uncap of funding for very long lasting contraception to further reduce unwanted pregnancies and cost associated with terminations	£100,000
LEGUp / Initial Practice Allowance	Investment to support practices to extend list sizes in light of population growth and restricted practice lists	£200,000
Advanced Nurse	Training of ANPs to support issues associated with GP	£130,000

Practitioners	recruitment and retention and new models of care for the frail elderly	
Access Pilots	Support a further 3 practices in 2015/16 to pilot alternative access models	£30,000

Some of these will require recurrent funding and others will require to be reviewed in one year.

- 3.4 Capital investment during 2015-16 in a number of primary care schemes totalling £1,261,814 has recently been approved via the Lothian Capital Investment Group and the Finance and Resources Committee to support creation of additional capacity within general practices. Investment will support the following schemes:

Scheme	Investment
Creation of clinical capacity in Carmondean, Howden and Linlithgow Health Centres	£37,600
Reconfiguration of medical storage to provide additional administrative space at Carmondean and Linlithgow Health Centres	£54,000
Additional clinical space at Newbattle Medical Practice	£20,214
Refurbishment of GP Practices – Small Schemes	£100,000
Leith Walk development	£1m
Ratho Practice	£50,000
Bundle (North West Edinburgh, Firhill and Blackburn Partnership Centres)	No figure agreed yet

- 3.5 In order to address difficulties associated with GP recruitment and retention and increasing workloads in primary care, a number of local funding schemes are proposed to ameliorate the situation though it should be noted these initiatives will not resolve the current position. These actions will also address issues of patient safety and quality of care. Four initial proposals are being developed, supported by the Primary Care Joint Management Group.

Local Scheme	Description	Investment
Local GP Returner Scheme	Three locally funded places in 2015-16 to encourage back to work doctors who leave the Performers List at a young age and encourage doctors going on maternity leave to apply for a retainer scheme to facilitate return to work and avoid loss of skill and confidence. NES is developing a national scheme to support four full time returners per annum across Scotland.	£105,000 (estimate)  3 trainer grants £23,000
Primary Care Clinical Development Fellows	Newly qualified GPs are in a unique position in terms of career choices, geographical location and being medically competent but wishing to gain further experience. These posts will offer successful applicants an opportunity to develop their clinical and professional competence in a purposeful and supervised manner. The posts will comprise of 4 sessions in general practice, weekly out-of hour's sessions and development time.	Investment £75,000 for 3 fellows (2015)  LUCS and practices will fund sessions within their areas
Locum Pool of Recently Retired GPs	West Lothian CHCP will pilot a locum pool of retired GPs with agreed terms and conditions attractive to older GPs (no house calls, no duty sessions, set surgeries, £200 session rate, 1 paid CPD session for	Investment of £60,000 for CPD sessions (up

	8 or more sessions per month)	to 5 locums working 8 sessions per month (£12,000 x 5 locums) West Lothian Practices funding £96,000 to support the locum sessions
Practice Emergency Care Fund	Details at 3.7 below	£500,000
Salaried Doctors – study leave -LUCS	Accrue study leave for salaried doctors.	£100,000
Ad hoc annual leave - LUCS	To offset the negative impact of HMRC decision.	£105,000

3.6 A Primary Care Information Technology Operational Board has been established to discuss and take forward developments within primary care eHealth systems. The remit of the Operational Board includes:

- Practice-specific issues – hardware; software, communication, including practice survey; business continuity; training; integration with other software e.g. GP Order Communications, data extraction relating to Quality Outcomes Framework, Primary Care Contractor Organisation requirements, GP requirements, Scottish Primary Care Information Resource (SPIRE), Emergency Care Summary/Key Information Summary
- Data sharing – to be explored, and all work requires agreement with Lothian Local Medical Committee. A particular need is to share information from Primary Care with Ophthalmology.
- Developments – specification and prioritisation of all developments
- Current Service Level Agreement (SLA) being explored in order to look at response times to IM&T issues

A number of work streams are being taken forward to support the performance and speed of primary care IT systems which has included increased memory for primary care PCs, terminal services configuration (use of a remote central server) is being piloted and showing good initial results, replacement programme to support upgrading of PCs is being explored and streamlining of eHealth Helpdesk support to general practice.

3.7 The Lothian GP Sub Committee has developed a paper outlining recommendations to support delivery of services to support Care of the Frail Elderly and 2020 Vision (Appendix 1). The proposed new model of care for the frail elderly focuses on three key groups: the housebound frail elderly, care homes and hospital at home. To support the development of the new models of care, a number of recommendations have been made, which include:

- Increasing community nursing (district nurse) capacity to account for the Current deficit and to meet the demands associated with demographic change and 2020 Vision

- New secondary care workforce in the community to undertake scheduled hospital work required for clinical safety e.g. post operative care, test arrangements, GPs being delegated follow up work
- Increased planned deaths at home and community work no longer undertaken by GPs, supported through increase in community nurses
- Advanced Nurse Practitioner (ANP) aligned to 60 care home patients to deal initially with all requests for medical input
- Senior district nurse and ANP to deal with all requests for house calls in those coded as housebound over 65 years (age 55 in most deprived areas) by 2020
- Community nurses to be locality based, practice-focussed and provide frailty anticipatory care.
- Community Respiratory Teams as first port of call for all Chronic Obstructive Pulmonary Disease (COPD) exacerbations in the housebound
- REACT-style teams for each locality to support admissions avoidance and delayed discharge operating 24 hours/ 7 days per week ('Complexity-HUBs)
- Community Pharmacists attached to every practice and contributing to polypharmacy review, but primarily undertaking core practice prescribing work to free up GPs to deal with their expanding medical workload.
- New nursing homes for palliative care when hospice capacity is exceeded
- A new model of care homes / intermediate care where there is opt-out of GMS, and instead residents are looked after by a separate, dedicated multi-disciplinary team
- Frailty assessment and management and generic geriatrician and MDT input to the frail elderly both at home and in hospital with a shift where possible from medical to nursing staffing in both settings
- A small high number of highly effective generic services
- Locality empowerment and development in the new H&SCP setting, with improved interface working between primary, secondary and social care.

The above are all consistent with the proposed model for radical reform of the Scottish GMS contract, which envisages the GP as the lead primary care diagnostician and medical decision-maker and co-ordinator of care, retaining the practice as the hub of care, whilst being supported by an extended team.

In order to progress development of new models of care for the frail elderly, a meeting has been convened in mid June 2015 involving representatives from NHS Lothian and the four Lothian Health and Social Care Partnerships where responsibility for strategically planning for primary care will sit going forward.

A review of the district nursing service will also be progressed to dovetail with the work to review models of care to support the management of the frail elderly in the community. An outline of the review will be taken to the meeting of NHS Lothian Board on 24 June 2015.

In Edinburgh, there are a number of practices which are being actively supported to prevent either collapse of service or a substantial reduction in list size. Additional support to these practices has been ad hoc to date and it is recognised there is a need for formalise arrangements. It is anticipated a number of practices in Lothian will require this type of support over the next 3 years.

With demographic pressures in Edinburgh, there is the potential for a worst case scenario that a combined population of 20,000 – 25,000 will be without GP services.

To support practices in difficulty, it is proposed an 'emergency fund' is established to allow partnerships to flexibly support a small number of practices where the challenge to continuity is judged to be severe. These are initially defined as:

- at least 1,000 or 25% of the list size is going to be unsupported
- recent experience and evidence of unsuccessful attempts to attract new partners
- no obvious reason why the practice should not be viable

Resource implications have been modelled on a theoretical practice of 5,000 with additional funding support of £105,000 per practice. If 5 such practices required this support in a given year the total required would be £500k. The second year of support for these practices would be less at approximately £100k. This gives the recommended available resource (Edinburgh only) of £0.6m.

### **3.9 Lothian Unscheduled Care Service (LUCS) review and recommendations**

A review of LUCS was carried out in 2014. It made a large number of recommendations. Many of the recommendations were about detailed operational issues. Some recommendations concerned changes to service provision.

Consultation on the review has been carried out from January to March 2015. Consultation has included staff meetings, public meetings, provision of information and meetings with other stakeholders. The review has also been discussed at CHP sub committees.

The issues that have attracted most comments have been:

- The reduction in hours of the bases in East and Midlothian.
- The proposal for car coverage for East and Midlothian.
- The issue of lone working in East and Midlothian bases.
- The proposals to centralise nurses to 3 main bases

In light of the feedback, the developing national picture (with a national review of GP Out of Hours services commencing) and in light of the fact that the festive and Easter long weekends were the busiest ever, the following final proposals were made.

- That there should no reduction in the hours of opening in either of the East or Midlothian bases
- That there should be one car to cover East and Midlothian on weekday evenings
- That there should be one GP and one nurse based at each of the East and Midlothian bases therefore avoiding lone working
- That the nurses staffing should be centralised to the three main bases with an outreach service to East and Midlothian.

This was discussed and approved by the East Lothian CHP subcommittee, where LUCS is hosted, on 30 April 2015.

The review also made recommendations about **Recruitment and Retention** of GPs within LUCS.

There is an ongoing national challenge in GP staffing within out of hours services. There are a number of reasons for this including increasing pressure within daytime general

practice, changes to working patterns, pension changes and increasing complexity and workload during the out of hours period. Recently HMRC have required the ad hoc doctors to pay tax and national insurance at source. This has meant an increase in national insurance for a majority of doctors which has translated into a reduction in take home pay for them. The last pay rise for GPs working within OOHs was December 2013.

There is a need to improve recruitment of new GPs to work within the service but also to improve terms and conditions and retain the loyal workforce currently working for the service. Below details the plans to improve both recruitment and retention within LUCS.

## **Recruitment**

- The LUCS team have been targeting GPs who have recently moved to the area or who may not have worked substantively within Lothian by updating and improving the LUCS page on the LASGP website. Further work is ongoing in association with communications to develop and maintain a LUCS internet page
- GP Development Fellows, similar to the current hospital Clinical Development Fellows, are being developed. These involve a commitment to working in out of hours as well as some development time and work within in-hours general practice. These jobs are targeted at recently qualified GPs and are currently out for advert. Funding is jointly by LUCS, GP practice and NHS Lothian.
- LUCS is also developing combination jobs which would involve working within LUCS and in-hours practice or in some cases hospital jobs. These jobs would be available to all but again are likely to be popular with newly qualified GPs

## **Retention**

LUCS is staffed by a combination of salaried and ad hoc GPs working, with a split of about 50/50. There are advantages to both ways of working and retention has to address both groups of staff.

LUCS struggles to staff the service at particular times of the year, notably school holidays and the Easter 4 day break. Other health boards offer enhanced rates at difficult to cover periods. To date LUCS has only offered enhanced rates on public holiday days and over the festive period. There is a need to change this to ensure safe and appropriate cover for the service.

## **Pay**

### **Public holiday rates**

A proposal is being developed to increase public holiday payment to improve shift coverage.

A proposal is being developed not to have the 4 day holiday at Easter. This recognises the pressure this holiday puts on hospitals and primary care as well as the Emergency Departments and LUCS. There are a number of Boards within Scotland who no longer take Good Friday and instead would have an extra Monday holiday in May. In view of the size of NHS Lothian and the continuing need and demand for healthcare 24/7 it is time to question whether Lothian should shut down for 4 days.

### **Enhanced rates for challenging shifts**

A number of boards recognising the difficulty in staffing shifts at certain times of the year particularly the summer holidays are increasing their rates for the weekends during the summer.

It has been agreed to increase LUCS ad hoc rates for 7 weekends over the summer and to offer the ability to swap salaried shifts to another weekend in the summer to minimise annual leave and provide as much salaried cover as possible.

## **Terms and Conditions**

### **Study Leave for salaried doctors**

One of the Review recommendations was that LUCS salaried GPs should have study leave. After reviewing what other health boards within Scotland offer their OOHs GPs the following proposal is being developed.

To allow salaried GPs to accrue study leave. This could be used to attend a course, for personal continuing professional development or to do some Quality Improvement/audit work within the service.

The cost of this would be circa £100k per annum recurring.

### **Annual leave for ad hoc doctors**

For ad hoc GPs it has been recognised that since the HMRC ruling there has been a decrease in pay. The HMRC ruling was one with which LUCS had to comply. To mitigate against the decrease in take home pay for our ad hoc doctors and to recognise and promote loyalty a proposal is being developed to offer annual leave to replicate the arrangements currently in place for other bank staff. This is in line with others boards within Scotland.

The cost of this would be circa £105k per annum recurring.

## **National Review**

On 30 January 2015 the Cabinet Secretary for Health, Sport and Wellbeing announced a National Review into Primary Care Out of Hours Services.

The Review will be led by Sir Lewis Ritchie, who will also Chair the Steering Group and Executive Group. Steering Group membership will be wide and diverse with stakeholders at a range of levels.

Sir Lewis Ritchie is to visit Lothian on 9 July to meet staff working within LUCS

The reasons for the Review relate to:

- Difficulties in securing commitment from GPs particularly in the busier out-of-hours centres and during peak holiday time such as Christmas and Easter exacerbated by:
- Shifting attitudes in relation to achieving a work/life balance and the preparedness or appetite of doctors to cover OOH sessions.
- the proximity of doctors earnings to key pensionable earnings thresholds (which additional sessions can quickly breach),
- Busier day-time practice reducing the inclination or ability of GPs to work additional OOH shifts.
- Staff availability is unpredictable making it difficult for the Board to forecast and plan staffing rotas and achieve necessary balance of skills mix.
- Demand can be difficult to predict leading to difficulty in delivering a consistent service which leads to difficulties in managing public expectation.

- Unpredictability, increasing demand and inconsistency can cause pressure on other services such as Accident & Emergency Departments.
- NHS Boards can be required to adjust their service delivery at short notice. Measures to deliver safe services now regularly include: increased/inflated session rate payment to attract GP and secure shifts (with Board often competing with each other to secure GPs (and other occupations); running the service from fewer local sites; and / or reducing or withdrawing home visiting.
- Solutions are currently being drawn up and deployed to enable a wider range of care providers to deliver out-of-hours services.

The **Primary Care Out-of-Hours Services Review** will review the current delivery landscape and recommend action to ensure primary care out-of-hours services:

- Are sustainable, high quality, **safe** and effective
- Provide access to relevant **urgent** care where needed
- Deliver the right skill **mix** of professional support for patients during the out-of-hours period

The Review will produce:

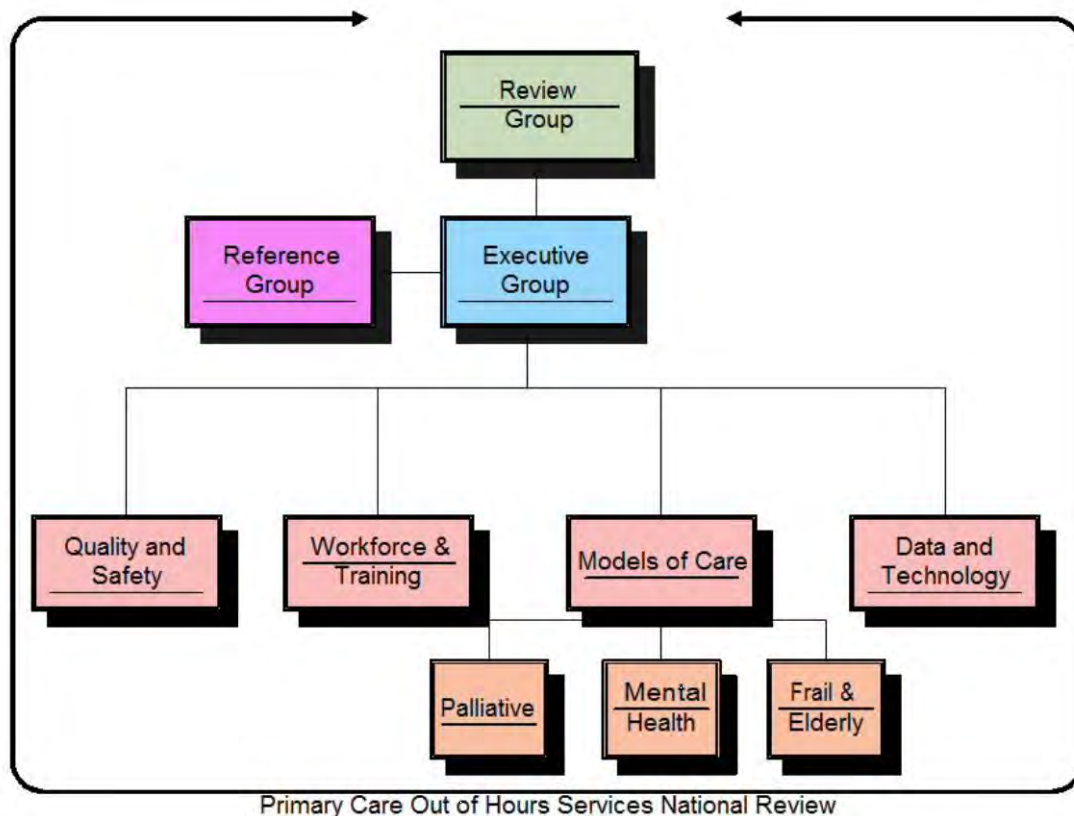
- **Profiles** of individual territorial Health Boards' primary care out-of-hours service models including components of models of care employed as well as human, revenue and capital resources utilised.
- A **summary** report highlighting key points from recent primary care out-of-hours services reviews and papers.
- A report of 2013/14 **demand** for primary care out-of-hours services in each Health Board area.
- A common understanding of the needs of the current **workforce** and their future requirements.
- A report including **recommendations** to the Cabinet Secretary for Health, Sport and Wellbeing by late summer 2015.

The Review objectives are:

- To map the full **range of primary care out-of-hours services** currently available when GP practices are closed, broken down by service type, service level and resource provision by Health Board.
- To identify the **variety of models** of delivery of primary care out-of-hours services operating out of each territorial Health Board including details of supporting infrastructure; resource management; interfaces with social care and other services (e.g. mental health services)
- To identify suggestions for elements of services where a National approach is possible and where variations are required for delivery of primary care out-of-hours services throughout Scotland.
- To develop programmes of tests of change which implement elements of the proposed models of Primary Care Out of Hours Services in selected Health Boards.

The Review will be structured as shown in the diagram below





## 4 Key Risks

4.1 Key risks associated with insufficient support for the primary care strategic propositions relate to :

- insufficient investment in primary care and community health services will need to be identified as a patient safety issue and would not support delivery of our own strategic ambitions or the Scottish Government 2020 vision and a shift in the balance of care
- delay in progress with the development of a revised model of care for the frail elderly in the community will impact on emergency admission rates and delay in discharge
- training of additional community Advanced Nurse Practitioners and other actions underway will be insufficient to address the emerging gap in primary care and community workforce
- individual GP practices destabilising to the point where they may have to close
- the potential for NHS Lothian not to be seen as a good place for a GP to work, thus destabilising primary care further
- Widening of health inequalities, increased costs, increased referrals, fewer planned deaths at home, increased admissions, increased morbidity, increased mortality – if significant ‘primary care shortage’ areas develop (in line with the established evidence of primary care efficacy).

## 5 Risk Register

5.1 At the NHS Lothian Risk Management Steering Group meeting on 15 June 2015, it was agreed Primary Care and GP Capacity should be placed on the Corporate Risk Register.

5.2 The difficulties associated with GP recruitment and increasing workloads which impact on primary care in terms of access should be highlighted on the PCCO and Health and Social Care Partnership risk registers.

## 6 Impact on Inequality, Including Health Inequalities

- 6.1 The enhancement of Primary Care Services should assist in addressing the causes and impact of inequality more effectively and efficiently but as stated above in the risk assessment there is the potential risk in that unless the capacity issues are addressed a number of scenarios could be forecast, one of which is the potential for a widening of health inequalities due to the lack of GP capacity to see, support and treat patients.

## 7 Involving People

- 7.1 The primary care priorities outlined in this paper were included in NHS Lothian's Strategic Plan 2014-2024 which was subject to a period of public consultation in 2014.
- 7.2 A number of papers detailing the recommendations outlined in this paper have been discussed and supported with a wide range of stakeholders who attend the Primary Care Forward Group, Primary Care Joint Management Team and Strategic Planning Committee.
- 7.3 Dialogue will continue to take forward the actions and recommendations outlined in this paper involving NHS Lothian, the four Lothian Health and Social Care Partnerships and General Practitioners.

## 8 Resource Implications

- 8.1 The 2015-16 NHS Lothian financial plans includes investment of circa £1.1m for primary care services. There is agreement to support investment in the following areas as outlined in section 3.2.

<b>Strategic Priority</b>	<b>Investment</b>
Domiciliary Phlebotomy	£300,000
Type 2 Diabetes Enhanced Service	£350,000
VLARC	£100,000
LEGUp / Initial Practice Allowance	£200,000
ANP Training	£130,000
Access Pilots	£30,000
<b>Total</b>	<b>£1,110,000</b>

- 8.2 The Lothian Capital Investment Group has recently approved investment of £1,261,814 in a number of primary care schemes during 2015-16 (as outlined in section 3.3).
- 8.3 There are also a number of additional investment priorities to support stabilisation of primary care services outlined in this paper which are currently unfunded in 2015-16 and beyond.

<b>Priority</b>	<b>Investment</b>
Local GP Returner Scheme	£128,022
Primary Care Clinical Development Fellows	£75,000
Locum Pool of Recently Retired GPs	£60,000
Practice 'Emergency Fund'	£500,000
LUCS - Salaried Doctors study leave	£100,000
LUCS Ad hoc annual leave	£105,000
<b>Total</b>	<b>£968,022</b>

- 8.4 As work relating to a new model of care to support the frail elderly in the community, review of district nursing service and support for investment in primary care IM&T infrastructure progresses, additional funding will be required to implement proposals.
- 8.5 NHS Lothian continues to await confirmation of an additional allocation of funds to support investment in primary care services. The Scottish Government has indicated an additional national investment of £50m.

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## **List of Appendices**

Appendix 1: Care of the Frail Elderly and 2020 Vision: Lothian GP Sub Committee 2015

## Care of the Frail Elderly & 2020 Vision: Lothian GP Sub-Committee 2015.

*“We humans are having to learn how to live longer and how to die of different things”*

*Margaret McCartney, ‘Living with Dying: Finding Care and Compassion at the end of life’*

### 3 main areas:

1. ‘Usual care’
2. Admissions avoidance
3. Integration and HSCPs.

The biggest challenges: – developing services to the new (‘industrial’) scale needed for the evolving demographic (requiring huge new resource); lack of care home capacity, money and GPs; the competing dilemmas (involving H&SCP too) - new care homes, home help / home care, isolation, poverty.

The ‘newer’ approaches to care – intelligent polypharmacy and multi-morbidity management; identification of vulnerable populations (frailty) and anticipatory care input to those patients; improving the quality of end of life discussions to support patient choices and extended palliative care. All these depend on clinician expertise and time, rather than technological ‘fixes’. Much of this work is done by GPs and Community Nurses – but the latter heavily dependent on GP input. Hospices-Palliative Care teams are an excellent, though limited, resource, and again, rely heavily on GP input.

Other hindrances to progress are multiple small pilots and that the vast majority of this work - which has increased in scale and complexity - is not accounted for by standard GMS arrangements. GPs provide a supreme service, but cannot maintain that with the new pressures: alternatives do not come close to the same provision. Public expectations need to change too. Carers are crucial – but many are ageing.

Finally there are new systems issues: the emphasis on joint and joined-up working, the developing locality and ‘District General’ structures, 2020 Vision and approaches to ‘bed blocking’. The proposals for the 2017+ Scottish GP Contract are still under discussion but envisage the GP as the hub of the team, the ‘expert medical generalist’ who maintains the role of the senior medical diagnostician and decision maker in the primary care team, but where all unscheduled work is possibly done by another team (chronic disease management, vaccinations, post-hospital care) with a greatly expanded community based team to respond to emergency care needs, too. The IJBs will be critical to deciding priorities and allocating funding. We are concerned that there will not be a named Health Board lead for older people’s care – this remains a crucial area of policy, which is absolutely central to the continued adequate functioning of the NHS.

### Recommendations:

1. In next 5 years need to double DN team capacity to account for current deficit and for demographic change (doubling of very elderly).
2. New secondary care workforce in the community to undertake scheduled hospital work (post-operative care, test arrangements): this is required for clinical safety as well as resource.
3. MAKING OPERATIONAL - 2020Vision, increased planned deaths at home and community work no longer done by GPs\*- will require *in addition* to 1:
  - a. One Senior DN (preferably an Advanced Nurse Practitioner (ANP)) for every 60 care home patients for 2 sessions per week to deal initially with ALL requests for medical input.
  - b. Senior DNs or ANP to deal with ALL requests for house calls in those coded as *housebound over 65* (over 55 in most deprived 15% SIMD data zones) by 2020.

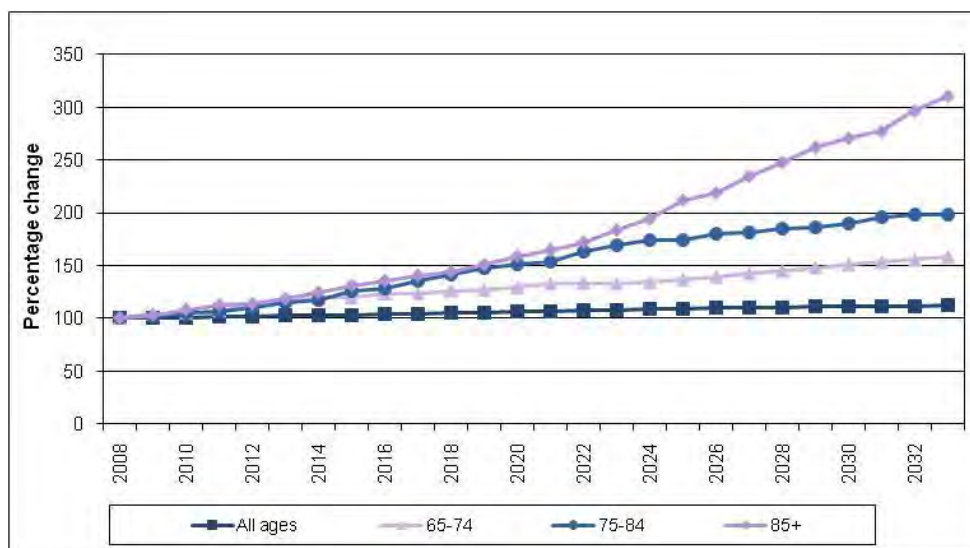
- c. IMPACT nurses to be locality-based, practice-focussed, and provide frailty anticipatory care. They will additionally support the senior DNs in their extended role of managing illness in the community.
- d. Community Respiratory Team (CRT) – first port of call for ALL COPD exacerbations in the housebound, referring to GP only if medical input required. Referral initially by SCI Gateway and subsequent updates, where required, via KIS-ACP.
- e. REACT-style teams for each locality to cover both admissions avoidance and delayed discharge, operating 24/7. Suggest a ‘complex care hub’, providing scheduled care, but co-ordinating and providing unscheduled care (either on emergency day care basis or home outreach). A hub would maximise team efficiency and provide a visible, readily accessible resource for GPs, and the wider team.
- f. Community pharmacists attached to every practice – both to free GP time for 2020 Vision work, but also contribute to polypharmacy review. (NB: *An estimated 6.5% of all admissions relate to adverse drug reactions, accounting for around 16,000 admissions in Scotland p.a.<sup>1</sup>*)
- g. New nursing homes for palliative care when Hospice capacity is exceeded – but with the aim of delivering holistic end of life care whilst avoiding unnecessary hospital admission.
- h. Entire new workforce for any care homes (or intermediate care) where there is opt-out of GMS.
- i. The same processes – of frailty assessment and management, and generic geriatrician and MDT input-apply to the frail elderly both at home and in hospital. There is much more room for joint working and approaches, with a shift where possible from medical to nursing staffing in both settings.
- j. SIMPLICITY with a small number of highly effective generic services.

\*Note SGPC briefing paper on 2017 contract possibilities – if introduced, these changes will be required anyway.

## 1. ‘Usual Care’

### Demographics and definitions.

In Lothian, the patients in the OLDEST age groups are increasing most rapidly (and are set to DOUBLE in terms of numbers) – we need *highly organised, generic, Lothian-wide, permanent, accessible systems to manage this, which are NOT GP-dependent.*



**The Strategic implementation update completely fails to adequately account for this work, whilst describing that it needs to happen. Implementation requires a seismic shift of resource into primary care – to make up for a 10-15 year deficit in funding w.r.t workload increase and transfer, thereby stabilising a General Practice which is under immediate threat, but also to fund an entire new workforce for 2020Vision and proposed bed closures.**

**Resource and Capacity.**

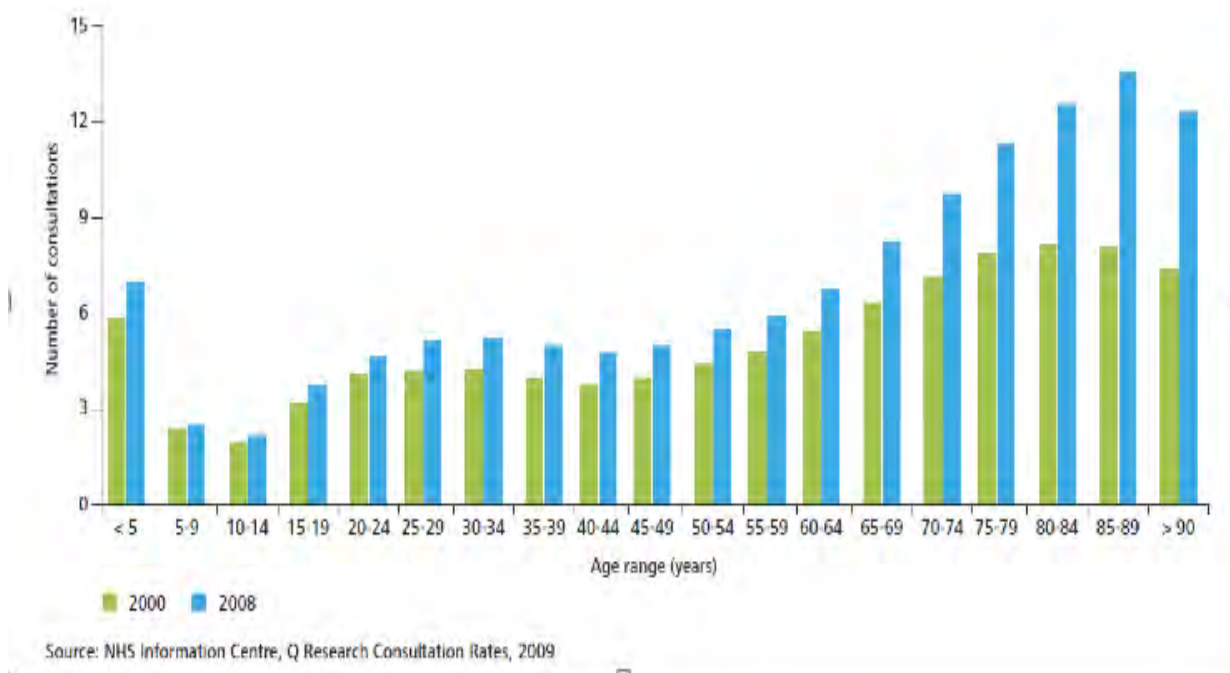
This requires an extension of:

- Community Nurse teams
- Intermediate care staff and structures
- Palliative Care provision in the patient’s home
- Practice teams – with specific consideration given to how GP time is used, now that this is a limited and rapidly diminishing resource
- Extended geriatrician-MDT teams.

**GP Resource.**

During a prolonged period of sustained population expansion, Lothian GP practice numbers remained essentially unchanged, so that we now have a marked deficit of provision. However there is now a superimposed GP workforce crisis, not helped by NHS Lothian providing less support for certain crucial areas than all other mainland Health Boards. The historical ‘solution’, namely that GPs and practices are the default for absorbing new work (with or without resource), is not feasible in relation to the expansion in the frail elderly workload. GP capacity is now falling in Lothian and whilst attempts are being made to shore it up with LEGUp, we have to have an understanding that ‘GP work’ has now to be done by others. GPs will need to maintain a strong role as Primary Care Physician, retaining oversight of the patient and continuing to provide the hub for team activities and communication. We will need to work much more seamlessly and collaboratively with secondary care and extended team staff.

The GP consultation workload has burgeoned – (with falling resource) but this is MOST marked in the elderly. Those over 80 on average consult *monthly* and these figures of course will be much higher for some.



In GP terms there are ***no longer significant differences between the 3 groups of frail elderly (nursing homes, care homes, housebound)***. These patient groups should therefore be considered as equivalent in planning terms. There will be differences in frailty, but differences in support services too.

**For ‘usual care’ three potential models are:**

1. **Residential Care – new model.** Patients completely removed from GMS provision, and ‘register’ with a virtual practice based on the GP model of longitudinal, holistic care, using nursing teams including ANPs. A small number of salaried GPs would provide the medical aspects of ‘virtual GMS’, and there would be input from MoE and the wider MDT too. This would align itself well with the SGPC vision of the post-2017 contract. The emphasis would be on team work, learning and development and be attractive. This would also allow for the massive proposed expansion of care homes now being discussed (see Strategy Update: RVH, Liberton, (both of which may include Integrated Care Facility components), other new care homes, Step Down, Step Up and so on). It costs £6m p.a. to keep 6 RVH wards open, so innovative approaches are crucial. We need urgent costings for this approach. Light touch telemedicine may have a role to play and, in keeping with other models, Council Care home staff would need to be upskilled too and this setting may support that.
2. **Generic Frail elderly care, maintaining the GP team.** (Residential and frail elderly-housebound). As this essentially requires community- rather than Health Centre-based care, the first point of contact would be a community nurse workforce with GPs visiting or consulting (either with patients or staff) where there was particular need and problems could not be resolved by a nurse visit. IMPACT nurses, ANPs and palliative care nurses – all working across the spectrum of patients and conditions - would undertake all ‘first line’ contacts and work. GPs can also hand over work to them as required. Teams would be centred on practices, but work at a locality level too because of the additional interfaces with secondary and social care, and the wider MDT.
3. **Strengthen the GP Practice role and team.** Expand GP teams to encompass some of the Community-based LTC work outlined above eg Practice Nurse teams would become more mobile, co-ordinating care in the community and bringing in Community Nurse colleagues as required. GPs would oversee the larger team. Would need a greatly expanded enhanced service. Significant disadvantages to this but does allow GPs to retain control of the team and direct accordingly. Is at odds with the locus of expansion envisaged in the SGPC proposals for the future GP contract.

**Care Home Configurations.**

It is likely that we will want to adopt a mixture of all the above and some GPs may want to keep their Care Homes, particularly if support is improved. Lothian GPs have reported that very high quality Nursing Home staff are leaving the service, and we must pay close attention to those aspects of retention, too.

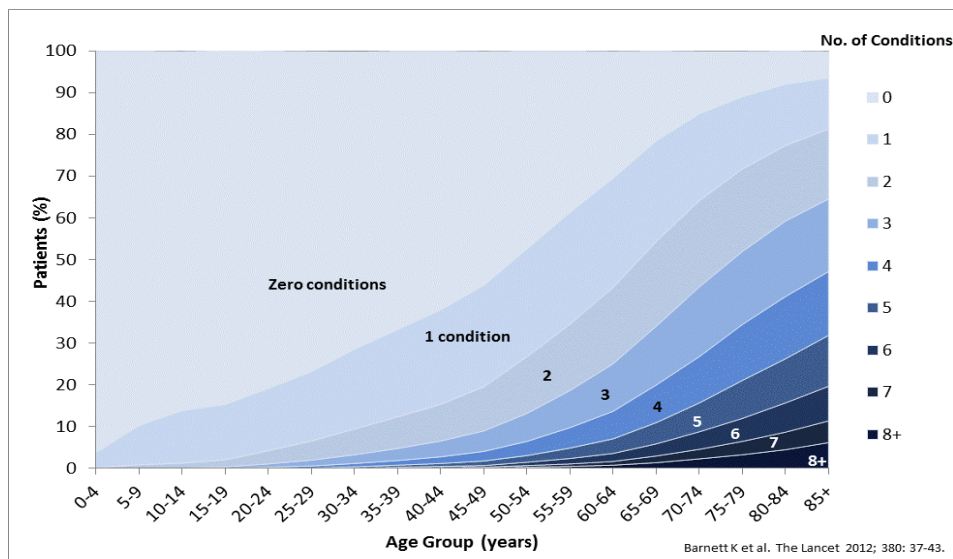
We now need to properly cost each of these options, recognising that the Care Home population will increase in line with the elderly one. The Alzheimer’s Society estimates that a third of those diagnosed with dementia require residential care, whilst two thirds are cared for at home, and that the number of people with dementia in the UK is estimated to rise by almost 40% in the 15 years to 2021 <sup>2</sup>.

**Lothian Care Homes (March 2015 figures):**

- 113 – four with no lead practice
- 5175 residents
- Care home size ranges from 8 to 120 residents
- One of the homes with no practice lead has 120 residents (Dalmuir).

## Community Nurse teams.

Clearly needs a greatly expanded service: increased numbers, further skill mix, particularly at the higher skill end. We need generic, rather than specialist, nurses, who are able to deliver a 'case management' approach for the frail elderly. The strategy requires additional palliative care nurses for each locality team and better alignment of all teams to practices. The strong GP view is that whoever the community nurse team employer, retaining the GP as the co-ordinator improves care and efficiency. Direct Community Pharmacist involvement in the team is necessary to reduce the burden of prescribing issues currently dealt with by the GP. All in-hours care needs to be considered in out-of-hours terms too. **All Care Home patients and all those on the housebound-frail elderly register should be considered to be on the Community Nurse caseload. Community nurses need to be able to manage LTCs –linked to ongoing practice work in this area.**



## All senior Community Nurses should be able to (and routinely):

- **Assess for frailty** – and ensure appropriate coding
- **Undertake frailty anticipatory care planning** including any associated referrals
- **Assess palliative status** – including use of SPICT tool
- **Sign DNACPR forms**
- **Pronounce life extinct** in all expected deaths (and certainly all those with DNACPR forms unless suspicious circumstances)
- **Be able to manage LTCs** using 'House of Care' principles<sup>3</sup>.

**Each care home should have a senior Community Nurse lead, preferably an ANP**, who will make ALL first assessments where there is a request to see a GP. In the next 3-5 years this should be extended to all housebound frail elderly patients requesting a GP home visit or clinical advice. (NHS Lothian needs to inform its population that there are not enough doctors to see frail elderly in community settings so that patients either need to travel to a surgery, or see a nurse).

**IMPACT (Improved Anticipatory Care and Treatment) nurses should be based in the community nurse hubs**, and realigned so that each works with a community nurse team. IMPACT nurses will continue their own caseload but be first point of contact for Community Nurses requiring assistance in the care of frail elderly in terms of the requisite competencies above. GPs would then be the *tertiary* avenue for advice.

**All housebound / care home patients** requiring treatment for a COPD exacerbation should be dealt with **FIRST** by the Community Respiratory Team (CRT) and only see the GP if there are additional problems.



**Skill mix for the Community Nurse teams needs to extend further:** more senior nurses to undertake multimorbidity care of the frail elderly instead of the GP; more HCAs to undertake vaccination work, bloods, and simple wound management including suture removal, B12 injections, giving of insulin and eye drops.

Secondary care nurses will need to move into the community: the new models, including the ‘complex care hub’ will provide new opportunities for gaining preparatory experience for this. Again, close joint working with secondary care nursing and medical colleagues will facilitate this, but the biggest expansion of nursing services needs to be community-based and GP co-ordinated. The erosion of Lothian’s Community Nurse provision will make this difficult to achieve and it is not clear how we can attain this required capacity.

GP teams will need to work differently too: this will be largely determined by the Scottish GP contract, but PNs are likely to be involved in more complex medical care planning, multi-morbidity rather than LTC work, and liaise more directly with community colleagues.

**CORE CONCEPTS FOR PLANNING**



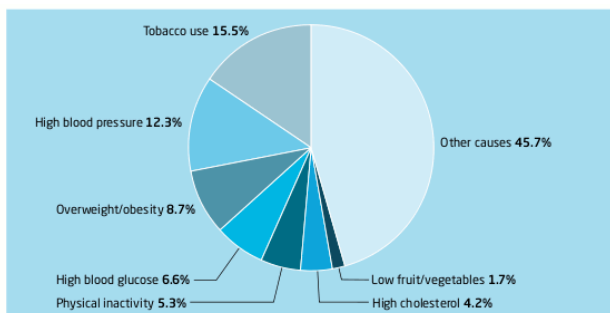
**Concepts crucial to this work are:**

- Living well and independently for longer
- Frailty and risk stratification
- Palliative care
- The third sector
- Carers.

These will be briefly considered further.

## Fit for the future.

Standard health promotion areas (smoking, BP, obesity, diabetes, physical activity, cholesterol and diet) account for half of the disease burden in those aged 60 and over<sup>4</sup>.



Source: World Health Organization 2011

These aspects of care – now core to General Practice – not only support improved survival, but reduce morbidity and can help promote independent living in later life. Physical activity in older years especially helps maintain independence and health status. Yet a third of people aged 65–74 are obese, and only 8% of women over 75 take the recommended levels of physical activity<sup>4</sup>.

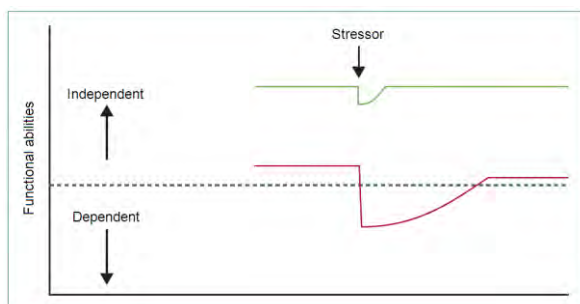
‘Minor’ needs (mobility, foot health, chronic pain, visual and hearing impairment, incontinence, malnutrition etc) have a substantial effect on maintaining independence if not addressed. It is crucial that these needs are anticipated early to avoid subsequent deterioration (Dr Andrew Coull). These are the very services where local delivery has been/ is being cut by NHS Lothian – and such local availability is particularly crucial for access by the elderly. We need to revolutionise our elderly settings with a new wave of ‘3<sup>rd</sup> age activity’: exercise bikes, Tai Chi classes, yoga in all Care Homes and Day Centres, with access by others too, helping to reduce elderly isolation.

Finally LTC management is crucial, though the focus has tended to be on general medical conditions rather than common geriatric ones and there is evidence of less input for self-management in some elderly groups<sup>4</sup>. (There is much scope for further educational initiatives – the complex care hub working will contribute to this, as will the new GP cluster groups).

## The Frailty Epidemic.

When the NHS was founded, virtually half the population died by the age of 65. Current life expectancy at 65 is 21 years for women and 19 years for men<sup>4</sup>. Because of diagnostic and therapeutic advances, older people now are generally healthier and more independent than previously, but the very old suffer multi-morbidity, polypharmacy (both of which add to further morbidity) and many more live with frailty. The King’s Fund considers frailty “*key to planning modern health and social care services*”<sup>4</sup> and we need a much more robust approach to quantifying and responding to frailty across all the health and care sectors.

Frailty in the elderly means that relatively minor illness can result in sudden catastrophic functional decline – causing falls, immobility, confusion or compromising usual ability to manage at normal levels<sup>5</sup>:



The original level of independence may not be recovered. Frailty can be non-specific (fatigue, weight loss, recurrent infections), relate to a ‘hot’ fall caused by inter-current illness, or delirium (the latter occurring in 30% of hospital admissions), or a pattern of fluctuating (unstable) disability, varying from day to day. In their

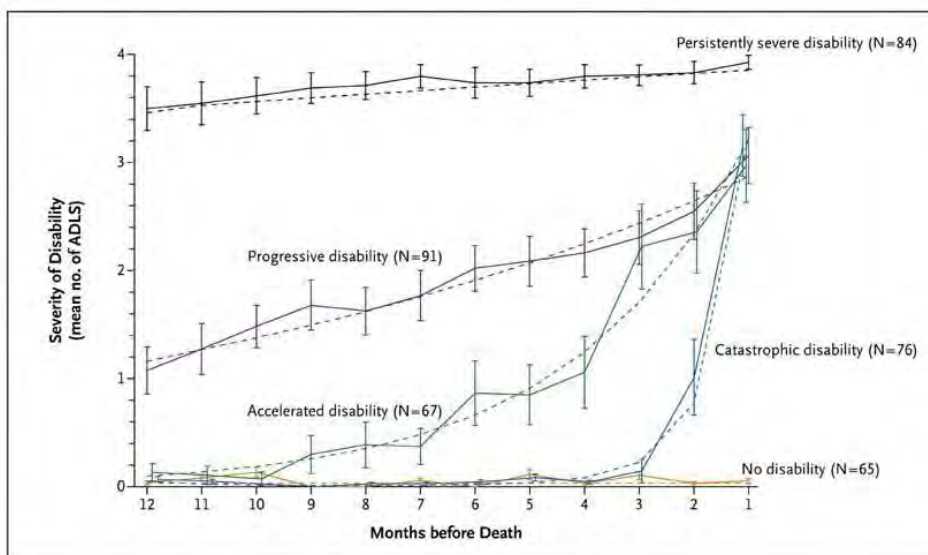
Lancet paper<sup>5</sup>, Clegg et al outlined frailty as a “disproportionate change in health state.... from independent to dependent, mobile to immobile, postural stability to proneness to falling, or lucid to delirious” in response to a stress or injury. The variable disability they describe, with the potential for rapid deterioration, requires flexible and speedy health and social care services.

Frail people are at substantially increased risk of falls, disability, long-term care, and death. The authors outline that most modern health services focus on single system disease. They emphasise the need instead to account for the presence (or not) of frailty in all health care interventions in vulnerable populations. They conclude that “*Frailty is a practical, unifying notion in the care of elderly patients that directs attention away from organ-specific diagnoses towards a more holistic viewpoint of the patient and their predicament*” – which surely also reflects GP values and approaches.

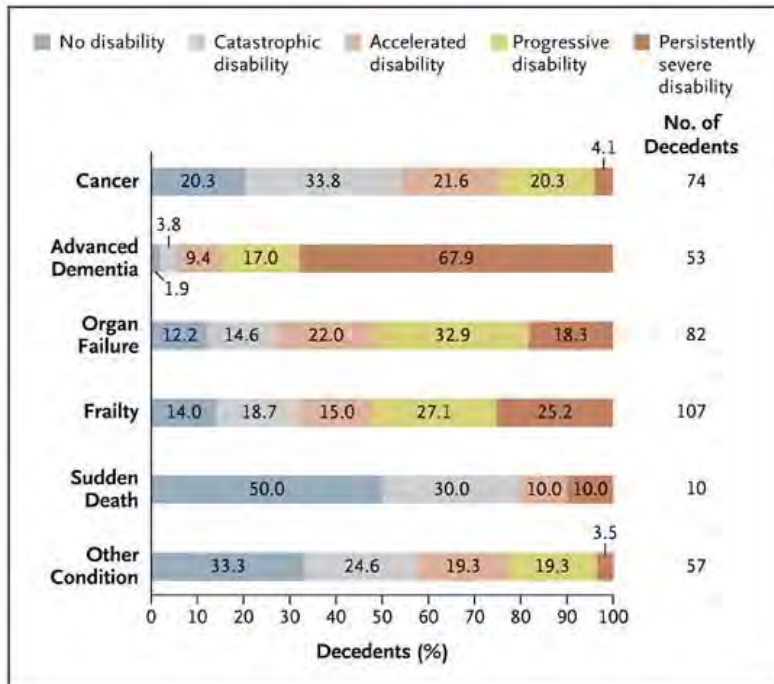
The British Geriatrics Society, in association with the Royal College of General Practitioners and Age UK, has produced useful guidance on frailty assessment and management (Fit for Frailty)<sup>6</sup>. We are already undertaking some of this work – particularly round anticipatory care planning and polypharmacy review - but lag in terms of frailty identification and local pathways with rapid response times (including for diagnostic facilities). The document also outlines that ‘frailty’ may not be welcome as a term by patients, many of whom develop ways of coping: we may need to develop a new language for this work.

IDENTIFYING frailty allows better targeting of resource with respect to vulnerability and development of new models of care for those with acute episodes of reduced function without hospitalisation (which tends to further compromise functional status in this group). There are screening tools and scales for this, the simplest involving a timed 3 metre walk. There is clear evidence that some interventions reduce the risks and progression of frailty including: initiatives supporting those with dementia, falls services, proactive exercise (‘activity’) programmes, reviewing polypharmacy and so on. Frailty identification and management is just as important in secondary care settings allowing better management and faster turnaround times (Dr Coull).

**Palliative Approaches.**



**Trajectories of Disability in the Last Year of Life<sup>7</sup>**



**Trajectories of Disability in the Last Year of Life...the associated conditions<sup>7</sup>**

**Palliative care** cannot be separated from frail elderly care - it can be very difficult to predict time of death, particularly where someone has multiple potentially life-limiting conditions. This seminal work, by Gill et al<sup>7</sup>, followed a large elderly cohort for a decade: final year of life trajectories in terms of disability are highly variable and cannot be predicted in terms of disease type (except for advanced dementia where dependency needs tend to be consistently and persistently high). We do need to be alert to when specific palliative care measures will help, but many of the principles of palliative care - aiming for quality of life not cure, minimising unnecessary treatments and hospitalisation, dying at home where that is chosen - apply to the frail elderly too.

Palliative care teams need to be larger, more community-based and a generic and integral part of community nursing ones. Recent pilots to improve palliative care approaches in Lothian care homes are to be welcomed. We need community teams to take on some of the roles traditionally done by GPs in this area too, whilst addressing some of the professional educational and support needs which still sometimes hinder us from the most difficult palliative discussions (despite the evidence that they increase quality and length of remaining life<sup>8</sup>).

One of the significant GP workloads associated with frailty is the requirement for domiciliary visits rather than surgery-based care, which also makes it difficult to extend routine Practice Nurse care to those patients.

**Risk Stratification.**

The Lothian patient model, 'Scott', represents those over 75, frail, with LTCs but no specific 'life-wrecking' diagnosis. 7% of people in Lothian in this group account for a third of A&E adult admissions.

Risk stratification allows health and social care to identify 'Scotts', or other groups who are vulnerable, to best tailor care to their needs – particularly important when funding is short. Knowing those at risk also allows for a case management approach – which has been shown to 'work'. The Nairn intervention (an active approach to 'case' finding and management)<sup>9</sup> demonstrated a 42% reduction in admissions, a halving of inpatient bed days, and improved patient-determined outcomes including dying at home, BUT at no significantly reduced cost. Anticipatory care planning also assists out-of-hours work.

Increasingly we also need to be able to quantify GP and Community Nurse workload round this so that we can quantify necessary resource, too. See appendix one for further detail.

### **The Third Sector and Carers**

Current budgetary constraints require that the provision of formal, higher level services – such as Day Care Services and Care at Home – be limited to those in the greatest need, and that there should be movement toward engagement with existing Third Sector provision to support others. Participation with community based preventative and support activities is likely to improve both community and individual resilience, expand capacity and reduce the risk of medical and social crises – such as a fall or social isolation. In Edinburgh alone, the 3<sup>rd</sup> Sector offers in the region of 2,000 activities every week, provided by 400 individual organisations.

Mapping of community assets is not easy to keep up to date and we are dependent on the individual groups registering themselves with LOOPs or other directories such as ALISS (A Local Information System for Scotland). ALISS is a search and collaboration tool for health and wellbeing resources, which helps signpost people to useful community support, but requires community resources to be registered with it and be kept up to date. Other directories such as ‘Edinburgh Choices’ (City of Edinburgh Council) and the EVOC Red Book offer information about other support available within the region. ‘Community Connecting’ is a partnership between Places for People Scotland and the Volunteer Centre, Edinburgh, supporting older people to increase their confidence and make connections in their local area. No one directory fits all needs, so using a one stop phone help line such as provided by LOOPs is useful.

GPs recognise the valuable service provided by these community assets and will signpost to help when possible. However during a busy surgery consultation, or a home visit, signposting may not be a top priority. We need to find other ways to encourage older people to ask for help and find out what is available in their community.

Detailed information about older people’s services is available at:  
<http://www.evocredbook.org.uk/>  
<http://www.evoc.org.uk/partnership/loops>  
<http://www.loopsprojects.org.uk/>  
[http://www.edinburgh.gov.uk/info/20080/edinburgh\\_choices](http://www.edinburgh.gov.uk/info/20080/edinburgh_choices)  
<http://www.alliance-scotland.org.uk/what-we-do/projects/a-local-information-system-for-scotland-aliss/>  
<https://portal.livingitup.org.uk>  
<http://www.volunteeredinburgh.org.uk/home>  
<http://www.placesforpeople.co.uk>

There are around 6 million unpaid carers in the UK. Increasingly carers are old themselves, and many couples provide mutual ‘partial’ care for each other, potentially increasing vulnerability if one half of the partnership is ill. There has been a welcome emphasis on carer support in Lothian but this needs to be integrated into the new H&SCP structures so that *acute carer failure* can be immediately responded to, preventing unnecessary admissions of the cared-for.

## **2. ADMISSIONS AVOIDANCE.**

### **Hospital at Home**

In England the number of hospital beds has fallen by a THIRD in the last 25 years<sup>10</sup> - presumably Scottish trends are similar. So Primary Care has already ‘absorbed’ a huge workload despite a SMALLER and FALLING share of overall funding. A further huge shift is anticipated with admissions avoidance work – and this will

require extensive new resource in GP, Community Nursing, the extended MDT and Medicine for the Elderly teams. This needs to be defined and funded in the strategy implementation plans. To address the aim of reducing emergency bed days, the King’s Fund analysis, suggests that LENGTH of stay is the crucial factor:

*“The majority of emergency bed days are used by patients who stay more than two weeks. Most emergency admissions are short: 50 per cent of patients admitted as an emergency stay for one day or less. However, the 10 per cent of patients who stay for more than two weeks account for more than half of all emergency bed days”<sup>11</sup>.*

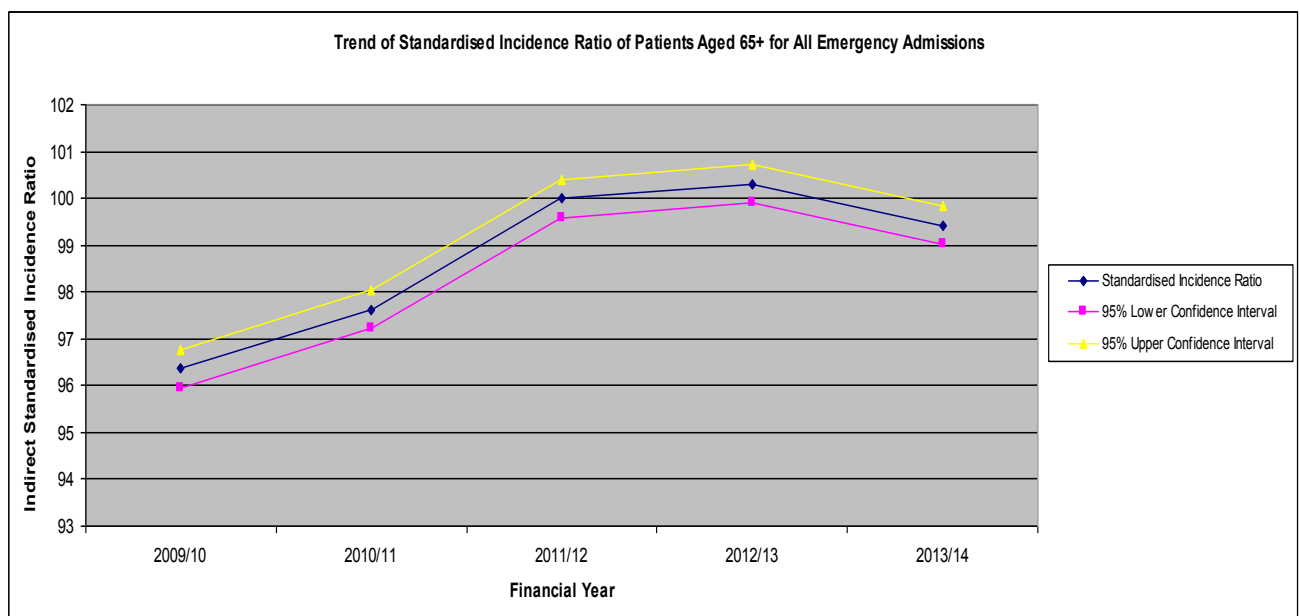
And most of these longer stay patients are older: for those hospitalised for more than a fortnight, 80% are over 65 and 30% over 85. Yet it is estimated that around 40-50% of bed days are for patients who could be cared for in alternative settings, albeit with additional medical input. Hospitals need to change practice too: optimising care for those with delirium and dementia reduces stays, as do more frequent ward rounds, and comprehensive geriatric assessment. But such changes ABSOLUTELY depend on establishing new structures and resource in the community: NHS Lothian is of course starting with a disadvantage compared with many other Boards because of its failure to adequately expand or support General Practice over the course of at least a decade. This can only be seen now as having created a huge and potentially unresolvable liability – disastrous in planning terms.

Hospitalisation is very damaging for patients too – not only distressing but also harmful in health terms. In the elderly, admissions to acute hospitals are associated with increased risks of life-threatening infections, falls and delirium, all of which have long-term consequences<sup>12</sup>. Prolonged admissions for dementia can result in worsening function, both mental and physical<sup>2</sup>. Structured planning, and particularly co-ordination with social care, reduces readmission rates. The evidence suggests that continuity of GP care prevents hospitalisation too<sup>13</sup>. Early interventions (intermediate care) can not only reduce hospitalisation rates, but help maintain independent living. In the case of dementia, they can improve quality of life and reduce admissions to care homes<sup>2</sup>. A Comprehensive Geriatric Assessment has been shown to increase patient’s survival (and being at home at 12 months), but only in the context of an MDT assessment on a geriatric ward, rather than when visited on another ward<sup>12</sup>. However in 2013, 40% of admissions to the RIE were aged >65, a quarter of whom were considered frail, yet only 30% of these patients were admitted under MoE.

Hospital at Home for admissions avoidance and similar schemes has been shown to be as effective as inpatient care, but with higher patient satisfaction, reduced mortality, and reduced costs (although the Cochrane review concluded that other outcomes were largely unchanged and comparisons difficult because of the small numbers of well-conducted trials and diversity of conditions and interventions)<sup>15</sup>.

It will be crucial that this core cross-sector planning maintains its direction in the new IJB setups: both General Practice and the complex care hubs could supply ‘anchor points’ for this.

GPs and others are already supporting a stabilisation of emergency admissions in Lothian:



### Current Lothian models:

- **COMPASS** (Edinburgh, SE, NW): weekly MDT meetings with other community teams to help integrate hospital and community services - to build trust, share knowledge and improve communication. Compass Plus is now piloting a domiciliary service with 6 practices.
- **MERRIT** Hospital at Home in Midlothian is an extension of the existing effective Rapid Response and Intervention Team with additional input from AHP and MoE Consultant, and has been taking patients on a pilot basis since August 2014, mainly from GP referrals.
- **ELSIE** Service in East Lothian aims to provide a whole system integrated care pathway for older people. A major barrier to progress had been securing MoE consultant sessions.
- **REACT**: see separate paper for fuller account of a team which is said to be robust and work well.

These teams are providing a useful, though in some cases embryonic, service.

### RECOMMENDATIONS:

- The King's Fund review of the evidence relating to emergency beds in the over 65 recommends a SINGLE multidisciplinary team involved with both admissions avoidance *and* discharge facilitation. For all teams and approaches, admissions avoidance and delayed discharges should be seen as part of one workstream.
- The existing Lothian teams each have their strengths but need to be permanent, scaled up to purpose, accessible and with established relationships, both in the locality they serve and the local hospital exercising 'District General' functions.
- The teams may want to keep their local configuration but should have a common composition and approach, based on the evidence, and offer a wide menu of alternatives. The team should include physiotherapy, OT, GP, ANP, and Medicine for the Elderly input. Having specific dementia staff (on wards) has been shown to facilitate earlier discharge and improve outcomes for those admitted<sup>2</sup>. The recommended dementia specialist team for wards should directly relate to this team too, with strengthening of community psychiatry team input as well.
- The generic 'complex care hub' (CCH) needs to have a Single Point of Access (SPA), available 24/7, with clear, one stop mechanisms for access, both in and out of hours. Response times need to be fast eg 2 hours (daytime).
- Access would be with a single phone-call, the Hub then accepting the assessment of risk and ongoing management, and arrange all subsequent care including transport.
- Patients in 'Hospital at Home' do not require the input of their GP following their 'admission'.
- Referral criteria might start with age (>75) but could account for frailty status too.
- These CCHs need to be able to provide same day placements (care / nursing homes or Step Up) as alternatives to admission for those with acute illness-frailty needs.
- New salaried GP workforce – to work JOINTLY in these teams the new Care Home 'practices' and some sessions in practices - *may also provide an alternative and new workstream for those who want a more defined working day* – the aim would be to recruit and retain, rather than divert the current GP workforce. Similar joint posts with LUCS should also be considered.
- There may be retired GPs (and other health professionals) who would be willing to work in new posts – supporting discharge arrangements on wards or anticipatory care planning, which might not even require them to maintain registration but continue to use their skills and knowledge.
- There would need to be agreed ways of working with LUCS, too.

**The Alzheimer's Society<sup>2</sup> has outlined that people with dementia over 65\***: occupy around a quarter of acute beds; account for almost half of those admitted aged over 80; two thirds no longer need to be on acute wards; have longer admissions and more complications than those without the disease and 43% are due to just two potentially ambulatory care conditions (pneumonia, UTI). People with dementia stay longer

in hospital than other people admitted for the same procedure. The longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual's physical health: discharge to a care home becomes more likely and antipsychotic drugs are more likely to be used. Admission is associated with declining function and increased likelihood of care home placement at discharge (for those admitted from home), yet the finding was that 68% did not need acute hospital care on a point prevalence survey. Over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home setting.

The report finds that supporting people with dementia to leave hospital one week sooner than they currently do for 4 diagnoses alone could result in savings of at least £80 million a year\*..... yet less than a fifth of patients with dementia discharged from hospital were offered additional support to help them recover (eg physiotherapy, OT). The Society recommends that resources would be far better used in community and intermediate care settings. \*English, Wales and N. Ireland figures, 2009.

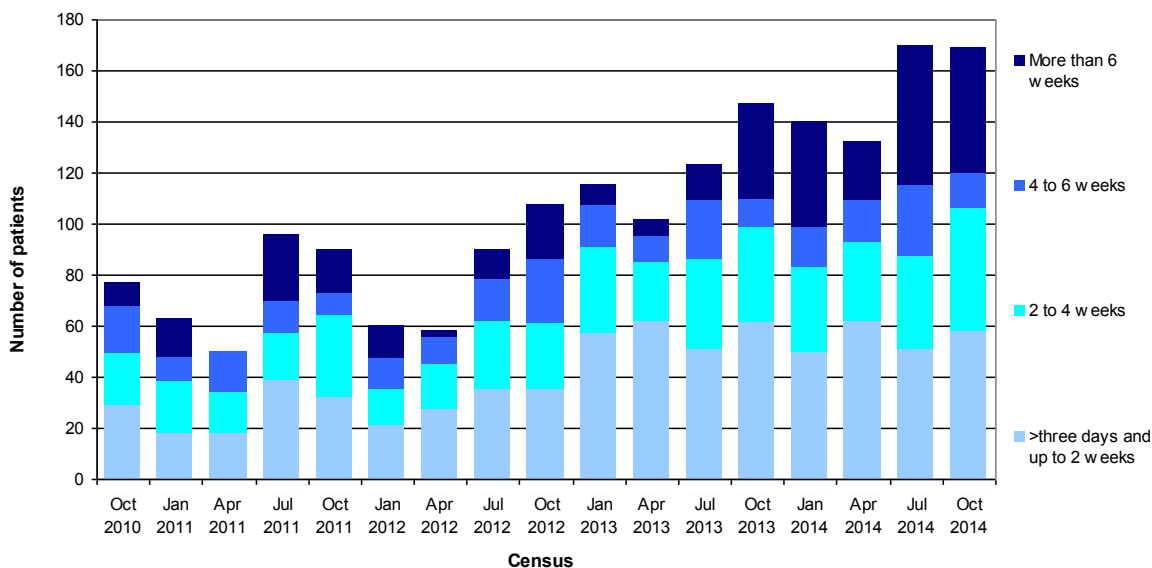
The King's Fund recommendation is for health care planners to at least recognise the financial impact of this care, and that it is set to grow further. Efficiency savings depend on planning for this and shifting resource into community settings, including intermediate care, and commissioning dementia clinical teams to manage patients on acute hospital wards. The other emphasis is on staff training and support and care planning with the active involvement of patients and their carers. (NB: Many of the day-to-day hospital issues – both problems and solutions - identified by nursing staff and carers, apply to Care homes too.)

The indications are that this work should be prioritised, with the emerging principles to 'discharge to assess' and 'decide to admit'. The former depends on rapid action 'wraparound' integrated teams - we simply do not have these in Lothian, which means that 2020 Vision is not currently feasible.

**DELAYED DISCHARGES**

In the last quarter of 2014, Lothian had 36,367 delayed discharge bed days – by far the highest in Scotland and almost 8.5 thousand more than the next Health Board (Greater Glasgow and Clyde). As delayed discharges largely relate to Community facilities, this is extremely worrying for the future, particularly as NHS Lothian is still not funding 2020 Vision structures, and has the worst GP practice capacity crisis in Scotland.

**Delayed discharges - NHS Lothian:**





There is service ‘over-optimism’ round some pilot schemes – many of which have been demonstrated elsewhere NOT to improve outcomes, reduce admissions or save money. These include routine health checks in the elderly, virtual wards (with some caveats) and telehealth. All these need to be abandoned and the funding put into a small number of highly reliable, generic, established services which are *known* to work. Again the King’s Fund has shown that all the integrated multi-disciplinary team approaches which support admissions avoidance also facilitate efficient discharge work and that *one team should be used for both*. Although delayed discharges seriously disrupt the cost effectiveness of hospitals, from a patient’s and relative’s perspective, they are also simply inhumane.

### **Out-of-Hours.**

The GP Sub-Committee notes that the recent Lothian Unscheduled Care Service (LUCS) review recommends – for understandable reasons – paring down of some locally-pointing services, and streamlining of others. But FUTURE service provision needs to be on the basis of population projections – both for the elderly and care homes, and will require instead new and expanding interfaces with locality structures.

### **Lothian Unscheduled Care Service: Dr Sian Tucker.**

Currently, out of hours, all medical care is provided by LUCS. This is not what the service was set up for, nor is it sustainable in the long term with more frail elderly to be cared for within the community. Out of hours care should mirror that in hours - albeit on a pared down scale - as it will only need to respond to emergencies rather than planned routine work. Hospital at Home services should provide care 24/7 and may involve LUCS as part of the journey, but should not rely on LUCS to provide all care. In the interim, whilst services are being set up, LUCS should be part of the conversation and may be able to provide some care. However there is, as with in-hours care, a capacity issue as staffing of the service becomes more challenging due to a lack of available GPs.

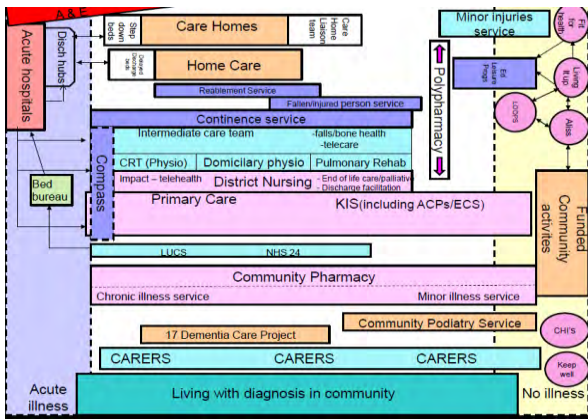
Services for frailty should recognise the 24/7 need for care and be established accordingly for the future. To attain the 2020 Vision more frail patients will remain within the community and, as this increases, so will their out of hours care needs. There should be recognition of the work for which LUCS was established and clarity about what it is now asked to do. Going forward there should be more services available within the community, be these nursing, social care or MoE colleagues to provide for an increasingly frail population resident within the community. LUCS could be accessed by these services if it was felt that an urgent GP review was required, but LUCS would not be the first point of contact for these frail patients. This will require significant changes in the current way of working but if we are to achieve the 2020 Vision it is essential that services are put in place to enable people to remain safely in the community. FUTURE service provision needs to be on the basis of population projections – both for the elderly and care homes, and will require instead new and expanding interfaces with locality structures.

Other areas are crucial too – see appendices.

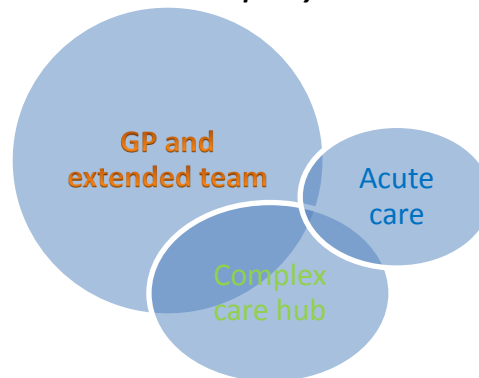
#### 4. INTEGRATION AND H&SCPs.

All the above will only work if H&SCPs do. They are also potentially a ‘danger’ to health – both through competing claims on funding but also because poor social care increases (often disproportionately) medical and nursing requirements.

*A simplified view of our current models...*



*And the new simplicity model....*



It is crucial that GPs and practices are involved at a grass roots level, and we still need to establish our working relationships with IJBs. The King’s Fund has demonstrated that council and social services were key to the achievements of those Health Authorities with the lowest emergency bed use in the over 65s<sup>10</sup>. These:

- Had larger numbers of elderly in the population and better elderly services
- Had well-developed integrated services for older people
- Had a SINGLE integrated team - good relationships were key
- Use the SAME team for admissions avoidance and discharge work
- Avoid hospital as a transition from home to supported accommodation
- Had ‘joined up’ IT – medical records
- Had simplicity of structure and purpose.

**Lothian GP Sub-Committee, April 2015**

*The Committee thanks Mr Jamie Megaw (Strategic Programme Manager: Integration and Older People's Care), Dr Sian Tucker (Clinical Director, LUCS) and Dr Andrew Coull (Clinical Director, Acute and General Medicine and Medicine for the Elderly, RIE & Liberton Hospitals) for their contributions and assistance.*

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## **APPENDIX ONE: Approaches for Funding for Frail Elderly Care and Demographic Change**

### **Defining workload is complex because:**

- Illness trajectories are unpredictable
- Patients with identical diagnoses may have hugely variable pathology, disabilities and coping strategies
- Other factors – eg carer support, deprivation, level of facilities and support in care homes are important too
- The 2017 onward GP contract will influence direction of travel: if current propositions are accepted, GPs will provide their expertise but IJBs take responsibility for ensuring much (?most) other care
- 2020 Vision requires substantial new resource in Primary Care...
- ....as does the demographic change.

It should be noted that although the WTE of community nursing staff between 2009 and 2013 has risen overall - by 1.34% (13.19 WTE) - practice list size has increased by over 3% (circa 29,000) ie resource has diminished w.r.t population and not increased in line with 2020 Vision aspirations.

The 2014-15 designated QOF Local Data Set required practices to code for housebound and those requiring a dossette box. This, and the Care Home LES practice-based figures, could act as a basis for much of this work. Planning & resource allocation can be centred on these, and also on populations over 75 (65 in those in top 15% SIMD zones reflecting the evidence base) for community and AHP staff. Case identification and risk stratification is crucial to effective care systems for the elderly (King's Fund): the IRF and other data sets are available too. Suggest continue this Local Data Set for this year – and practices to review numbers and reflect on factors of frailty and how these can be considered conceptually and in terms of intervention.

### **Probably highest GP and DN workloads relate to:**

1. Terminally ill
2. Frail – particularly housebound
3. Those in care homes
4. Age is a proxy for some of the above (particularly the very elderly)
5. Those with life-changing conditions or where multi-morbidity significantly affects function

*1-4 above can be defined using current data and it might be possible with IRF to quantify 5. Dependence on care help for everyday activities would be useful data.*

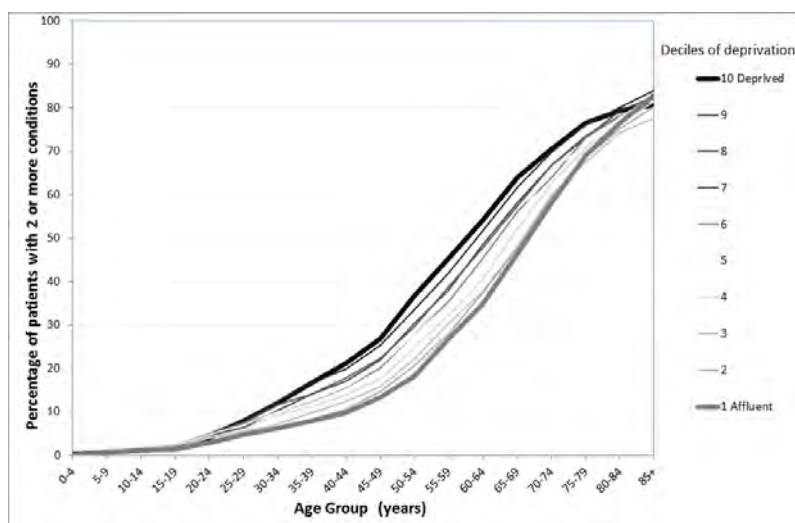
<b>Population group</b>	<b>Proxy Measure</b>	<b>Source / comments</b>
Terminally ill	Palliative care register	Practice QOF register
Frailty	<ol style="list-style-type: none"> <li>1. Housebound</li> <li>2. Need to routinely code</li> </ol>	<ol style="list-style-type: none"> <li>1. Local data set</li> <li>2. For development</li> </ol>
Care homes	Standard data sources	
Age (particularly the very elderly)	Standard data sources	Minus 10 years for populations in 15% most deprived SIMD
Multi-morbidity	<ol style="list-style-type: none"> <li>1. Severe illness codes eg MS, Renal failure, advanced dementia.</li> <li>2. Code combinations</li> </ol>	Practice data

**Current Lothian Populations and projected change: (From Strategic Plan, Appendix 1)**

Age Group	1000's			Projected Change	
	2010	2015	2020	2010-20	%
All Ages	836.7	883.7	925.2	88.5	10.58%
0-15	141.4	147.4	157.1	15.7	11.10%
16-64	571.4	595.5	613	41.6	7.28%
<b>65+</b>	<b>124</b>	<b>140.8</b>	<b>155.3</b>	<b>31.3</b>	<b>25.24%</b>

However on these projections the current Lothian *total* population is estimated at 883,700 (2015) whereas it is over 910,000 so the above will be *underestimates*. The very elderly population is set to increase by much more. Also, in 2012 the NRS (National Records Scotland) population figures for Lothian were 38,000 fewer than the numbers of people registered with GP practices.

Note that deprived populations develop multi-morbidity 10-15 years earlier, so this needs weighting for resource allocations:-



Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie. The Lancet; May 10, 2012 DOI:10.1016/S0140-6736(12)60240-2.*

**REQUIRED COSTINGS**

1. In next 5 years need to double DN team capacity to account for current deficit and for demographic change (doubling of very elderly). Historical allocations were 1 DN per 3,000 population (all ages) but staffing is now more complex, reflecting skill mix (David White, personal communication). Suggest ratios relate to housebound over 65 (over 55 for those in the most deprived SIMD (15%) Data Zones).
2. New workforce to undertake all secondary care scheduled work. This is quantifiable: bloods, other procedures (swabs etc), post-operative care including suture removal, dressings.

3. Making operational - 2020Vision, increased planned deaths at home, community work no longer done by GPs:

- a) One Senior DN (preferably an ANP) for every 60 care home patients for 2 sessions per week to deal with ALL requests for medical input = 258 sessions on current care home capacity (5,175 residents). Slightly fewer are likely as there may be less demand from nursing homes. Assuming 8 sessions per week this is 32 new senior staff WTE.
- b) Senior DNs or ANP to deal with ALL requests for housecalls in those coded as *housebound over 65* (over 55 in SIMD 5 populations) by 2020. Practice-based data required (local data sets or Vision 360).
- c) IMPACT nurses to be locality-based and support the senior DNS in their extended role of managing illness in the community. The first source of advice for DNs is the IMPACT nurse, and *then* the GP.
- d) CRT – first port of call for ALL COPD exacerbations in the housebound, referring to GP only if medical input required. Referral initially by SCI Gateway and subsequent updates where required via KIS-ACP. Numbers of housebound with COPD exacerbations will be available at least for some practices (all those undertaking the COPD SESP).
- e) REACT-style teams for each locality to cover both admissions avoidance and delayed discharge ('complex care hubs'). In 2013-14 the team managed 369 virtual ward patients and 434 rehabilitation patients and comprised:
  - Administrator – 1.0 wte Band 3
  - Consultant Geriatricians – 1.1 wte
  - Specialty Doctors – 1.1 wte
  - Advanced Nurse Practitioners – 1.0 Band 7, 2.8 Band 6, 1.4 Band 5
  - Nurse/Generic Worker – 1.06 Band 3 (support for all service)
  - Physiotherapists – 1.0 Band 6, 3.0 Band 5
  - Occupational Therapists – 1.0 Band 6, 3.0 Band 5
  - Community Pharmacist – am W/R
  - Psychiatry for the Elderly – by referral
  - Speech & Language Therapist – p/t
  - Medical Trainees – CMT, FY2, MoE STs

Many of these Lothian models developed opportunistically rather than strategically. Suggest use evidence-based model, with a standard generic team per 10,000 older patients over 75 (could consider weightings for deprivation, housebound etc). May want to include a small number of salaried GP sessions too, as well as integral SW, psychiatry for elderly and 3<sup>rd</sup> sector input. Would need to scope up to cover discharge work by the same team.

- f) Community pharmacists attached to every practice – both to free GPs for 2020 work, but also contribute to polypharmacy review. Numbers could be based on patients with more than 4 medications on repeat prescriptions – data readily available (QOF). Could also weight for severe polypharmacy (>10 items, or BNF chapter data). Such pharmacists should undertake core GP work, directed by the GP team, rather than schemes determined by others.
- g) New nursing homes for palliative care when Hospice capacity is exceeded – but with the aim of delivering holistic end of life care whilst avoiding hospital admissions/ promoting earlier discharge.
- h) Entire new workforce for any care homes (or intermediate care) where there is opt-out of GMS. (Note that the LMC has a recommended SLA for Step Down beds).

**Risk stratification.**

Models and data available include:

- **SPARRA** – which identifies a frail sub-population, but not all those who are frail and identifies many others who are at high risk of admission but not frail at all. SPARRA risks do not always correlate with GP / DN workload – but often do. The in-house modifications of the SPARRA list, required for QOF, would be more appropriate for case finding.

- We are increasingly coding for functional and dependency status (housebound, dossette, falls) and able to track patient activity (admissions, discharges, referrals including to non-medical specialties) and this will provide useful frameworks. All those on DN caseload (ie all elderly housebound and Care home patients) to be coded for frailty status (by the DN).
- Blue Matrix. This system from British Columbia ‘synthesises’ data including medical conditions and dependency / care needs and has shown to correlate well with health care needs and spends. These are evidence- based and relate to levels of medical complexity, which also accounts for multi-morbidity:

Chronic Conditions Population Segment		
CC Sub-Group	Conditions	Combinations
High Complex Chronic Conditions	Dementia Cystic Fibrosis Dialysis Transplant CHF Stroke	(Angina & COPD) (AMI & CKD_pre Dialysis) (RA & Ostpr) (DM, HTN & OA)
Medium Complex Chronic Conditions	Acute Myocardial Infarction (AMI) Pre-dialysis Chronic Kidney Disease (CKD_pre Dialysis) Chronic Obstructive Pulmonary Disease (COPD) Intervention Cardiac Procedure (CABG, PCI) Angina Rheumatoid Arthritis (RA)	(OSTPR & OA) (OSTPR & HTN) (DM & Depr) (OA & HTN )
Low Complex Chronic Conditions	Osteoporosis (Ostpr) Diabetes (DM) Hypertension (HTN) Osteoarthritis (OA) Depression (Depr) Asthma	

Data from social care, too, is integrated – and all is accessed through a single data array, the ‘Blue Matrix’ although it is possible to drill down for detail:

Use of Publicly Funded Health Care 2009/10	People (thousands)		Millions of Dollars					Grand Total	
			Physican	Hospital	PharmaCare	HCC comm	Res care		
Non User	606	13%	\$0	\$0	\$0	\$0	\$0	\$0	0%
Healthy	1,671	37%	\$345	\$0	\$9	\$0	\$0	\$354	4%
Major all ages	159	3%	\$179	\$372	\$46	\$3	\$0	\$600	7%
Low Complex Chronic Conditions	1,271	28%	\$673	\$341	\$199	\$7	\$0	\$1,221	13%
Medium Complex Chronic Cond.	343	7%	\$377	\$348	\$195	\$7	\$0	\$926	10%
Mental Health and Substance Use	103	2%	\$142	\$344	\$119	\$3	\$0	\$608	7%
Maternity and Healthy Newborns	117	3%	\$166	\$215	\$4	\$0	\$0	\$385	4%
Frail In The Community_Disability	14	0%	\$24	\$92	\$25	\$153	\$7	\$302	3%
High Complex Chronic Conditions	184	4%	\$362	\$869	\$243	\$219	\$10	\$1,703	18%
Cancer	56	1%	\$118	\$295	\$28	\$16	\$1	\$458	5%
Frail In Care (In Residential Care)	37	1%	\$60	\$349	\$48	\$41	\$1,769	\$2,267	25%
End Of Life	14	0%	\$42	\$241	\$23	\$46	\$32	\$384	4%
All Population Segments	4,574 100%		\$2,491	\$3,466	\$939	\$495	\$1,819	\$9,210	100%
			27%	38%	10%	5%	20%	100%	

The IRF is already producing robust data across similar domains and has quantified the older Lothian population in terms of health & social care costs, which have very skewed distributions:

- 5.6% of patients (aged 75+) are responsible for 50% of total health care costs
- 12.4% of clients (aged 75+) are responsible for 50% of all social care costs

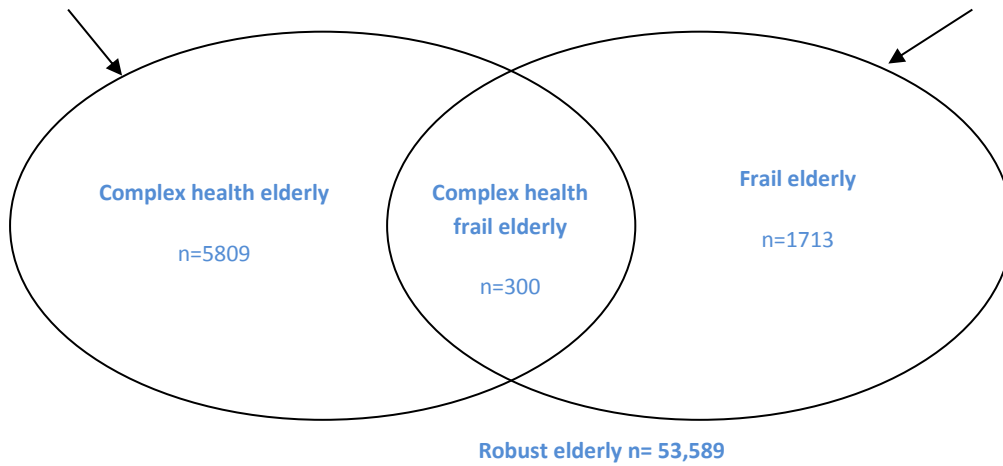
The aged 75+ population has been categorised:

1. Complex health frail elderly = High health care costs and high social care costs
2. Complex health elderly = High healthcare costs but not high social care costs
3. Frail elderly = High social care costs but not high health care costs
4. Robust elderly = low health and social care costs.

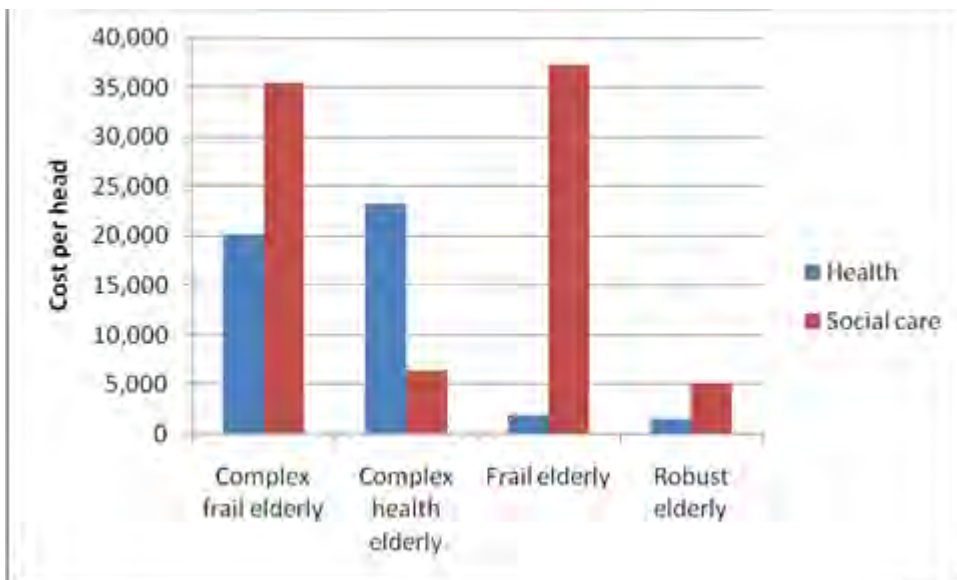
**Numbers of patients/clients in the four resource use categories (total number n=61,411):**

Top 10% healthcare resource users

Top 10% social care resource users



And the associated costings:



This approach to data should contribute to planning, particularly in the IJB setting.



## **Appendix 2: 'rules' established at 19 Dec 2014 NHS Lothian Care of Elderly workshop.**

### **COMMUNITY.**

1. Home-based frail elderly assessment is the norm.
2. We prioritise continuity of care at home.
3. Integrated community support services are organised around GP practices not home address (Torbay model).
4. Step down facilities should be able to provide rehabilitation and nursing care, including parenteral nutrition and IV antibiotics.
5. Admission to a care home from community becomes the norm - instead of admission from hospital.
6. The health and care landscape is simple to understand and simple to navigate.
7. General Practice is prioritised for GMS and is not the default for medical cover in the community for increasing frail older people who would previously have been in hospitals or nursing care homes.
8. The optimal care option is always the path of least resistance, so we want our system to make it:
  - a) Easier for a GP to arrange a package of care to keep a patient at home – than admit (to a partnership hub which can access multi-agency resources in place of bed bureau).
  - b) Easier to prescribe an L1F recommended drug for a particular indication - than any other.
  - c) Easier for a patient to speak to a member of the practice clinical team – than turn up at A&E.
  - d) Easier to refer to the third sector – than give an antidepressant.
  - e) Referral to community services should not be the sole right of GPs (eg nurses should be able to refer to podiatry).

### **HOSPITAL.**

9. No-one is in an acute hospital that does not need access to the specialist medical and diagnostic facilities there.
10. Rehabilitation is community based and most rehabilitation in hospitals is provided by in-reaching community teams. There are specific exceptions to this rule including stroke rehabilitation and post-op orthopaedic rehabilitation.
11. The health and care landscape is simple to understand and simple to navigate.
12. The optimal care option is always the path of least resistance, so we want our system to make it:
  - a) Easier for secondary care to arrange for a community blood test they are initiating – than get a GP to do it.
  - b) Easier to get a patient seen by a hospital team in daytime hours – than admit overnight due to delayed transport.
  - c) Easier for A&E to arrange for a patient to return home than be admitted regardless of the day of the week, or the hour of the day.

### **INTERFACE BETWEEN HOSPITAL AND COMMUNITY.**

13. A patient can access advice and diagnostic interventions without the need for admissions where at all possible.
14. Discharge to assess is the norm.
15. It is easier to email a specialty or speak to a consultant – than refer a patient unnecessarily.

Board Meeting  
24 June 2015

Director of Strategic Planning, Performance Reporting & Information/Chief Officer

**SUMMARY PAPER - IMPROVING OLDER PEOPLE’S CARE IN EDINBURGH - 2015-2017**

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"> <li>The investment objectives of the programme of work to improve the quality of care for older people, particularly in Edinburgh, but closely inter-related with care in East Lothian and Midlothian, are described</li> </ul>	3.2
<ul style="list-style-type: none"> <li>A more detailed discussion paper is provided which describes the progress made and underway to confirm deliverable timelines and costings for the required programme of work</li> </ul>	Appx 1
<ul style="list-style-type: none"> <li>Development of primary care and community capacity to support older people’s care at home and in homely settings is a key dependency for the success of this programme</li> </ul>	3.6
<ul style="list-style-type: none"> <li>The high level financial framework developed to date indicates that this programme overall is feasible, if supported by a bridging plan</li> </ul>	8, Appx 2
<ul style="list-style-type: none"> <li>A Programme Board is being established to oversee progress, led by the Director of Strategic Planning, Performance Reporting and Information.</li> </ul>	3.5
<ul style="list-style-type: none"> <li>The Board is asked to support the strategic direction of travel and work underway to improve the quality of care for older people in Edinburgh</li> </ul>	2.1, 2.2
<ul style="list-style-type: none"> <li>It is expected that a definitive strategy and costed plan will be developed by September and presented to the Board in October 2015</li> </ul>	2.3

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**IMPROVING OLDER PEOPLE'S CARE IN EDINBURGH, 2015-2017**

**1 Purpose of the Report**

- 1.1 The purpose of this report is to recommend that the Board support the direction of travel and work underway to develop more detailed plans to improve older people's care.

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

**2 Recommendations**

- 2.1 Support the direction of travel and the ongoing negotiations to develop a definitive plan to improve care arrangements for older people in Edinburgh through a number of related developments
- 2.2 Endorse in principle the overall strategy and request that the Edinburgh, East and Midlothian Integration Joint Boards build this work into their Strategic Commissioning Plans
- 2.3 Note the governance arrangements being established through the Programme Board
- 2.4 Request that an update on progress is provided to the Strategic Planning Committee in August and definitive costed programme plan provided in October for consideration by the Board and by the Integration Joint Boards.

**3 Discussion of Key Issues**

- 3.1 This paper and the discussion paper attached as Appendix 1 describe the programme of work to improve the quality of care for older people, particularly in Edinburgh, but closely inter-related with care in East Lothian and Midlothian, and to deliver models of care which are financially sustainable. The Board discussed the proposals set out in the attached paper in private session in April 2015 and sought further detail on the timings and costs of the various stages involved in delivering the outcomes. The attached discussion paper reflects the current progress made in developing and delivering a highly complex programme of work which will fundamentally change the nature of care for older people in Edinburgh, with a greater emphasis on supporting people at home or in homely surroundings, rather than in hospitals.
- 3.2 The investment objectives this programme seeks to achieve include:-
- Changes in the deployment of resources to be managed going forward by the Edinburgh, East Lothian and Midlothian Joint Integration Boards, to better serve the care needs of older people;
  - Increasing capacity in social care, including expanding the short-medium term role of Gylemuir House in Edinburgh;

- Significant reductions in the number of delayed discharges from hospitals in Edinburgh;
  - The closure of the Royal Victoria and Liberton Hospitals, which are outmoded and expensive, releasing revenue funding to invest in facilities and services more appropriate to the needs of older people;
  - The repatriation of delayed discharges from Edinburgh to more appropriate facilities closer to home in Midlothian and from Midlothian back to East Lothian;
  - The development of an Integrated Care Facility serving mainly North Edinburgh on the site of the Royal Victoria Hospital;
  - The redesign of Medicine of the Elderly pathways linked to RIE services, and creation of an Integrated Stroke Unit;
  - The sale and disposal of the Liberton Hospital site, once vacated;
  - The development of an Integrated Care Facility serving mainly South Edinburgh on a site currently owned by the Health Board adjacent to the Royal Edinburgh Hospital.
- 3.3 Negotiations are continuing with senior clinicians and other leaders to firm up on achievable timescales for the changes that will bring about service improvement, with an expectation that a definitive strategy, including a financial plan, will be available in September 2015. In the meantime, work continues along this 'direction of travel' in order to deliver the necessary reduction in the number of delayed discharges.
- 3.4 The majority of this programme is designed to deliver integrated health and care services for older people in Edinburgh and will be the primary responsibility of the new Edinburgh Integrated Joint Board. There are also inter-related Midlothian and East Lothian older people's service change workstreams. It is essential therefore that the programme and associated projects are fully incorporated into the three IJB's Strategic Plans.
- 3.5 To ensure focus on the changes required to deliver the plan within challenging timescales, a Programme Board is being established as a matter of priority. This will be led by the Director of Strategic Planning, Performance Reporting and Information, supported by the Chief Officer, University Hospitals Division, the Director of Nursing, Finance Director NHS Lothian and Chief Social Worker, City of Edinburgh Council. This will bring together the key stakeholders and influencers and will oversee and coordinate the work of four project teams. The Programme Board will routinely report to the Edinburgh IJB as well as to the Health Board and the City of Edinburgh Council as required.
- 3.6 A key dependency for successful delivery of this programme will be the development of primary care and community care capacity and capability to support older people's care at home and in homely surroundings. A separate report on the agenda for this meeting sets out short and medium term plans to mitigate capacity shortfalls and support infrastructure developments in primary care.

#### **4 Key Risks**

The key risks associated with this programme are:

- That the quality of care for older people is not improved, mitigated by a range of actions including the adoption of evidence-based best practice and the involvement of patients and their carers in the planning process.

- That the costs of the new models of care are not able to be sustained, mitigated by actualising real savings from disposal of outmoded facilities and robust resource deployment which moves the Health Board and other key partners towards a balanced budget.

A full risk register will be developed as part of the overall project plan and issues arising will be considered at the NHS Lothian Risk Management Steering Group and where required elevated to the Board.

## **5 Risk Register**

- 5.1 There are no new implications for NHS Lothian's risk register.

## **6 Impact on Inequality, Including Health Inequalities**

- 6.1 Impact assessments will be carried out as part of the overall project plan to confirm that proposed changes do not adversely impact on inequalities.

## **7 Involving People**

- 7.1 While a range of stakeholders across health and social care are involved in development of this programme, staff, patients and relatives remain to be consulted on a number of the propositions in this programme and this will take place as more detailed plans and timescales emerge. Short term engagement and communication priorities focus on patients, staff and relatives affected by the closure of delayed discharge beds at the Royal Victoria Hospital and the creation of the integrated stroke unit at the Royal Infirmary of Edinburgh.
- 7.2 The proposals should be incorporated into the strategic plans of the three Integration Joint Boards which have been or will be subject to wide public consultation and engagement during 2015.

## **8 Resource Implications**

The financial framework appended to the Discussion Paper contains high-level estimates, assumptions and allocations of costs which require more robust examination, but are presented for illustrative purposes at this point. This demonstrates that the project overall appears to be feasible and that the interim steps can be managed on the basis of a bridging plan.

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Martin Hill  
Strategy Consultant

## **List of Appendices**

- Appendix 1: Improving Older People's Care in Edinburgh, 2015-2017: Discussion Paper June 2015
- Appendix 2: Summary Costing

Lothian NHS Board

24 June 2015

## IMPROVING OLDER PEOPLE'S CARE IN EDINBURGH, 2015-2017

### Strategic Plan

#### 1 Title

The title of the programme outlined in this document is **"Improving Older People's Care in Edinburgh, 2015-2017"** and is composed of a complex series of four interdependent projects, as follows, along with a range of enabling schemes: -

- Replacement and closure of the Royal Victoria Hospital
- Replacement and closure of Liberton Hospital
- Development of a new Integrated Care Facility for North Edinburgh
- Development of a new Integrated Care Facility for South Edinburgh

#### 2 Introduction

The purpose of the paper is to seek consideration and approval in principle for the strategy to improve care arrangements for older people in Edinburgh through a number of related developments in the short, medium and longer term, detailed herein, and for this to inform the Initial Agreements required for the enabling developments.

***The overarching objectives of the programme are to improve the quality of care for older people and to deliver models of care which are financially sustainable.***

The Strategic Planning Committee has seen and discussed an earlier version of this paper and, on behalf of the Board, sought further detail on the timings and costs of the various stages involved in delivering the outcomes. This version reflects the progress made in a highly complex programme of work which will fundamentally change the nature of care for older people in Edinburgh, with a greater emphasis on supporting people at home or in homely surroundings, rather than in hospitals.

Negotiations are continuing with senior clinicians and other leaders to firm up on achievable timescales for the changes that will bring about service improvement, with an expectation that a definitive strategy, including a financial plan, will be available for the Board meeting in October 2015. In the meantime, work continues along this 'direction of travel' in order to deliver the necessary reduction in the number of delayed discharges as quickly as possible.

Although this programme represents 'planning in action' in dynamic and changing circumstances, it should be noted that staff, patients and relatives have still to be consulted on a number of the propositions.

### **3 Leadership and Governance**

This programme is principally designed to deliver a modern, integrated health and care service for the people of Edinburgh and, as such will be led by, and be the primary responsibility of, the new Edinburgh Integrated Joint Board. It is essential, therefore that the programme and associated projects are fully incorporated into the IJB's Strategic Plan.

In order to focus on the changes required to deliver the plan within the challenging timescales dictated by the need to improve service quality and achieve affordability, a Programme Board is being established as a matter of priority. Professor McMahon will ensure leadership and constitute the Programme Board, supported by Jim Crombie, Melanie Johnson, Susan Goldsmith and Michelle Miller. This will bring together the key stakeholders and influencers and will oversee and coordinate the work of four project teams. The Programme Board will routinely report to the IJB as well as to the Health Board and the Council as required.

### **4 Strategic Context**

#### **Strategic Plan – “Our Health, Our Care, Our Future”**

In April 2014, NHS Lothian Board approved a draft Strategic Plan, which was subsequently issued for public consultation and reported back to the NHS Lothian Board in October 2014. A subsequent Report summarising progress in the development and implementation of some of the key propositions in the Plan was presented in January 2015, along with emerging propositions in areas such as the management of acute medicines and key elements in the savings plan.

The Plan reflects considerable activity across a wide range of work streams, leading towards a clearer articulation of the 2020 Vision. What has become clear, in the interim, is the scale of the challenge in seeking to deliver the Health Board's strategic ambitions in the absence of a balanced financial position.

Work has concentrated on: -

- Finding innovative ways of delivering the strategic ambitions within a constrained financial position;
- Refining service models and identifying how current provision will need to be fundamentally reshaped to deliver the future;
- Prioritising the role of primary care and the immediate steps to address capacity challenges to support the shift in the balance of care;
- Agreeing the right 'footprint' for acute services, recognising the conflict of short-term expectations and longer term need in terms of meeting treatment time guarantees, the 4 hour waiting targets in A&E departments, delayed discharges and other performance targets;
- Reviewing and reorganising the workforce profile so that it is fit and sustainable to deliver the future.

## **5 Policy choices**

Successful delivery of the ambitions in the Strategic Plan is promulgated on the adoption by the Health Board (and other strategic partners) of a number of fundamental policy choices, including: -

- a renewed emphasis on providing services in the community, to support people to remain at home, regardless of the time of day or night, with hospital admission being the exception and only when it is clinically required;
- discharging patients as soon as possible to assess their ongoing needs at home, instead of retaining them in hospital beyond their acute clinical need;
- rehabilitating patients in their home, rather than retaining them in hospital beyond their acute clinical need;
- phasing out the provision of delayed discharge beds in hospitals, in favour of appropriate levels of social care;
- the closure and disposal of outmoded institutions and their replacement with integrated care facilities and other such models of care;
- reprofiling of the workforce to support more appropriate and contemporary models of care.

## **6 Investment objectives**

The investment objectives this programme seeks to achieve include: -

- Changes in the deployment of resources to be managed, going forward by the Joint Integration Board, to better serve the care needs of older people;
- Increasing capacity in social care, including expanding the short-medium term role of Gylemuir House;
- Significant reductions in the number of delayed discharges from hospitals in Edinburgh;
- The closure of the Royal Victoria and Liberton Hospitals, which are outmoded and expensive, releasing revenue funding to invest in facilities and services more appropriate to the needs of older people;
- The repatriation of delayed discharges from Edinburgh to more appropriate facilities closer to home in Midlothian and from Midlothian back to East Lothian;
- The development of an Integrated Care Facility serving mainly North Edinburgh on the site of the Royal Victoria Hospital;
- The sale and disposal of the Liberton Hospital site, once vacated;
- The development of an Integrated Care Facility serving mainly South Edinburgh on a site currently owned by the Health Board adjacent to the Royal Edinburgh Hospital.

The closure of Liberton Hospital will also require the relocation of the Stroke Rehabilitation services to the Royal Infirmary of Edinburgh, facilitating the provision there of a comprehensive, specialist unit to be developed to deliver best clinical practice and improved outcomes for patients.



## **7 Existing Arrangements**

The NHS Lothian Strategic Plan identified the need to review a number of specific hospital sites in Lothian. The Royal Victoria and Liberton Hospitals had been identified as having outmoded facilities and a range of services which no longer served the health and care needs of the people of Edinburgh and therefore required appropriate replacement and up to date models of care to deliver better outcomes for people.

### **Liberton Hospital**

Liberton Hospital has 152beds, of which 150 are recurrently funded in ten wards with radiology, outpatient clinics and a Medicine of the Elderly (MoE) Day Assessment Unit. The hospital specialises in acute MoE, MoE general, Stroke and Orthopaedic Rehabilitation. In 2013-14 Liberton Hospital admitted 1376 patients. 27% of patients were admitted directly by their GP, 65% were transferred from the RIE and 6% were transferred from the WGH.

The Day of Care Audit on 26th Feb 2015 identified 68 patients (45% of total inpatients) in the Hospital who could be cared for in an appropriate non-hospital setting.

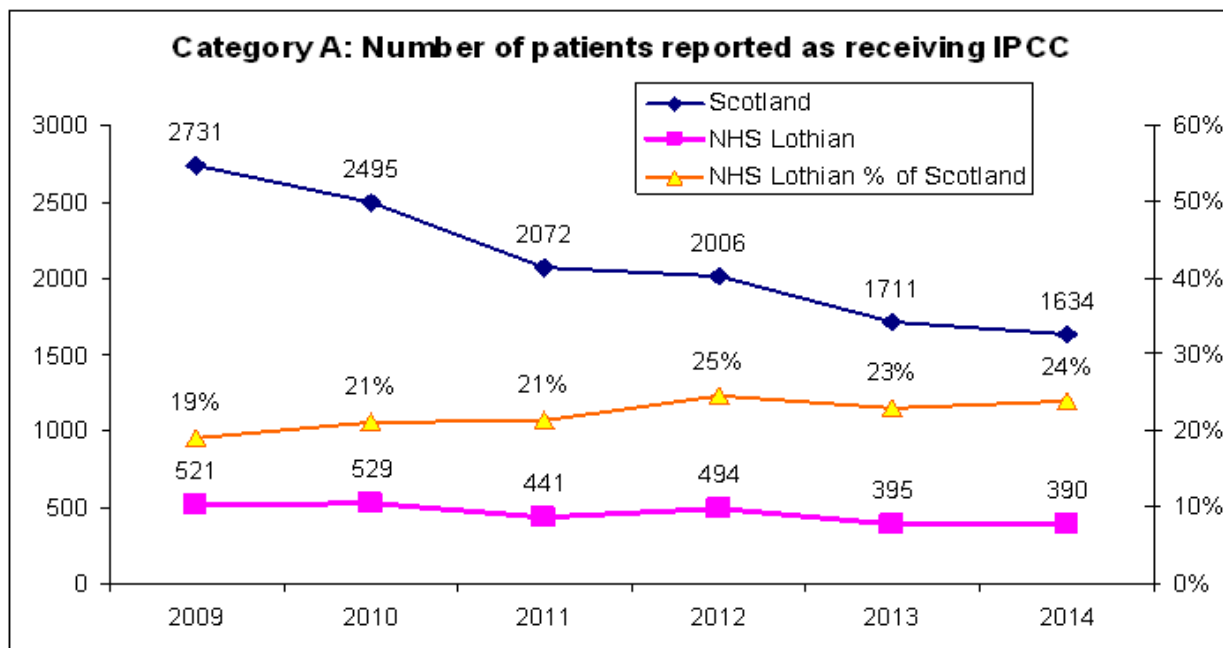
There are currently 33 patients in Liberton Hospital whose home is in Midlothian.

### **Royal Victoria Hospital**

Royal Victoria Hospital currently accommodates 122inpatients in six wards. Of these, 67 beds are recurrently funded, with the remaining 55 beds funded on a non-recurrent, unbudgeted basis.

The 55 unfunded beds are occupied by patients whose acute care and inpatient treatment have been completed, but whose discharge from hospital has been delayed due largely to a lack of social care packages or available care home places. The Scottish Government has very recently allocated £2.5m to support hospital discharge. This will initially be utilised to fund the 55 delayed discharge beds on the RVH site and will be released recurrently, to support places at Gylemuir House, other care homes and home care packages as RVH beds close.

The majority of the remaining patients are categorised as requiring inpatient continuing care (IPCC). With the imminent redefinition of IPCC following national review by the Scottish Government, it is important that a clinically-led audit is undertaken to ensure that people are not retained in hospital when they could more appropriately be living at home or in more homely surroundings. Such an audit is expected to require significantly fewer hospital beds than are currently provided, supporting the removal of outmoded hospital facilities and their replacement in more appropriate care settings. Even before the imminent redefinition, Lothian's provision of IPCC beds at March 2014 was higher than the Scottish Average, illustrated thus: -



## 8 Business Needs

The current configuration of services and the balance between hospital and community care provision is neither efficient nor sustainable. It also fails to deliver the best care for patients, but is capable of being significantly improved in ways described in this programme.

However, in the absence of long term bridging finance to support double-running, this will only be achieved by releasing the resources tied up in outmoded facilities, rapidly developing new models of care, allocating finances as part of a sustainable financial strategy and establishing a new discipline and shared priorities around the activities of the new integrated management structure. This will be a prime objective of the proposed new Programme Board

## 9 Potential Business Scope

The scope of the programme relates essentially to the actions necessary to vacate and release the Royal Victoria hospital site for the development of a new North Edinburgh Integrated Care Facility and to vacate and dispose of the Liberton Hospital site, in order to realise the full resource savings for appropriate redeployment. A major enabling resource in the immediate term is Gylemuir House, a modern BUPA-owned care home currently on a short-term (18 months) lease to City of Edinburgh Council. Provision also needs to be found in Midlothian and East Lothian, to 'repatriate' capacity in Liberton currently occupied by residents of these counties.

The programme is necessary and urgent, in order to address the pressing issues generated by an ageing population around the lack of community care capacity, patients' discharge from hospital being inappropriately delayed and the knock-on impacts including restrictions on the capacity of acute hospitals to respond to patients' unscheduled care needs. The care pathway improvement delivered by this

strategy will also benefit the wider patient population requiring hospital-based unscheduled care.

- **Replacement and closure of the Royal Victoria Hospital**
- **Development of a new Integrated Care Facility for North Edinburgh**

These projects aim to close all hospital facilities at Royal Victoria Hospital by late 2015 or early 2016, enabling the site's marketing and redevelopment as South Edinburgh Integrated Care Facility, providing a combination of up to 120 care home and short term places, together with a range of supported housing and the co-location of a new GP teaching Practice.

An assessment process is currently ongoing with a view to closing a total of 77 beds (a combination of delayed discharge, respite and IPCC beds) as quickly as possible and transferring recurring funding to support provision at Gylemuir House and to increase other care home and home care capacity, by the end of June 2015. Early consideration will also have to be given to respite capacity across the city.

The remaining wards will be closed on a phased basis throughout 2015 in accordance with the IPCC audit and review, which would release circa £4.5M of recurring costs, to be made available to fund the provision of appropriate step down, home care and care home capacity, including the redevelopment of the RVH site as an Integrated Care Facility.

- **Replacement and closure of Liberton Hospital**

This project originally aimed to close all hospital facilities at Liberton Hospital by the end of 2016, enabling site sale and disposal immediately thereafter. Replacement of Liberton capacity will require sustainably funded community capacity in an interim setting as well as step down for ongoing rehabilitation and repatriation of patients back to Midlothian. In common with the changes in North Edinburgh, this requires to be aligned with admission avoidance strategies, improved pathways for the frail elderly, improved earlier discharge and reduced risk of readmission.

The first phase of the Liberton hospital site reduction involves the closure of Wards 5-10, totalling 88 beds at Liberton during 2015 and the relocation of services to RIE (stroke and MOE), Midlothian, Gylemuir House and community care.

The second phase, completing the closure of Liberton Hospital and involving the closure of Wards 1-4, totalling 62 beds, is unlikely to take place before 2016 or 2017, with re-provision at RIE AMU and MOE.

The project also incorporates the following specific actions within its scope: -

- Support the planned creation of an integrated stroke unit at RIE and closure of stroke beds at Liberton with a reduction of 13 beds by August 2015
- Closure of a rehabilitation ward at Liberton Hospital as part of existing LRP plans with a reduction of 14 beds by October 2015

- Closure of an additional 33 beds at Liberton site with transfer of delays from Liberton and RIE to release funding for Gylemuir House and home care packages by October 2015. RIE currently has 25% delays within MoE(= 24 beds) that do not need in-patient care and would require to be accommodated at home, step-down or in interim setting. Removal of delays at RIE would allow closure of 2 wards at Liberton.
- Rationalisation of IPCC beds across Edinburgh in line with the IPCC audit and review, identifying vacated capacity to release further savings to support community funding. Inform the further changes to release capacity at Liberton in 2016 and support expansion of Acute Medical Unit at RIE in 2017.
- Note the planned relocation of Midlothian patients from Liberton to Highbank, Midlothian Community Hospital or other discharge interventions, freeing up further capacity at Liberton. It is expected funding will transfer from Liberton to Midlothian to support this transfer.

- **Development of a new Integrated Care Facility for South Edinburgh**

Although a site has been earmarked adjacent to the Royal Edinburgh Hospital for development of an ICF to serve communities in South Edinburgh and is firmly believed to be necessary in the longer term, the business case has yet to be established and this project therefore remains speculative. Planning is more advanced on the North Edinburgh ICF, which will be developed on the site of the RVH, once vacated.

## **Enabling Schemes**

- **Gylemuir House**

This is essentially a temporary, enabling facility serving the two main projects. It does, however, represent a significant improvement in environmental standards over the existing hospital provision at RVH and Liberton. The strategic intention is that, as the focus of care shifts from RVH and Liberton to the community, Edinburgh residents who would otherwise be delayed in hospital beds there will be discharged home, or to appropriate care facilities such as Gylemuir House directly from acute wards at the Western General Hospital or Royal Infirmary of Edinburgh.

Gylemuir House is a relatively modern care home, on lease to the Council, with a total capacity of 120 places, of which 60 have been recently upgraded and 30 are in use. However, funding of these 30 places was temporary and expired on 30<sup>th</sup> April 2015. The Council's intention is to move from there starting in mid-2016, as the North Edinburgh ICF and new care home capacity come on stream.

A number of permutations of the best way to use Gylemuir House are currently being discussed, although there is consensus that at least 60 places need to be retained and funded on a recurring basis, until such time as the North Edinburgh ICF or other capacity comes on stream. The Council's expectation is that the 30 places currently staffed on a non-recurring basis will be permanently funded from transfers as part of the first-phase closure of 77 beds from RVH. A further 30 beds would be opened and

permanently funded with the transfer of patients currently in delayed discharge and IPCC beds at Liberton Hospital. These 60 places at Gylemuir House would be used to test and develop innovative 'step up' and 'step down' models of care to further reduce pressure on the acute hospitals.

There is not yet agreement, nor is there an explicit rationale, for the upgrading and use of the remaining 60-place capacity at Gylemuir House. While this might seem to represent a valuable capacity which could be deployed following minor upgrading within about 2 months, if necessary, the Council believe that the additional, new care home capacity which is expected to come on stream across the city within the coming 12 months will obviate the need for such expansion at Gylemuir House.

- **Midlothian and East Lothian**

There is currently an average of 33 patients in Liberton Hospital whose home is in Midlothian. There are also a number of East Lothian residents in Midlothian Community Hospital.

The new model of care, which also supports the closure of Liberton Hospital, provides care for these 33 patients in a combination of more appropriate facilities in Midlothian Community Hospital (Edenview Ward), in Highbank (Midlothian's Intermediate Care Facility) or in a care home or at home with appropriate community support.

It is Midlothian's intention to have reduced the number of their residents in Liberton to less than 20 by the end of December 2015. The remaining bed closures are dependent on capacity being created in East Lothian to support the move of patients in Edenview Ward in MCH. Midlothian have indicated that, if this could be achieved within the same timescale, then the ambition would be that Midlothian patients would no longer use Liberton Hospital by the end of 2015.

However, the construction programme for the new East Lothian Community Hospital/ICF, including the repatriated stroke, orthopaedic and rehabilitation beds, will not be completed until late 2019. Earlier repatriation would require temporary accommodation at Herdmanflat, which could be in place by 2016, but at a higher cost of approximately £3.5m for the 3 year period of use. This raises questions of both affordability and value for money.

- **RIE – Redesign of Medicine of Elderly Pathways and Creation of Integrated Stroke Unit**

This scheme involves the redesign of Medicine of the Elderly and Stroke pathways. It encompasses the creation of an integrated stroke unit at RIE by transferring stroke capacity in Ward 10 at Liberton to RIE. The beds used for Stroke at Liberton would then be closed with a reduction of 13 beds.

The key principle of the proposal is to invest within community services including hospital at home, in-reach models including fast turnaround of patients admitted as

well as link in with plans within Midlothian to reduce reliance on beds at Liberton. The expectation is that further bed capacity can be released at Liberton, with the closure of an additional rehabilitation ward and reduction of a further 14 beds.

Closure of beds will result in a lower number of Medicine of Elderly beds and in order to ensure flow and access is maintained is part of an overall plan;

- Reduction in length of stay
- Reduction in delayed discharges and changes within discharge hub
- Processes at front door to turnaround and avoid MoE admissions with appropriate community support
- Investment in other models of care e.g. COMPASS and COMPASS + to support patients at home rather in hospital
- Potential initial transfer of some Midlothian patient to local facilities.

If successful there are further opportunities to reduce bed capacity as a result of these models of care. This has not been included in proposals at this stage and will need alternative models to be in place and successfully working, prior to implementation.

- **Additional primary and community capacity**

The modernisation of care for older people will require further development of community based health and social services to avoid unnecessary hospital admission, to support earlier discharge and to provide appropriate support to vulnerable older people living at home or in a care home. Specifically, this will include:-

- Roll out of the Compass model, extending single point of contact for GPs
- Expansion of virtual ward services
- Redesign of day hospital concept as acute frailty assessment unit
- In the longer term, creation of integrated admission hub for frail elderly aligning Bed Bureau, SAS, LUCS, Social Care Direct, NHS24, Intermediate Care, Voluntary Sector and Compass model

A paper has been developed for the Strategic Planning Committee and the NHS Lothian Board and will be brought at the same time as this paper. The two should be seen as part of the capacity and infrastructure developments required not only to strengthen general practice and primary care, but to support a different approach to meeting the needs of frail elderly people across Lothian.

Additional changes are being sought in respect of GP, nursing and pharmacy capacity in the community and in care homes. Better use of care home, step down and integrated care facilities and an increase in general practice capacity through better recruitment and retention will meet current and future need more effectively. This will also prepare NHS Lothian and the Integrated Joint Boards for the new Scottish General Practice contract changes which are due to come into effect in 2017. (See the accompanying papers on primary care capacity and frailty for more detailed descriptions of the investment required in the short, medium and long term to support a new model and way of working, in and out of hours)

## **10 Potential Benefits**

In addition to significant improvement in environmental conditions for older people requiring care, this programme will also enable more appropriate and responsive models of care to be instituted and sustained. In summary, the benefits expected to be delivered by this programme include: -

- More rapid reablement and return home or to homely surroundings for older people following unscheduled admission to an acute hospital
- Improved survival and more rapid rehabilitation and return home for stroke sufferers
- Significant reduction in number of delayed discharges
- Significant reduction in number of patients boarded into inappropriate wards
- Significant reduction in cancellation of scheduled treatments in acute hospitals
- Significantly higher likelihood of compliance with treatment time guarantees and targets
- More older people able to stay at home or in care accommodation more appropriate to their needs
- People supported to die at home rather than in an acute hospital bed

## **11 Main Risks**

The following main risks relate to the twin, principal objectives of the programme, viz. improving the quality of care for older people and delivering models of care which are financially sustainable: -

- That the quality of care for older people is not improved, mitigated by a range of actions including the adoption of evidence-based, best practice and the involvement of patients and their carers in the planning process
- That the costs of the new models of care are not able to be sustained, mitigated by actualising real savings from disposal of outmoded facilities and robust resource deployment which moves the Health Board and other key partners towards a balanced budget

There are also potential risks identified to patients care, to maintaining effective flow and to the overall financial risk. A full risk register will be developed as part of the overall project plan, which will be considered at the NHS Lothian Risk Management Steering Group and, where required, issues elevated to the Board.

## **12 Dependencies**

The key dependencies that concern the programme include the following: -

### **Liberton Hospital**

- Scottish Blood Transfusion Centre vacating the site in 2017/18
- Health Foundation (adjoining land owner)
- Scottish Government (capital receipt)
- Coordination across Lothian Integration Joint Boards (mainly Edinburgh, Midlothian and East Lothian)
- Financial viability of the revised service model
- RIE restructuring of clinical areas

### **Royal Victoria Hospital**

- CEC care capacity plans to enable closure of delayed discharge beds
- Keeping vacated beds out of use and unavailable to acute services at times of high demand
- Rapid redevelopment of site to deliver sustainable model of Integrated Care Facility, capital receipt and savings

### **Gylemuir House**

- Potential need to extend use up to and beyond 60 places
- Negotiations with BUPA, if capacity required longer than 18 months

### **Midlothian and East Lothian**

- Identifying capacity to repatriate provision

### **Additional primary and community capacity**

- A paper has been developed for the Strategic Planning Committee and the NHS Lothian Board and will be brought at the same time as this paper

## **13 Impact on Patients and Staff**

Notwithstanding the ultimate benefits in terms of better environment and improved quality of care, there is recognition that for many people, change creates uncertainty and anxiety. Ways of minimising these concerns will be factored in to the planning of the changes.

Proper assessment is required to minimise the impact of these changes on patients and to ensure that there is full involvement of them, their families and their carers in the lead up to any transitional changes being made.

Similarly, there requires to be a full process of engagement with staff likely to be affected and for transition to be in accordance with the Board's established organisational change policies and procedures. Detailed staffing plans will be prepared and agreed in advance of significant changes taking place.

## **14 Programme Content**

There are four main projects in this Programme, along with a number of enabling schemes all of which require to be delivered in order to fulfil the principal objectives of the Programme, i.e. improving the quality of care for older people and delivering models of care which are financially sustainable

Maintaining the status quo fails to deliver on any of the policy choices in para 5 or any of the potential benefits at para 10. It is also the least patient-centred and the most expensive option, involving the accommodation of patients in inappropriate hospital wards which cost more than the alternatives. This option is unsustainable in the longer term.



- **Replacement and closure of the Royal Victoria Hospital**

The aim of this project to close all hospital facilities at Royal Victoria Hospital by late 2015 or as soon as possible thereafter, enabling the site's marketing and redevelopment as North West and East Edinburgh's Integrated Care Facility.

This will involve the provision of appropriate levels of care in the community, in terms of both care home places and home care packages, sufficient to enable closure of all hospital accommodation on the RVH site on a phased basis throughout 2015. This needs to be achieved in ways which release total site costs to reinvest part in sustaining the alternative community care capacity and part in contributing to a balanced budget.

Significant service changes/development plan - implementation

Change	Start	Finish	£000, non-recur.	£000, recurring
Close 77 beds (a combination of delayed discharge, respite and IPCC beds) and transfer recurring funding to support provision of 30 places at Gylemuir House, other care homes and home care capacity	4/15	6/15	nil	- ? (net saving?)
Close the remaining 45 beds on a phased basis in accordance with the IPCC audit and review and fund the provision of appropriate step down, home care and care home capacity	6/15	12/15	nil	- ? (net saving?)

- **Replacement and closure of Liberton Hospital**

This project aims to close all hospital facilities at Liberton Hospital, ideally by 2017, enabling site sale and disposal thereafter. Replacement of Liberton capacity will require sustainably funded community capacity in an interim setting, as well as step down for ongoing rehabilitation and repatriation of patients back to Midlothian. All of this requires to be accompanied by admission avoidance strategies, improved pathways for the frail elderly, improved earlier discharge and reducing the risk of readmission.

Significant service changes - implementation

Change	Start	Finish	£000, non-recur.	£000, recurring
Create an integrated stroke unit at RIE and close stroke beds at Liberton with a reduction of 13 beds		8/15	?	?
Close a rehabilitation ward at Liberton Hospital as part of existing LRP plans with a reduction of 14 beds		10/15	nil	

Close 33 beds at Liberton with transfer of delays from Liberton and RIE to release funding for Gylemuir House and home care packages. RIE currently has 25% delays within MoE (= 24 beds) that do not need in-patient care and would require to be accommodated at home, step-down or in interim setting. Removal of delays at RIE would allow closure of 2 wards at Liberton.		10/15	nil	
Rationalise IPCC beds across Edinburgh in line with the IPCC audit and review, identifying vacated capacity to release further savings to support community funding.		?/16	nil	
Relocate Midlothian patients from Liberton to Highbank, Midlothian Community Hospital or other discharge interventions, freeing up further capacity at Liberton. Transfer funding from Liberton to Midlothian to support this transfer. This is dependent upon East Lothian patients being repatriated from Midlothian [???].		12/15	£???	
Release remaining capacity at Liberton in 2016 and support expansion of Acute Medical Unit at RIE.		3/17	£???	?

- **Development of a new Integrated Care Facility for North Edinburgh**

Initial site master planning has been undertaken into the development of this Facility on the site of the Royal Victoria Hospital, and is awaiting clarity on the service content and agreement on a financial and affordability plan.

Development plan - implementation

Stage	Start	Finish	£000, non-recur.	£000, recurring
Planning and approvals	1/15	3/16		
Site clearance/ contract procurement	3/16	9/16		
construction	9/16	6/18		
commissioning	7/18	9/18		

- **Development of a new Integrated Care Facility for South Edinburgh**

Although the former Ambulance Service HQ site adjacent to the Royal Edinburgh Hospital has been earmarked for development as an ICF to serve communities in South Central and South West Edinburgh and is firmly believed to be necessary in the longer term, the business case has yet to be established and this project therefore remains speculative.

## Development plan - implementation

Stage	Start	Finish	£000, non-recur.	£000, recurring
[Detailed planning on this project has not yet begun and is currently envisaged as a subsequent phase of the overall redevelopment of the REH site. Inclusion in Phase 1 would require early planning, a business case and contract renegotiation]				

### **15 Financial Case**

This is an extremely complex project with a number of moves and bed rationalisations, some of which could be carried out in parallel and some in series, depending upon the availability of enabling arrangements and the need to minimise uncertainty and disruption for patients and staff.

The draft financial framework at Appendix 1 contains high-level estimates, assumptions and allocations of costs which require more robust examination, but are presented for illustrative purposes. This demonstrates that the project overall appears to be feasible and that the interim steps may be able to be managed on the basis of a bridging plan.

### **16 Recommendations**

It is recommended that the Health Board

- approve in principle the overall strategic direction and request that the Edinburgh, East and Midlothian Integration Joint Boards build this work into their Strategic Commissioning Plans;
- endorse the establishment of a Programme Board to drive the programme;
- note the direction of travel and the ongoing planning and negotiations; and
- request a definitive programme plan with a firmer indication of costs and affordability to come back to the Board in October having also taken a draft of work in progress to the August Strategic Planning Committee.

15 June 2015

## Financial Framework to support closure of Liberton and Royal Victoria Hospitals

		RVH		Liberton		ML		EL / Highbank		REH		RIE		Community		Total	
		Total £m	Funded £m	Total £m	Funded £m	Total £m	Funded £m	Total £m	Funded £m	Total £m	Funded £m	Total £m	Funded £m	Total £m	Funded £m	Total £m	Funded £m
Current																	
Beds	Total	122	67	152	150											274	217
Budget	Clinical	4.8	3.0		8.5								2.5	4.8	14.0		
	Overheads	1.5	1.5		1.1									1.5	2.6		
Offsets	LRP				-0.9									0.0	-0.9		
	Reinvestment				-0.4									0.0	-0.4		
<b>Total Funding Available</b>		<b>6.212</b>	<b>4.497</b>	<b>0</b>	<b>8.417</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2.457</b>	<b>6.212</b>	<b>15.371</b>	
<b>Future</b>																	
Beds			120			0		35		60		14			0	229	
Cost	Clinical		5.6					1.8		3.0		2.4		3.0	0.0	15.7	
	Overheads		1.3							0.7					0.0	2.0	
Offsets	CEC Funding		-2.0											0.0	-2.0		
	Self Funding		-1.3											0.0	-1.3		
<b>Total Funding Required</b>			<b>3.6</b>		<b>0</b>		<b>0</b>	<b>1.8</b>		<b>3.6</b>		<b>2.4</b>		<b>2.96236</b>		<b>14.3624</b>	
<b>Funding Surplus / (Deficit)</b>			<b>0.897</b>		<b>8.417</b>		<b>0</b>	<b>-1.8</b>		<b>-3.6</b>		<b>-2.4</b>		<b>-0.5054</b>		<b>1.00864</b>	

Board Meeting  
24 June 2015

Director of Strategic Planning, Performance Reporting & Information

**PUBLIC SOCIAL PARTNERSHIPS: A VEHICLE FOR DELIVERY**

<p>Acknowledge the key role of the Public Social Partnership in the delivery of the Royal Edinburgh Campus Re-provisioning programme and NHS Lothian strategic priorities.</p>	<p><b>3.2</b> <b>6.1</b> <b>8.1</b></p>
<p>Support the four PSP workstands currently active</p>	<p><b>3.6</b> <b>3.7</b> <b>3.8</b> <b>3.9</b></p>
<p>Support the application of the PSP model to other areas of health and social care delivery which in turn will support the delivery of the NHS Lothian Clinical Strategy Framework.</p>	<p><b>3.10</b></p>

**PUBLIC SOCIAL PARTNERSHIPS: A VEHICLE FOR DELIVERY**

**1. Purpose of the Report**

- 1.1 The purpose of the paper is to summarise the progress made to date and further opportunities which Public Social Partnerships offer to NHS Lothian and partners.
- 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 Acknowledge the key role of the Public Social Partnership in the delivery of the Royal Edinburgh Campus Re-provisioning programme and NHS Lothian strategic priorities.
- 2.2 Support the four PSP workstands currently active
- 2.3 Support the application of the PSP model to other areas of health and social care delivery which in turn will support the delivery of the NHS Lothian Clinical Strategy Framework.

**3. Discussion of Key Issues**

- 3.1 Public Social Partnerships (PSPs) are strategic partnering arrangements, based on a co-planning, and co delivery approach, through which the public sector can connect with people, third sector organisations (voluntary organisations, community groups, charities, social enterprises) to share responsibility for designing services focused on responding to service user needs and improving outcomes.
- 3.2 Using a PSP approach will achieve a number of key outcomes. These include:
  - Designing services which are of the highest quality, and both effective and efficient.
  - Strengthening existing relationships and building new robust relationships with Third Sector organisations and, essentially, with service users.
  - Building knowledge of a co-production approach to designing services which could be utilised and enhanced in later stages of the redevelopment.
- 3.3 In collaboration with NHS Lothian and the City of Edinburgh Council, the Royal Edinburgh campus redevelopment programme was identified as a major opportunity to build social value and introduce a wide ranging and ambitious number of community benefit outputs using the Public Social Partnership (PSP) Model. The commitment of partner organisations to the PSP model was explicitly stated in the Initial Agreement for the programme approved by the Scottish Government
- 3.4 The Developing Markets for Third Sector Providers programme forms a key part of the Scottish Government support strategy for the Third Sector for the period 2011 - 2014 and complements other initiatives and activities including the Procurement Reform programme and the forthcoming Procurement Reform Bill. The programme, offers a

unique opportunity to develop and embed a number of leading market development solutions, including the Public Social Partnership (PSP) model, Community Benefit Clauses (CBC) and the use of Social Value throughout public sector commissioning and procurement in Scotland. The programme is being delivered by Ready for Business, a third sector led consortium called Ready for Business, KPMG, Social Value Lab and MacRoberts.

- 3.5 With support and guidance from the consortium, Ready for Business, to date four PSPs are now well established.
- 3.6 The **Wayfinder** PSP is an academic practice partnership between NHS Lothian and Queen Margaret University. The aim of the partnership is to redesign rehabilitation services for people with complex mental health needs with a focus on shifting the balance of care into the community. The Wayfinder PSP has made significant progress within the past year, moving from service design into piloting of the Wayfinder Graded Support Model, with a particular focus on the development of Grade 5 support and accommodation. Grade 5 service describes a high level of support provided in accommodation in the community.
- 3.7 **green space: art space** PSP was developed to maximise the potential of the extensive REH campus, which has lots of trees and woodland most of which will be preserved. This provides a great opportunity to develop a truly therapeutic and green environment as a priority to assist in treatment, recovery and health gain. A successful submission for £1.4million to support the green space: art space PSP was approved by Edinburgh and Lothian Health Foundation in November 2014.
- 3.8 **GameChanger** is an exciting and innovative new PSP led by NHS Lothian, Hibernian Football Club and the Hibernian Community Foundation. The aim is to unlock the power and passion associated with football and to make greater use of all Hibernian's physical, cultural and professional assets, to deliver a better, healthier future for the most vulnerable, disenfranchised or disadvantaged in our communities. There is a great potential for the inclusion of private sector within the Game Changer PSP. It is envisaged that the input of private sector working within the parameters of the partnership model, will have positive impact on the range and diversity of services that will be co-created and co- delivered by stakeholders. Over 85 partners have signed up to date.
- 3.9 **The Rivers Centre** PSP is focused on developing a specialist psychological trauma centre which will deliver open access serves to people of all ages within a community resource. The first gathering to discuss took place on 7 May with 54 people from a wide range of organisations attending. To date 18 different agencies have signed up to this PSP.
- 3.10 There is potential to develop further PSPs. Two being actively considered are:
- Creating a unique environment and living spaces for people with dementia in Lothian.
  - PSP to support and complement the activities of the new Community Hospital.

#### 4. Key Risks

- 4.1 To militate against the key risk of stakeholders not fully understanding what a PSP is stakeholder events are held at the onset of any new PSP workstream - this includes a dedicated session on what is a PSP is and what it is not. This is supplemented by stakeholders having access to training by Ready for Business.

## 5. Risk Register

- 5.1 Any risk identified will be included in the overall risk registers for the appropriate programme / project.

## 6. Impact on Inequality, Including Health Inequalities

- 6.1 Each of the PSPs have an explicit focus on addressing inequalities and health inequalities in line with the social value approach embedded within the Royal Edinburgh Campus Programme.
- 6.2 Each of the PSPs offer unique opportunities to shape the outside environment and community assets to support health gain for patients and wider communities.

## 7. Involving People

- 7.1 Each PS workstrand builds on the existing participation and engagement structures currently in place. Attendance at the initial stakeholder events is open to members of the public, people with lived experience, carer and families and staff from third sector and public sector agencies, academia and the private sector.

## 8. Resource Implications

- 8.1 A number of funding applications will continue to be made to various grant bodies to support the priorities and deliver on the aspirations of all the PSPs. Successful applications to date include:

Funding Body	Amount	Purpose	Date of award
Scottish Government Local Government and Communities Division	£65,272	Admin and Research support for PSPs	April 2014
Edinburgh and Lothian Health Foundation	£98,700	To employ green space: art space development officer for two year period and funding to support engagement activities	December 2013
Edinburgh and Lothian Health Foundation	£1,411,250	Renovation and development of the Church Centre; independent arts consultant; overarching arts strategy; range of PSP developments and activities	November 2014
Scottish Government Local Government and Communities Division	£65,272	Admin and Research support for PSPs	April 2015

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8 June 2015

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